Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED FEDERAL REIMBURSEMENT FOR CONSUMER-DIRECTED PERSONAL ASSISTANCE SERVICES THAT DID NOT MEET MEDICAID REQUIREMENTS

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

Daniel R. Levinson
Inspector General

June 2018
A-02-16-01026

Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: June 2018
Report No. A-02-16-01026

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

New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance Services That Did Not Meet Medicaid Requirements

Why OIG Did This Review

Previous OIG reviews have identified Medicaid personal care services in New York as vulnerable to waste, fraud, and abuse. Based on these results, we decided to review New York's consumer-directed personal assistance program (CDPAP) services, which include personal care, home health, and nursing services.

New York's CDPAP permits chronically ill and physically disabled beneficiaries flexibility and freedom in choosing, training, and supervising their providers. New York claimed Federal Medicaid reimbursement totaling more than $579 million for CDPAP services provided from January 2012 through June 2016 (audit period).

Our objective was to determine whether New York claimed Federal Medicaid reimbursement for CDPAP services in accordance with applicable Federal and State requirements.

How OIG Did This Review

We selected a statistical sample of 120 CDPAP claims for services provided during the audit period. We obtained and reviewed documentation to determine whether each selected claim was billed correctly.

What OIG Found

For 27 of 120 sampled claims, New York claimed Federal reimbursement for CDPAP services claims that did not meet Medicaid requirements. Specifically, New York did not provide documentation of services claimed, claimed reimbursement for services that were not authorized or supported, and claimed reimbursement for claims for which documentation was not completed in a timely manner. New York also claimed reimbursement for services provided after a 6-month authorization period had lapsed.

This occurred because New York did not effectively monitor the CDPAP for compliance with certain CDPAP requirements.

Based on our sample results, we estimated that New York improperly claimed at least $74.8 million in Federal Medicaid reimbursement during our audit period. New York's lack of effective monitoring of the CDPAP leaves the program vulnerable to misuse of Federal funds and could potentially place beneficiaries at risk of harm.

What OIG Recommends and New York's Comments

We recommend that New York refund $74.8 million to the Federal Government, reinforce guidance related to CDPAP documentation and billing requirements, and improve its monitoring of the CDPAP to ensure compliance with CDPAP requirements.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations (though it did disagree with our findings related to 24 sample claims); however, it described the actions it was taking or planned to take in response to each of our recommendations. Specifically, New York provided a list of policies and guidance materials issued during our audit period related to CDPAP compliance and requirements and stated that it continues to provide guidance on an as-needed basis through routine audits of local social services districts.

Under separate cover, New York provided documentation for 39 of the 43 sample claims questioned in our draft report. After reviewing New York's comments and the documentation provided, we revised our determinations for 16 claims and modified our statistical estimates accordingly. We maintain that our revised findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews have identified Medicaid personal care services in New York as vulnerable to waste, fraud, and abuse. Based on these results, we decided to review consumer-directed personal assistance program (CDPAP, the program) services, which include personal care services. The CDPAP permits chronically ill and physically disabled beneficiaries flexibility and freedom in choosing, training, and supervising their providers.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for CDPAP services in accordance with applicable 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.

New York's Medicaid Consumer-Directed Personal Assistance Program

New York's CDPAP is operated by the State agency. Although the State agency is responsible for the program, local social services districts[1] are responsible for authorizing CDPAP services, arranging service delivery, and monitoring the program.

New York's CDPAP permits Medicaid beneficiaries flexibility and freedom in choosing their personal care, home health, or nursing services providers. Personal care services are intended to assist beneficiaries with activities of daily living, such as bathing, light housework, or meal preparation, so that they can remain in their homes and maintain a basic quality of life. CDPAP services also include home health services (e.g., assistance with using medical devices) and nursing services (e.g., administration of medications). To receive CDPAP services, the beneficiary's social services district must authorize the services based on a physician's order, a

[1] In New York State, each county is considered its own social services district, except the five counties that make up New York City, which are considered a single district.

social assessment, and a nursing assessment.[2] The services must be provided at home and follow a specific plan of care.

The State agency requires that authorizations for personal care services be completed before the services start. The reauthorization process generally includes the same procedures as the initial authorization. After completing the authorization process, beneficiaries or, if applicable, their designated representatives may then hire their own providers.

HOW WE CONDUCTED THIS REVIEW

From January 2012 through June 2016 (audit period), the State agency claimed Federal Medicaid reimbursement for 8,214,480 CDPAP claims totaling $1,156,790,090 ($579,043,995 Federal share). We reviewed a stratified random sample of 120 of these claims.

