

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK STATE IMPROPERLY
CLAIMED MEDICAID REIMBURSEMENT
FOR CONTINUOUS 24-HOUR PERSONAL
CARE CLAIMS**

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Office of Inspector General

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EXECUTIVE SUMMARY

New York State claimed at least \$12 million in Federal Medicaid reimbursement over 5 years for continuous 24-hour personal care services claims that were unallowable.

WHY WE DID THIS REVIEW

In October 2011, the Federal Government reached a settlement with the City of New York for \$70 million related to certain claims for Medicaid personal care services for beneficiaries residing in New York City. Specifically, these claims did not comply with requirements related to the authorization and reauthorization of continuous 24-hour care. On the basis of the Federal Government's findings, we audited similar claims for Medicaid beneficiaries residing outside New York City and Ulster County (we are auditing claims from Ulster County separately). Prior Office of Inspector General reviews have consistently identified Medicaid personal care services claims as an area vulnerable to waste, fraud, and abuse.

The objective of this review was to determine whether certain New York State claims for Federal Medicaid reimbursement for continuous 24-hour personal care services claims submitted by providers outside New York City and Ulster County complied with Federal and State requirements.

BACKGROUND

Personal care services provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. These nonmedical services include supporting activities related to daily living, including bathing, dressing, light housework, money management, meal preparation, and transportation.

In New York State, the Department of Health (State agency) administers the Medicaid program. Each county in the State is considered its own local social services district, except the five counties that make up New York City, which are considered a single district. Although the State agency has overall responsibility for the Medicaid program, the local districts are responsible for authorizing and arranging personal care services and monitoring the program.

Personal care services must be authorized/reauthorized prior to the initiation of services. As part of the authorization/reauthorization process, the State agency requires a physician, physician's assistant, or nurse practitioner (medical professional) to complete the order for personal care services within 30 calendar days after conducting a medical examination of the Medicaid beneficiary. Further, a registered nurse must prepare a nursing assessment based on a review of the applicable physician's order. A social assessment must also be prepared as part of the authorization/reauthorization process. In addition, individuals providing personal care services are subject to nursing supervision as well as basic and inservice training. Also, the provision of services must be supported by documentation of the time spent providing services to each patient. For continuous 24-hour personal care services, an independent medical review must be completed for each authorization and reauthorization period by the local professional director, a

physician designated by the local professional director, or a physician under contract with the local social services department.

HOW WE CONDUCTED THIS REVIEW

For calendar years 2007 through 2011, the State agency claimed Federal Medicaid reimbursement totaling approximately \$33.8 million (\$16.9 million Federal share) for 67,063 high-dollar continuous 24-hour personal care services claims submitted by providers outside New York City and Ulster County. (High-dollar claims included services for beneficiaries with total Medicaid paid amounts greater than \$10,000.) We reviewed a simple random sample of 100 of these claims.

WHAT WE FOUND

Most of the State agency's claims for Federal Medicaid reimbursement for high-dollar continuous 24-hour personal care services claims did not comply with Federal and State requirements. Of the 100 claims in our random sample, 20 complied with Federal and State requirements, but 80 did not.

These deficiencies occurred because (1) certain local districts did not comply with, and stated that they were unaware of, requirements related to continuous 24-hour personal care services and (2) the State agency did not adequately monitor the local districts and personal care providers for compliance with these requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$12,063,508 in Federal Medicaid reimbursement for high-dollar continuous 24-hour personal care services that did not meet Federal and State requirements.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$12,063,508 to the Federal Government,
- issue guidance to the local districts related to the requirements for continuous 24-hour personal care services, and
- improve its monitoring of local districts and personal care providers to ensure their compliance with Federal and State requirements related to continuous 24-hour personal care services.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our first recommendation (financial disallowance) and generally agreed with our remaining recommendations.

