

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK FOLLOWED ITS
APPROVED METHODOLOGY
FOR CLAIMING ENHANCED
MEDICAID REIMBURSEMENT
UNDER THE COMMUNITY FIRST
CHOICE OPTION**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

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A-02-17-01015

Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: February 2020
Report No. A-02-17-01015

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why **OIG** Did This Audit

In October 2015, the Centers for Medicare & Medicaid Services (CMS) approved New York's Community First Choice option (CFCO). The approval allowed New York to receive an additional 6 percent of Federal Medical Assistance Percentage (FMAP), referred to as "enhanced FMAP," for eligible home and community-based services and supports provided to individuals that would otherwise require an institutional level of care.

Under the CFCO, New York claimed enhanced FMAP for calendar year (CY) 2016 totaling \$18.6 million for fee-for-service payments and \$269 million for managed care payments. We decided to audit New York's methodology for claiming enhanced FMAP on payments made for CFCO services.

Our objective was to determine whether New York followed its CMS-approved methodology for claiming enhanced FMAP on payments made for CFCO services.

How **OIG** Did This Audit

Our audit covered \$310 million in fee-for-service payments and \$4.5 billion in managed care payments for beneficiaries determined eligible by New York. New York claimed enhanced FMAP of \$287.6 million related to these payments on its Form CMS-64s for CY 2016. We reviewed New York's CFCO eligibility determinations for 60 beneficiaries for whom New York claimed the enhanced FMAP.

New York Followed Its Approved Methodology for Claiming Enhanced Medicaid Reimbursement Under the Community First Choice Option

What **OIG** Found

New York followed its CMS-approved methodology for claiming enhanced FMAP on Medicaid fee-for-service and managed care payments made for CFCO services provided to beneficiaries that New York determined eligible in CY 2016.

What **OIG** Recommends

This report contains no recommendations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	1
Medicaid Program.....	1
Community First Choice Option.....	1
New York’s Community First Choice Option Services.....	2
How We Conducted This Audit.....	3
RESULTS OF AUDIT.....	4
APPENDICES	
A: Audit Scope and Methodology.....	5
B: State Agency Comments.....	7

INTRODUCTION

WHY WE DID THIS AUDIT

The Community First Choice option (CFCO) allows States to amend their Medicaid State plans to provide home and community-based services and supports to certain individuals who would otherwise require an institutional level of care. States receive an additional 6 percent of Federal Medical Assistance Percentage (FMAP), referred to as “enhanced FMAP,” for CFCO services. In October 2015, the Centers for Medicare & Medicaid Services (CMS) approved New York’s Medicaid State plan amendment to implement the CFCO¹ and subsequently approved a methodology for the State to claim enhanced FMAP. We decided to audit New York’s methodology for claiming enhanced FMAP on payments made for CFCO services.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) followed its CMS-approved methodology for claiming enhanced FMAP on payments made for CFCO services provided to beneficiaries that the State agency determined eligible for CFCO services during calendar year (CY) 2016.

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, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In New York, the State agency administers the Medicaid program.

States use the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64), to report actual Medicaid expenditures for each quarter. CMS uses the information on the CMS-64s to calculate the reimbursement due to the States for the Federal share of Medicaid expenditures. The Federal Government determines the Federal share amount that it reimburses to State Medicaid agencies by their FMAPs.

Community First Choice Option

Under section 1915(k) of the Social Security Act, States have the option to provide personal attendant services and supports through CFCO services to certain eligible Medicaid

¹ Specifically, CMS approved New York’s Medicaid State plan amendment on October 23, 2015, with a July 1, 2015, effective date.

beneficiaries who would otherwise qualify for an institutional level of care.^{2,3} States must provide CFCO services in a home and community-based setting and complete an assessment of the functional need of each beneficiary at least every 12 months.⁴ States that participate in the CFCO receive an additional 6 percent FMAP for CFCO services provided to eligible Medicaid beneficiaries.⁵

New York’s Community First Choice Option Services

In New York, covered CFCO services and supports include assistance with activities of daily living and health-related tasks and expenditures related transitioning beneficiaries from an institutional setting to a home and community-based setting. CFCO services do not include room and board or special education and related services.⁶

After CMS approved its CFCO, the State agency submitted to CMS a proposed methodology for claiming enhanced FMAP. In March 2016, CMS approved the proposed methodology. Subsequently, the State agency implemented processes to claim enhanced FMAP for eligible CFCO services provided in both the fee-for-service and managed care environments. Specifically, by comparing service data with demographic information (e.g., level of care assessments and residential information) contained in a beneficiary database, the State agency identified CFCO services received by eligible beneficiaries who required nursing facility level of care, were eligible for Medicaid under the Medicaid State plan, and lived in their own or a family member’s home.