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, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency claimed reimbursement for some CDPAP services claims that were not in accordance with Medicaid requirements. Of the 120 claims in our stratified random sample, the State agency properly claimed reimbursement for 93 claims but improperly claimed reimbursement for the remaining 27 claims. The table on the next page summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix D contains a summary of deficiencies for each sampled claim.

[2] The physician's order initiates the process and describes the beneficiary's medical condition and regimens, including any medication regimens, and his or her need for assistance with personal care services tasks. The social assessment includes a discussion with the beneficiary about his or her willingness to self-direct services and an evaluation of support to the beneficiary's care to be provided by informal caregivers, such as family and friends. The nursing assessment includes (1) a review and interpretation of the physician's order; (2) an evaluation of the functions and tasks required by the beneficiary; (3) an evaluation of whether adaptive or specialized equipment or supplies, including walkers and wheelchairs, meet the beneficiary's need for assistance; and (4) recommendations for authorization of services.

Table: Summary of Deficiencies in Sampled Claims

Deficiency Category	No. of Unallowable Claims[a]
Documentation not provided	14
Services not authorized or supported	7
Documentation not completed in a timely manner	4
Services provided outside of authorization period	3

[a] The total exceeds 27 because 1 claim contained more than 1 error.

The improper payments occurred because the State agency did not effectively monitor the CDPAP for compliance with certain CDPAP requirements.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $74,871,340 in Federal Medicaid reimbursement during the audit period.[3] Lack of effective monitoring of the CDPAP by the State agency leaves the program vulnerable to misuse of Federal funds and could potentially place beneficiaries at risk of harm.

DOCUMENTATION NOT PROVIDED

Before authorizing CDPAP services, the social services district must assess whether a beneficiary is eligible for the program. The assessment process includes a physician's order, a social assessment, and a nursing assessment.[4]

For 14 of the 120 claims in our sample, the social services district did not provide documentation that it assessed the associated beneficiary as eligible for CDPAP services. Specifically:

- for nine claims, the social services district did not provide applicable social and nursing assessments covering our sampled service date;

- for four claims, the social services district did not provide an applicable physician's order, a social assessment, and a nursing assessment covering our sampled service date; and

- for one claim, the social services district did not provide an applicable physician's order covering our sampled service date.

[3] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

[4] Title 18 § 505.28(d) of the New York Codes, Rules and Regulations (NYCRR).

The physician's order and social and nursing assessments are used to develop a plan of care that meets the beneficiary's needs. The physician's order certifies that the beneficiary can be safely cared for at home and that the information provided in the order accurately describes the beneficiary's medical condition and regimens. The social assessment provides an evaluation of the beneficiary's willingness to self-direct services. The nursing assessment includes a review and interpretation of the physician's order and an assessment of the beneficiary's needs. Lack of a signed physician's order could result in a beneficiary receiving CDPAP services when the beneficiary cannot be safely cared for at home. Further, without the completed physician's order and social and nursing assessments, the beneficiary's plan of care cannot be adequately developed.

SERVICES NOT AUTHORIZED OR SUPPORTED

No payment will be made for authorized CDPAP services unless the claim is supported by documentation of the time spent providing services for the beneficiary.[5]

For 7 of the 120 claims in our sample, the State agency claimed reimbursement for services not authorized or supported by documentation.[6] Specifically:

- for five claims, the provider billed for an incorrect number of units;[7]
- for one claim, the provider billed for more units than were authorized by the social services district;[8] and
- for one claim, the provider did not provide supporting documentation for the time it claimed it spent providing services.

[5] 18 NYCRR § 505.28(j)(3).

[6] We only questioned the number of units (e.g., hours or quarter-hours) that were not authorized or supported.

[7] For example, the personal care assistant's timesheet showed that he or she worked eight hours (eight units), but the provider billed nine units.

[8] For example, the social services district authorized 12 units, but the provider billed 48 units.

DOCUMENTATION NOT COMPLETED IN A TIMELY MANNER

The physician's order must be completed, signed, and submitted to the social services district within 30 calendar days after the medical examination.[9, 10, 11]

For 4 of the 120 claims in our sample, a medical professional did not examine the beneficiary and complete the physician's order within 30 calendar days before the physician's order was signed and submitted to the social services district.[12, 13]

SERVICES PROVIDED OUTSIDE OF AUTHORIZATION PERIOD

Authorization for CDPAP services may not exceed 6 months unless the social services district has requested and the State agency has approved authorization periods of up to 12 months.[14]

For 3 of the 120 claims in our sample, the State agency claimed reimbursement for services provided outside of the authorization period covering our sampled service date. On average, CDPAP providers billed for services on these claims 90 days after the 6-month authorization period had lapsed, and the State agency had not granted the social services districts its approval for 12-month authorization periods. Lack of a completed assessment every 6 months could potentially harm the beneficiary because the social services district cannot ensure that the beneficiary's needs are being met.