The State agency stated that its Office of the Medicaid Inspector General (OMIG) was in the process of receiving documentation related to our findings and will determine whether a refund is appropriate. The State agency stated that it addressed issues related to case reviews by local medical professionals, nursing assessments, and physician's orders through the issuance of policies and guidance materials to social services districts. Further, the State agency indicated that it had increased its onsite monitoring of local districts since receiving our draft report and that it had sent staff to visit each district to develop and test a new monitoring tool to identify patterns of noncompliance. Finally, the State agency stated that OMIG is conducting audits of 24-hour personal care services providers as part of its normal auditing and monitoring of the personal care program.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We applaud the State agency's efforts to improve its statewide education and monitoring efforts as they relate to 24-hour personal care services.

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INTRODUCTION

WHY WE DID THIS REVIEW

In October 2011, the Federal Government reached a settlement with the City of New York for \$70 million related to certain claims for Medicaid personal care services for beneficiaries residing in New York City. Specifically, these claims did not comply with requirements related to the authorization and reauthorization of continuous 24-hour care. On the basis of the Federal Government's findings, we audited similar claims for Medicaid beneficiaries residing outside New York City and Ulster County.¹ Prior Office of Inspector General (OIG) reviews have consistently identified Medicaid personal care services as an area vulnerable to waste, fraud, and abuse. Appendix A contains a list of related OIG reports on Medicaid personal care services.

OBJECTIVE

Our objective was to determine whether certain New York State claims for Federal Medicaid reimbursement for continuous 24-hour personal care services claims submitted by providers outside New York City and Ulster County complied with Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New York State, the Department of Health (State agency) administers the Medicaid program. Each county in the State is considered its own local social services district, except the five counties that make up New York City, which are considered a single district. Although the State agency has overall responsibility for the Medicaid program, the local districts are responsible for authorizing and arranging personal care services and monitoring the program.

New York's Medicaid Personal Care Program

Personal care services provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. These nonmedical services include assistance with personal hygiene, dressing, and feeding; nutritional and environmental support functions; and other health-related tasks. Under its Medicaid State plan, the State agency offers continuous 24-hour personal care services, which it defines as "the provision of uninterrupted care, by more than one person, for a patient who, because of his/her medical condition and disabilities, requires total assistance with toileting

¹ We are auditing claims from Ulster County separately.

and/or walking and/or transferring and/or feeding at unscheduled times during the day and night.”²

Federal and State Requirements Related to Continuous 24-Hour Personal Care Services

Federal regulations require Medicaid personal care services to be authorized by a physician in accordance with a treatment plan or (at the option of the State) with a service plan approved by the State. Services must be provided by a qualified individual who is not a member of the beneficiary’s family.

Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR part 225), establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards.³ To be allowable, costs must be authorized or not prohibited by State or local laws or regulations (2 CFR part 225, App. A, C.1.c).

Personal care services must be authorized/reauthorized prior to the initiation of services. As part of the authorization/reauthorization process, the State agency requires a physician, physician’s assistant, or nurse practitioner (medical professional) to complete the order for personal care services within 30 calendar days after conducting a medical examination of the Medicaid beneficiary. Further, a registered nurse must prepare a nursing assessment based on a review of the applicable physician’s order. A social assessment must also be prepared as part of the authorization/reauthorization process. In addition, individuals providing personal care services are subject to nursing supervision as well as basic and inservice training. For continuous 24-hour personal care services, an independent medical review must be completed for each authorization and reauthorization period by the local professional director, a physician designated by the local professional director, or a physician under contract with the local social services department. Finally, claims for personal care services must be supported by documentation of the time spent providing services.

For details on Federal and State requirements related to continuous 24-hour personal care services, see Appendix B.

HOW WE CONDUCTED THIS REVIEW

For calendar years 2007 through 2011, the State agency claimed Federal Medicaid reimbursement totaling approximately \$33.8 million (\$16.9 million Federal share) for 67,063 high-dollar continuous 24-hour personal care services claims submitted by providers outside

² Effective December 30, 2011, after our audit period, the State agency replaced the term “continuous 24-hour personal care services” in State regulations at 18 NYCRR § 505.14(a)(3) with “continuous personal care services.” The new language applies to individuals who require personal care services for more than 16 hours per day at times that cannot be predicted.