² Specifically, CFCO-eligible beneficiaries must be determined to meet one of the following institutional levels of care: long-term hospital care, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. In addition, CFCO-eligible beneficiaries must have income that is at or below 150 percent of the Federal poverty level or be in an eligibility group that includes nursing facility services.

³ Social Security Act section 1915(k)(1) and 42 CFR § 441.510.

⁴ Social Security Act section 1915(k)(1) and 42 CFR §§ 441.530 and 441.535.

⁵ Social Security Act section 1915(k)(2) and 42 CFR §§ 441.590.

⁶ Social Security Act section 1915(k)(1), 42 CFR §§ 441.520 and 441.525, and New York SPA #13-0035.

Under the CFCO, the State agency claimed enhanced FMAP on its Form CMS-64s for CY 2016 for fee-for-service⁷ and managed care payments.⁸ The State agency retroactively claimed the enhanced FMAP every 6 months.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$310 million (\$174 million Federal share) in fee-for-service payments and \$4.5 billion (\$2.5 billion Federal share) in managed care payments for beneficiaries that the State agency determined eligible for CFCO services. The State agency claimed enhanced FMAP totaling \$287.6 million (\$18.6 million for fee-for-service payments and \$269 million for managed care payments) related to these payments on its Form CMS-64s for CY 2016. We analyzed claims and enrollment data to identify CFCO beneficiaries and services and traced summary amounts in the State agency's calculations to its Form CMS-64s.⁹ In addition, we reviewed a judgmental sample of 60 beneficiaries (30 fee-for-service beneficiaries and 30 managed care beneficiaries) and confirmed their assessed level-of-care scores and residential settings with the State agency's beneficiary database.¹⁰

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 A contains the details of our audit scope and methodology.

⁷ For Medicaid fee-for-service payments, the State agency paid providers directly for each CFCO service and generated a report with those payments every 6 months. The State agency then used demographic information in its beneficiary database to identify eligible beneficiaries and to claim enhanced FMAP for CFCO services provided to those beneficiaries.

⁸ For Medicaid managed care payments, the State agency paid a monthly fee, called a capitation payment, to managed care plans for all services provided to each beneficiary enrolled. Every 6 months, the State agency claimed enhanced FMAP on the portion of total managed care capitation payments that it attributed to CFCO services provided to eligible beneficiaries. To calculate the CFCO portion of managed care payments attributed to CFCO services in 2016, the State agency used the prior year's ratio of plans' reported expenses for CFCO services to total capitation payments made to the plans and applied that ratio to capitation payments made to the managed care plans during 2016.

⁹ The summary amounts showed only covered CFCO services reported in the fee-for-service and managed care payments claimed as CFCO expenditures.

¹⁰ We reviewed only the State agency's methodology for claiming enhanced FMAP. We did not review the associated CFCO services provided to beneficiaries. We plan to review these services as part of a future audit.

RESULTS OF AUDIT

The State agency followed its CMS-approved methodology for claiming enhanced FMAP on Medicaid fee-for-service and managed care payments made for CFCO services provided to beneficiaries that the State agency determined eligible in CY 2016. Accordingly, this report contains no recommendation.

In written comments on our draft report, the State agency indicated that it was pleased that OIG found compliance with the CMS-approved methodology. The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed \$310,146,772 (\$173,682,192 Federal share) in fee-for-service payments and \$4,482,417,098 (\$2,510,153,575 Federal share) in managed care payments for beneficiaries that the State agency determined eligible for CFCO services. The State agency claimed enhanced FMAP of \$287,553,832 related to these payments on its Form CMS-64s for CY 2016.¹¹

We limited our review of the State agency's internal controls to those applicable to claiming enhanced FMAP for CFCO services because our objective did not require an understanding of all internal controls over the New York Medicaid program.