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[9] The physician, a physician assistant, or nurse practitioner must conduct a medical examination of the individual and complete the physician's order within 30 calendar days after conducting the medical examination (18 NYCRR § 505.28(d)(1)(i)). Further, the physician or other medical professional who conducted the examination must complete the physician's order by accurately describing (1) the beneficiary's medical condition and regimens, including any medication regimens, and (2) the beneficiary's need for assistance with personal care services, home health aide services, and skilled nursing tasks (18 NYCRR § 505.28(d)(1)(ii)).

[10] A physician must sign the physician's order and certify that the individual can be safely cared for at home (18 NYCRR § 505.28(d)(1)(iii)).

[11] The physician's order may be submitted by the physician, other medical professional, the beneficiary, or the beneficiary's representative (18 NYCRR § 505.28(d)(1)(iv)).

[12] For three of these claims, a medical examination date was indicated on the physician's order. For these claims, the physician's order was completed an average of 97 days after the medical exam. The order associated with the remaining claim did not indicate the date of the examination.

[13] If a medical professional had not examined the beneficiary within 60 calendar days before the date the physician's order was signed, we considered the documentation to be untimely and not in accordance with State requirements.

[14] 18 NYCRR § 505.28(e)(4). The State agency may approve a district's request for authorization periods of up to 12 months, provided that the social services district's professional staff or designee conducts a home visit with the beneficiary every 6 months.

STATE AGENCY MONITORING NOT EFFECTIVE

The improper payments occurred because the State agency did not effectively monitor the CDPAP for compliance with certain CDPAP requirements. Although the State agency conducts periodic onsite monitoring visits of its social services districts to review case records for compliance with applicable State regulations, it did not conduct monitoring visits at personal care providers or at the offices of physicians who ordered CDPAP services. In some cases, reports from the State agency's monitoring visits at social services districts noted instances of noncompliance similar to those identified in this report and recommended corrective actions. However, despite these monitoring visits and recommended corrective actions, some social services districts did not comply with requirements related to completing documentation within specified time frames. As a result, the State agency continued to improperly claim Federal Medicaid reimbursement for some CDPAP services.

RECOMMENDATIONS

We recommend that the State agency:

- refund $74,871,340 to the Federal Government,
- reinforce guidance to the social services districts and providers related to CDPAP documentation and billing requirements, and
- improve its monitoring of the CDPAP to ensure that social services districts and providers comply with CDPAP requirements.

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 recommendations; however, as detailed below, it described the actions it was taking or planned to take in response to our recommendations. With regard to our first recommendation, the State agency stated that it reviewed the 43 claims we identified as improper in our draft report and believed that 24 claims were properly reimbursed. The State agency further stated that it anticipated the additional documentation provided would have a significant impact on the refund amount in our first recommendation. Under separate cover, the State agency provided documentation for 39 of the 43 sample claims questioned in our draft report.

After reviewing the State agency's comments and the documentation provided, we revised our determinations for 16 claims and modified our statistical estimates accordingly.[15] We maintain our determinations for the remaining sample claims are valid.

POLICIES AND GUIDANCE

The State agency indicated that it issued numerous policies and guidance materials both during and after the audit period to reinforce compliance with CDPAP requirements and attached a list of these materials to its comments. The State agency also stated that it continues to provide guidance on an as-needed basis through routine audits of local social services districts.

We recognize the State agency's efforts and maintain that our recommendations are valid. The State agency should continue to reinforce guidance to social services districts and providers related to CDPAP documentation and billing requirements as well as improve its monitoring of the CDPAP. Specifically, the State agency should ensure that the local social services districts conduct assessments in a timely manner and obtain required physician's orders.

SAMPLE DESIGN

The State agency also indicated that the audit period was characterized by high levels of change across New York's Medicaid program and encompassed the transitioning of Medicaid beneficiaries from fee-for-service to managed care and managed long-term care plans. According to the State agency, the sample design does not account for the significant change over time this caused in the volume of CDPAP services provided through local districts. Such a change, the State agency argued, could affect the validity of our estimation based on our sample.

We disagree with the State agency's contention that our extrapolation could be invalid. Our overpayment estimate does not extend beyond the fee-for-service claims included in our sampling frame. We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation. The shift of beneficiaries from fee-for-service to managed care plans could have affected the size of our frame but would not have otherwise influenced our fee-for-service estimate. In addition, we appropriately handled the variability in the sampling frame, including any variability caused by changes in the Medicaid program during the audit period.[16]

[15] Specifically, we are no longer questioning 11 claims for services provided outside of the authorization period, 4 claims for services for which documentation was not provided, and 3 claims for services not authorized or supported. The total exceeds 16 because 2 claims contained more than 1 error.