³ The circular was relocated to 2 CFR part 230. After our audit period, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200.

New York City and Ulster County.⁴ We reviewed a simple random sample of 100 of these claims. Specifically, we reviewed documentation maintained by local districts, providers, and physicians to determine whether the claims complied with Federal and State requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix C contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

FINDINGS

Most of the State agency’s claims for Federal Medicaid reimbursement for high-dollar continuous 24-hour personal care services claims did not comply with Federal and State requirements. Of the 100 claims in our random sample, 20 complied with Federal and State requirements, but 80 did not. Of the 80 claims, 29 contained more than 1 deficiency. The table below summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims ^a
No independent medical review	80
No nursing assessment	13
No physician’s order	9
Physician’s order not completed within 30 days of medical examination	8
No social assessment	4
Aide did not meet inservice training requirements	2
Services not documented	2
No nursing supervision	1
Aide did not receive basic training	1

^a The total exceeds 80 because 29 claims contained more than 1 deficiency.

These deficiencies occurred because (1) certain local districts did not comply with, and stated that they were unaware of, requirements related to continuous 24-hour personal care services and

⁴ High-dollar claims included those with total Medicaid paid amounts greater than \$10,000.

(2) the State agency did not adequately monitor the local districts and personal care providers for compliance with these requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$12,063,508 in Federal Medicaid reimbursement for high-dollar continuous 24-hour personal care services that did not meet Federal and State requirements.

NO INDEPENDENT MEDICAL REVIEW

State regulations require independent medical review to be completed for each authorization and reauthorization period for continuous 24-hour personal care.⁵

For 80 of the 100 sampled claims, no independent medical review was completed for the authorization or reauthorization period applicable to the service date. Officials at most local districts we visited stated that they were not aware that independent medical review was required for each authorization and reauthorization during our audit period.

NO NURSING ASSESSMENT

A nursing assessment prepared by a registered nurse and based on a review of the applicable physician's order must be prepared for each authorization and reauthorization period.⁶

For 13 of the 100 sampled claims, the local district did not provide an applicable nursing assessment completed before the service date and after the applicable physician's order.

NO PHYSICIAN'S ORDER

Personal care services must be authorized by a physician for each authorization and reauthorization period.⁷

For 9 of the 100 sampled claims, a physician's order for personal care services was not completed before the service date.

PHYSICIAN'S ORDER NOT COMPLETED WITHIN 30 DAYS OF MEDICAL EXAMINATION

A medical professional is required to complete the physician's orders for personal care services within 30 calendar days after conducting a medical examination of the beneficiary.⁸

⁵ 18 NYCRR §§ 505.14(b)(4)(i) and (b)(5)(ix).

⁶ 18 NYCRR §§ 505.14(b)(2)(iii), (b)(5)(ix), and (b)(3)(iii)(b).

⁷ 18 NYCRR §§ 505.14(b)(2)(i) and (b)(5)(ix).

⁸ 18 NYCRR §§ 505.14(b)(3)(i)(a)(1) and (b)(5)(ix).

For 8 of the 100 claims in our sample, a medical professional did not complete the physician's order within 30 calendar days of the beneficiary's medical examination.⁹

NO SOCIAL ASSESSMENT

A social assessment must be completed for each authorization and reauthorization period.¹⁰

For 4 of the 100 sampled claims, the local district did not provide us with an applicable social assessment completed before the service date.

AIDE DID NOT MEET INSERVICE TRAINING REQUIREMENTS

Personal care services must be provided by a qualified individual.¹¹ On a semiannual basis, providers must provide inservice training for at least 3 hours for each person providing personal care services (other than household functions) to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training.¹²

For 2 of the 100 sampled claims, the provider did not provide evidence that the personal care aide associated with the claim received the required inservice training for the calendar year that included the service date.