We performed our fieldwork at the State agency's office in Albany, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements and guidance;
- met with CMS officials to gain an understanding of New York's CFCO;
- met with State agency officials to gain an understanding of New York's policies and procedures related to how CFCO-eligible services are provided, how beneficiary eligibility is determined, and how services are reimbursed and monitored;
- obtained from the State agency data and documentation to support the CFCO fee-for-service and managed care payments claimed for enhanced Federal reimbursement on the State agency's Form CMS-64s for CY 2016;
- obtained and analyzed New York Medicaid claims and encounter data for CFCO fee-for-service and managed care payments to identify CFCO beneficiaries and services;
- traced summary amounts from the State agency's calculations to amounts claimed as enhanced FMAP on the State agency's Form CMS-64s for CY 2016;
- obtained from the State agency sampling frames of eligible CFCO fee-for-service beneficiaries for the periods of January 2016 through June 2016 (7,679 beneficiaries) and July 2016 through December 2016 (6,356 beneficiaries);

¹¹ We reviewed only the State agency's methodology for claiming enhanced FMAP. We did not review the associated CFCO services provided to beneficiaries. We plan to review these services as part of a future audit.

- obtained from the State agency sampling frames of eligible CFCO managed care beneficiaries for the periods of January through June 2016 (153,350 beneficiaries) and July through December 2016 (172,770 beneficiaries);
- selected from the fee-for-service and managed care sampling frames a judgmental sample of 60 beneficiaries (30 fee-for-service and 30 managed care) who had payments for CFCO services in CY 2016;¹²
- for each judgmentally selected beneficiary, obtained documentation from the State agency to determine whether:
 - the beneficiary was eligible for nursing facility services with a level of care score of 5 or higher,¹³ and
 - the beneficiary resided in their own or a family member's home;¹⁴ and
- summarized the results of our audit and discussed these 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.

¹² Our judgmental sample of 60 CFCO beneficiaries consisted of 15 fee-for-service beneficiaries from January 2016 through June 2016, 15 fee-for-service beneficiaries from July 2016 through December 2016, 15 managed care beneficiaries from January 2016 through June 2016, and 15 managed care beneficiaries from July 2016 through December 2016. We ensured that each selected beneficiary had at least one corresponding payment eligible for CFCO services in CY 2016.

¹³ The nursing facility level of care is determined using a scoring index in the State agency's Universal Assessment System (UAS) web-based electronic instruments that assess the following domains: (1) Cognition and Executive Functioning, (2) Communication and Vision, (3) Mood and Behavior, (4) Functional Status, (5) Continence, and (6) Nutritional Status. Automatically calculated based on the assessment responses, a level of care score of 5 or greater establishes eligibility for several home and community-based long-term care service programs. We did not perform a medical review of the level of care to determine if the level-of-care scores were appropriate.

¹⁴ The residential/living status is part of the UAS web-based electronic instruments and documents the beneficiary's living arrangement at the time of assessment. A residential assessment score of 1 means that the beneficiary resides in a house, condominium, apartment, or room in the community, whether owned or rented by the beneficiary or another party. Also included in this category are retirement communities and independent housing for older adults or the disabled. We did not perform an independent verification of beneficiaries' residential status to determine if the reported status was appropriate.

APPENDIX B: STATE AGENCY COMMENTS



Department
of Health

ANDREW M. CUOMO
Governor

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

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

January 22, 2020

Ms. Brenda Tierney, Audit Director
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
26 Federal Plaza
New York, New York 10278

Dear Ms. Tierney:

Thank you for the Office of Inspector General's (OIG) draft report A-02-17-01015 entitled, "New York Followed Its Approved Methodology for Claiming Enhanced Medicaid Reimbursement Under the Community First Choice Option (CFCO)." We are pleased to note OIG found compliance with Center for Medicaid and Medicare Services (CMS)-approved methodology for claiming enhanced Federal Medicaid Assistance Percentage (FMAP) on Medicaid fee-for-service and managed care payments made for CFCO services provided to beneficiaries that New York determined eligible in calendar year 2016. We have no additional comments.

Sincerely,

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

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Geza Hrazdina
Dan Duffy
Erin Ives
Timothy Brown
Amber Rowan
Brian Kiernan
Jeffrey Hammond
Jill Montag
Michael Spitz
James DeMatteo
James Cataldo
OHIP Audit SM