SERVICES NOT DOCUMENTED

Claims for personal care services must be supported by documentation of the time spent providing services for each beneficiary.¹³

For 2 of the 100 claims in our sample, the provider could not provide documentation supporting the time spent providing services.

NO NURSING SUPERVISION

All persons providing personal care services are subject to supervision by a registered nurse. These supervisory nursing visits must be made at least every 90 days, except when the beneficiary is self-directing and their medical condition is not expected to require any change in the level, amount, or frequency of personal care services authorized during the time period. In

⁹ To be conservative, we questioned a claim only when a medical professional had not completed the physician's order within 60 calendar days after the beneficiary's medical examination.

¹⁰ 18 NYCRR §§ 505.14(b)(2)(ii) and (b)(5)(ix). Regulations further state that the social assessment must be completed by professional staff of the local district and include a discussion with the beneficiary to determine perception of their circumstances and preferences.

¹¹ 42 CFR § 440.167(a)(2).

¹² 18 NYCRR § 505.14(e)(2)(ii).

¹³ 18 NYCRR § 505.14(h)(1).

those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months.¹⁴

For 1 of the 100 claims in our sample, there was no evidence that a registered nurse supervised the personal care aide within the 6 months before the service date.

AIDE DID NOT RECEIVE BASIC TRAINING

Personal care services must be provided by a qualified individual. Personal care aides are required to receive basic training, as approved by the State, prior to performing any service.¹⁵

For 1 of the 100 claims in our sample, the aide did not receive basic training until after the service date.

CONCLUSION

These deficiencies occurred because (1) certain local districts did not comply with, and stated that they were unaware of, requirements related to continuous 24-hour personal care services and (2) the State agency did not adequately monitor the local districts and personal care providers for compliance with these requirements. We obtained reports of monitoring visits performed by the State agency from 9 of the 14 counties in our 100-claim random sample. Of the 9 reports, only 1 listed a deficiency related to independent medical review; however, 57 of our 80 claims questioned for no independent medical review were in these 9 counties. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$12,063,508 in Federal Medicaid reimbursement for high-dollar continuous 24-hour personal care services that did not comply with Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$12,063,508 to the Federal Government,
- issue guidance to the local districts related to the requirements for continuous 24-hour personal care services, and
- improve its monitoring of local districts and personal care providers to ensure their compliance with Federal and State requirements related to continuous 24-hour personal care services.

¹⁴ 18 NYCRR § 505.14(f)(3). For all 100 sampled claims, to be conservative, we questioned a claim only if we did not find evidence of nursing supervision within 6 months of our service date.

¹⁵ 18 NYCRR § 505.14(e)(3).

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our first recommendation (financial disallowance) and generally agreed with our remaining recommendations.

The State agency stated that its Office of the Medicaid Inspector General (OMIG) was in the process of receiving documentation related to our findings and will determine whether a refund is appropriate. The State agency stated that it addressed issues related to case reviews by local medical professionals, nursing assessments, and physician's orders through the issuance of policies and guidance materials to social services districts. Further, the State agency indicated that it had increased its onsite monitoring of local districts since receiving our draft report and that it had sent staff to visit each district to develop and test a new monitoring tool to identify patterns of noncompliance. Finally, the State agency stated that OMIG is conducting audits of 24-hour personal care services providers as part of its normal auditing and monitoring of the personal care program.

The State agency's comments are included in their entirety as Appendix F.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We applaud the State agency's efforts to improve its statewide education and monitoring efforts as they relate to 24-hour personal care services.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Maryland Improperly Claimed Personal Care Services Provided Under Its Medicaid Home and Community-Based Services Waiver for Older Adults</i>	<u>A-03-11-00201</u>	4/11/2013
<i>Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims Submitted by The Whole Person, Incorporated</i>	<u>A-07-11-03170</u>	3/6/2013
<i>Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement</i>	<u>OIG-12-12-01</u>	11/15/2012
<i>West Virginia Improperly Claimed Some Personal Care Services Under Its Medicaid State Plan</i>	<u>A-03-11-00204</u>	10/3/2012
<i>New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services Made by Bayada Nurses, Inc., in Accordance With Federal and State Requirements</i>	<u>A-02-10-01001</u>	9/24/2012
<i>Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims</i>	<u>A-07-11-03171</u>	9/24/2012
<i>Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc.</i>	<u>A-06-09-00117</u>	6/15/2012
<i>Review of Medicaid Personal Care Services Claims Made by Providers in New York State</i>	<u>A-02-08-01005</u>	10/13/2010
<i>Review of Medicaid Personal Care Services Claims Made by Providers in New York City</i>	<u>A-02-07-01054</u>	6/8/2009

APPENDIX B: FEDERAL AND STATE REQUIREMENTS RELATED TO CONTINUOUS 24-HOUR PERSONAL CARE SERVICES

FEDERAL REQUIREMENTS

Section 1905(a)(24) of the Social Security Act authorizes personal care services under the Medicaid State plan. Federal regulations (42 CFR § 440.167) define personal care services as services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (1) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home, or at the State's option, in another location.

OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR part 225), establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. To be allowable, costs must be authorized or not prohibited by State or local laws or regulations (2 CFR part 225, App. A, C.1.c).

STATE REQUIREMENTS

State regulations (18 New York Compilation of Codes, Rules and Regulations (NYCRR) §§ 505.14(b)(4)(i) and (b)(5)(ix)) specify that all continuous 24-hour personal care services must receive an independent medical review with each authorization and reauthorization period. The independent medical review should be completed by the local professional director, a physician designated by the local professional director, or a physician under contract with the local social services department. Each independent medical review should include a review of the physician's order, the social assessment, and the nursing assessment. Also, there should be evidence in the medical records/case records that indicates that the patient requires total assistance with toileting, walking, transferring, and/or feeding.

State regulations (18 NYCRR §§ 505.14(b)(2)(iii), (b)(5)(ix), and (b)(3)(iii)(b)) specify that the nursing assessment shall be completed for each authorization and reauthorization period by a nurse from the certified home health agency, or a nurse employed by the local social services department, or a nurse employed by a voluntary or proprietary agency under contract with the local social services department. The nursing assessment must include a review and interpretation of the physician's order.

State regulations (18 NYCRR §§ 505.14(b)(2)(i) and (b)(5)(ix)) specify that personal care services are required to be authorized by a physician for each authorization period.

State regulations (18 NYCRR §§ 505.14(b)(3)(i)(a) and (b)(5)(ix)) specify that the physician's order form must be completed by a physician licensed in accordance with article 131 of the Education Law, a physician's assistant or a specialist's assistant registered in accordance with

article 131-B of the Education Law, or a nurse practitioner certified in accordance with article 139 of the Education Law.

State regulations (18 NYCRR §§ 505.14(b)(3)(i)(a)(1), (b)(3)(i)(b), and (b)(5)(ix)) specify that such medical professional must complete the physician's order form within 30 calendar days after he or she conducts a medical examination of the patient, and the physician's order form must be forwarded to a social services district. A physician must sign the physician's order form and certify that the patient can be cared for at home and that the information provided in the physician's order form accurately describes the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks, at the time of the medical examination.

State regulations (18 NYCRR §§ 505.14(b)(2)(ii), (b)(3)(ii), and (b)(5)(ix)) specify that the social assessment shall be completed by professional staff of the local social services department on forms approved by the State Department of Social Services. The social assessment shall include a discussion with the patient to determine perception of his/her circumstances and preferences. The social assessment shall include an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and shall consider all of the following: (1) number and kind of informal caregivers available to the patient, (2) ability and motivation of informal caregivers to assist in care, (3) extent of informal caregivers' potential involvement, (4) availability of informal caregivers for future assistance, and (5) acceptability to the patient of the informal caregivers' involvement in his/her care. The social assessment shall be completed on a timely basis and shall be current.

State regulations (18 NYCRR § 505.14(e)(2)(ii)) specify that inservice training shall be provided, at a minimum, for 3 hours semiannually for each person providing personal care services to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training.

State regulations (18 NYCRR § 505.14(h)(1)) specify that no payment to the provider shall be made for an authorized service unless the provider's claim is supported by documentation of the time spent in provision of service for each individual patient.

State regulations (18 NYCRR § 505.14(f)(3)) specify that nursing supervision must assure that the patient's needs are appropriately met by the case management agency's authorization for the level, amount, frequency, and duration of personal care services and that the person providing such services is competently and safely performing the functions and tasks specified in the patient's plan of care.

The nursing supervisor must make nursing supervisory visits at least every 90 days. However, supervisory and nursing assessment visits may be combined and conducted every 6 months when the patient is self-directing, and the patient's medical condition is not expected to require any change in the level, amount, or frequency of personal care services authorized during this time period.

State regulations (18 NYCRR § 505.14(e)(3)) specify that before performing any services, each person providing personal care services, other than household functions, shall successfully complete the prescribed part of the basic training program.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 67,063 high-dollar continuous 24-hour personal care claim lines, totaling \$33,775,230 (\$16,887,615 Federal share), submitted by 57 personal care providers outside New York City and Ulster County for the period January 1, 2007, through December 31, 2011. (In this report, we refer to these lines as claims.)

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information file for our audit period, but we did not assess the completeness of the file.

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's offices in Rensselaer, New York, at 14 local district offices, and at 30 personal care providers and 65 physician offices throughout New York State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of the Medicaid personal care services program;
- ran computer programming applications at the Medicaid Management Information System (MMIS) fiscal agent¹⁶ that identified a sampling frame of 67,063 high-dollar continuous 24-hour personal care services claims, totaling \$33,775,230 (\$16,887,615 Federal share), submitted by providers outside New York City (excluding those in Ulster County, which we are auditing in a separate review)¹⁷;
- selected a simple random sample of 100 claims from the sampling frame of 67,063 claims, and, for each of the 100 claims, reviewed:
 - the local district's documentation supporting the claim,
 - the provider's documentation supporting the claim, and

¹⁶ The State agency has contracted with Computer Sciences Corporation to be its MMIS fiscal agent.

¹⁷ High-dollar claims included those with total Medicaid paid amounts greater than \$10,000.

- documentation from the physician ordering the personal care services to determine whether a medical professional had examined the beneficiary within 30 days before the order was signed.
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 67,063 claims; and
- discussed our results with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population was Medicaid continuous 24-hour personal care services claim lines (claims) submitted by New York State providers outside New York City and Ulster County, for which Medicaid paid more than \$10,000 per beneficiary, during our January 1, 2007, through December 31, 2011, audit period.

SAMPLING FRAME

The sampling frame was a computer file containing 67,063 detailed claims for continuous 24-hour personal care services for beneficiaries with a total of more than \$10,000 Medicaid paid. The total Medicaid reimbursement for the 67,063 claims was \$33,775,230 (\$16,887,615 Federal share). The Medicaid claims were extracted from the claim files maintained at the State's MMIS fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim for 24-hour personal care services.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with the unallowable claims at the lower limit of the 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
67,063	\$16,887,615	100	\$24,870	80	\$19,733

Estimated Unallowable Costs

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$13,233,810
Lower limit	12,063,508
Upper limit	14,404,112

APPENDIX F: STATE AGENCY COMMENTS



**Department
of Health**

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 16, 2015

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-12-01004

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-12-01004 entitled, "New York State Improperly Claimed Medicaid Reimbursement for Continuous 24-Hour Personal Care Claims."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
Thomas Meyer
Robert Loftus
James Cataldo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Diane Christensen
Lori Conway
OHIP Audit SM

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-12-01004 entitled
“New York State Improperly Claimed Medicaid Reimbursement for
Continuous 24-Hour Personal Care Claims”**

The following are the New York State Department of Health’s (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-12-01004 entitled, “New York State Improperly Claimed Medicaid Reimbursement for Continuous 24-Hour Personal Care Claims.”

General Comments:

New York State’s (NYS) Personal Care Services Program (PCSP) was established in 1973 and is one of the oldest and largest in the country. Regulations were developed when the program largely served elderly women living alone who had some informal supports and who had occasional need for assistance with the activities of daily living. As a result of federal initiatives and incentives to rebalance states’ long term care systems, individuals formerly cared for in institutional settings are now served in their homes and community. Today’s PCSP population includes mentally and physically disabled children and younger adults and elderly with co-morbidities whose health and safety are dependent upon the availability of personal care services. NYS has long been nationally recognized as a leader in the development of innovative long term care programs and services which allow individuals to remain in their homes and communities.

NYS continues to successfully implement the transition of individuals in need of community based long term care services for more than 120 days to a managed long term care (MLTC) service model. The transition is close to statewide as of December 22, 2014 with remaining counties scheduled to transition to mandatory status in early 2015. The transition began with the PCSP and has extended to the Consumer Directed Personal Assistance Program (CDPAP), Certified Home Health Services, Private Duty Nursing and the Long Term Home Health Care Program.

To better understand member’s experiences as they transition from fee-for-service (FFS) to MLTC, New York’s Enrollment Broker, New York Medicaid Choice, conducts a post enrollment Outreach survey with questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant; consistently over 86 percent of consumers polled expressed satisfaction with the transition and the consistence services. The Department has also developed policies and procedures during the transition to assure the integrity of the home care services provided to all consumers.

The MLTC program meets the budget neutrality requirement. Projected expenditures for both population groups served by the programs, Adults Ages 18-64 Duals and Adult Ages 65+ Duals are lower than they would have been without the Partnership MLTC Program. MLTC Adult Ages 18-64 Expenditures: For MLTC Adults Ages 18-64 Duals, expenditures without the waiver would have been 2.1 percent greater than the waiver. For the one year period Federal Fiscal Year (FFY) 2011-2012 through FFY 2012-2013, the waiver has yielded \$25.7 million in projected savings.

A link to the Medicaid Redesign Team (which includes PCSP reforms) and the reports linked to the success of the transition of the personal care services program, as well as other community based FFS programs, is as follows:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/interim_eval_report.pdf

Recommendation #1:

Refund \$12,063,508 to the Federal Government.

Response #1

The Office of the Medicaid Inspector General (OMIG) requested, and is in the process of receiving the documentation for review from OIG. After review of that documentation, OMIG will determine if a refund is appropriate.

Recommendation #2:

Issue guidance to the local districts related to the requirements for continuous 24-hour personal care services.

Response #2

The Department has issued many policies and guidance materials since the audit period occurred in an effort to reinforce compliance with 24-hour cases. Attachment A lists examples of PCSP and/or CDPAP materials shared with districts by subject matter and date.

Recommendation #3:

Improve its monitoring of local districts and personal care providers to ensure their compliance with Federal and State requirements related to continuous 24-hour personal care services.

Response #3

The OMIG is currently conducting these types of audits as part of its normal auditing and monitoring activities of personal care providers.

As stated in Response # 2, the Department has issued many policies and guidance materials since the audit period occurred in an effort to reinforce compliance with 24-hour cases. Attachment A lists examples of PCSP and/or CDPAP materials shared with districts by subject matter and date.

Conclusion:

The Department concludes the following:

1. Of the 100 claims in the random sample outside NYC and Ulster County, 80 were out of compliance with Federal and State requirements and 29 contained more than one deficiency. These claims were primarily out of compliance because the local districts were unaware of the requirements pertaining to the requirement for a local medical professional to review 24-hour personal care service cases. The Department has since resolved this issue by issuing policies that articulate how the program must be administered.
2. The draft report states that 13 of the 100 sampled claims did not have a nursing assessment before the assessment date and after the physician's order. Districts have been reminded that a nursing assessment must include a review and interpretation of physician orders prior to completion of the assessment.
3. Of the sampled claims, 9 of the 100 did not have a completed physician's order prior to the service date. While a physician's order must be in place prior to the assessment of need, it is imperative even when there may be a delay in receiving an updated copy of the physician orders that services continue to be provided to assure the health and safety of the consumer in the community which is the ultimate goal of the PCSP.
4. Since the implementation of the Mainstream Managed Care and MLTC mandatory transition from FFS care, there has been a significant decrease in the number of personal care cases being served in the PCSP. For example, in NYC, the PCSP caseload has decreased from approximately 30,000 recipients to approximately 4,000 recipients.
5. The Department increased its on-site monitoring visits to local social services districts post release of OIG's audit. Each district was visited by staff from the Bureau of Long Term Care and a new monitoring tool was completed and tested; this allows for the identification of non-compliance patterns. The Department continued to release and respond to questions related to the overall programmatic guidelines of the PCSP. Questions from all districts were captured and policy clarifications issued on an as needed basis.

STATE MASTER POLICY LIST

ATTACHMENT A

Policy Name	Policy Link	Effective Start Date
Personal Care Services:		
CDPAP	https://www.emedny.org/ProviderManuals/CDPAP/PDFS/CDPAP_Policy_Manual.pdf	12/22/2011
CDPAP Documents	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/10oltc-005.pdf	08/25/2010
CDPAP Scope and Procedures	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6.pdf	09/12/2011
Attachment 1	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att1.pdf	09/12/2011
Attachment 2	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att2.pdf	09/12/2011
Attachment 3	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att3.pdf	09/12/2011
Attachment 4	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att4.pdf	09/12/2011
Attachment 5	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att5.pdf	09/12/2011
Changes to Personal Care Services Program and CDPAP Regulations Resulting from MRT #4652	http://health.state.ny.net/docs/2012adm/12adm1.pdf	04/09/2012
GIS 10 LTC 005 – CDPAP Documents	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/10oltc-005.pdf	08/25/2010
NYS UB04 Billing Guidelines – CDPAP	https://www.emedny.org/ProviderManuals/PersonalCare/PDFS/PersonalCare_Billing_Guidelines_UB04.pdf	01/04/2012
11LTC004 – CDPAP Services Provided Out of State	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/11oltc004.pdf	04/13/2011
11LTC007 – New State Law Requiring Automatic Change to No More than 8 Hours Per Week of Nutritional and Environmental Support Functions (Level 1) For Personal Care and CDPAP Consumers Who Are Authorized to Receive Only Nutritional and Environmental Support Functions	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/11oltc007.pdf	06/03/2011
Attachment 1	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/11oltc007att1.pdf	06/03/2011
Attachment 2	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/11oltc007att2.pdf	06/03/2011
Personal Home Care Manual Policy Guidelines	https://www.emedny.org/ProviderManuals/PersonalCare/PDFS/PersonalCareManual-Policy.pdf	2005
Availability of 24-Hour Split-Shift Personal Care Services	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma026.pdf	10/03/2012
GIS 06 MA/027 – Personal Care Services Contracts Notification of District Interest to Contract for the Provision Of Personal Care	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/06ma027.pdf	
http://www.health.state.ny.net/docs/dss/lc/b3b1.pdf		
2011 OLCM – 1 – Personal Care Services Program Assessment Protocols	http://www.health.ny.gov/health_care/medicaid/publications/docs/olcm/olclcm-1.pdf	08/25/2011
Attachment 1	http://www.health.ny.gov/health_care/medicaid/publications/docs/olcm/olclcm-1att1.pdf	08/25/2011
Attachment 2	http://www.health.ny.gov/health_care/medicaid/publications/docs/olcm/olclcm-1att2.pdf	08/25/2011
09OLTC005 – District Authorization of Personal Care Services Program (PCSP) and CDPAP Services for Traumatic Brain Injury (TBI) Waiver Participants	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/09oltc005.pdf	04/29/2009