[16] By recommending recovery at the lower limit of a two-sided 90-percent confidence interval, we accounted for differences in claim volume and error amounts in a manner that generally favors the State agency. In fact, our approach results in an estimate that is lower than the actual overpayment amount 95 percent of the time, regardless of the variability in the sampling frame.

The State agency's comments are included as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 8,214,480 Medicaid CDPAP claims, totaling $1,156,790,090 ($579,043,995 Federal share), that the State agency claimed for reimbursement for services provided during the audit period. We reviewed a stratified random sample of 120 of these claims. Specifically, we reviewed documentation provided to verify whether each selected claim was billed correctly.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State agency's claim for reimbursement on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medicaid Program.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We conducted fieldwork at various social services district offices throughout New York State from March through April 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with State agency officials to obtain an understanding of the procedures followed for submitting and processing CDPAP service claims;
- obtained from the State agency's MMIS electronic files that contained 8,214,480 Medicaid fee-for-service CDPAP claims, totaling $1,156,790,090 ($579,043,995 Federal share), made during our audit period;
- selected a stratified random sample of 120 claims from our sampling frame of 8,214,480 Medicaid CDPAP claims;
- obtained and reviewed documentation for each sampled claim, including the applicable authorization form, physician's order, social assessment, and nursing assessment for the beneficiary, as well as timesheets or billing documentation from providers, to determine whether the claim was billed correctly;
- summarized the results of our review;

- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 8,214,480 claims; and

- discussed our results with State agency officials.

See Appendix B for our statistical sampling methodology and Appendix C for our sample results and estimates.

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 B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of all fee-for-service CDPAP claims paid for services provided during the audit period.

SAMPLING FRAME

The sampling frame consisted of five Access database files (one per audit-period year) containing 8,214,480 Medicaid CDPAP claims totaling $1,156,790,090 ($579,043,995 Federal share) that the State agency claimed for reimbursement for services provided during the audit period. The data were obtained from the New York State MMIS.

SAMPLE UNIT

The sample unit was a CDPAP claim.

SAMPLE DESIGN

We used a stratified random sample, as follows:

- Stratum 1: CDPAP claims with total payments of less than or equal to $66.78.
- Stratum 2: CDPAP claims with total payments of greater than $66.78 and less than or equal to $117.60.
- Stratum 3: CDPAP claims with total payments of greater than $117.60.

SAMPLE SIZE

We selected 120 CDPAP claims (40 claims from each stratum).

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the claims within each stratum. After generating 40 random numbers for each of these strata, we selected the corresponding claims in the frame for our sample.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of improper Medicaid payments for unallowable CDPAP claims at the lower limit of the two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	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)
1	4,725,560	$174,611,323	40	$1,532	5	$156
2	2,276,103	208,571,019	40	3,784	10	721
3	1,212,817	195,861,653	40	6,287	12	1,589
Total	**8,214,480**	**$579,043,995**	**120**	**$11,603**	**27**	**$2,466**

Estimated Federal Share of Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$107,648,442
Lower limit	$74,871,340
Upper limit	$140,425,545

APPENDIX D: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Legend

Deficiency	Description
1	Documentation not provided
2	Services not authorized or supported
3	Documentation not completed in a timely manner
4	Services provided outside of authorization period

Office of Inspector General Review for the 120 Sampled Claims

Sample Number	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-1					
S1-2					
S1-3					
S1-4					
S1-5					
S1-6					
S1-7					
S1-8					
S1-9					
S1-10					
S1-11					
S1-12				X	1
S1-13					
S1-14					
S1-15	X				1
S1-16					
S1-17					
S1-18					
S1-19					
S1-20					
S1-21					
S1-22					
S1-23					
S1-24					
S1-25			X		1
S1-26					

Sample Number	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-27					
S1-28	X				1
S1-29					
S1-30					
S1-31					
S1-32					
S1-33					
S1-34					
S1-35					
S1-36					
S1-37					
S1-38					
S1-39			X		1
S1-40					
S2-1	X				1
S2-2					
S2-3					
S2-4					
S2-5					
S2-6					
S2-7					
S2-8					
S2-9	X				1
S2-10					
S2-11					
S2-12					
S2-13	X				1
S2-14	X				1
S2-15					
S2-16					
S2-17		X			1
S2-18					
S2-19					
S2-20					
S2-21	X				1
S2-22					

Sample Number	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S2-23				X	1
S2-24		X			1
S2-25					
S2-26					
S2-27					
S2-28					
S2-29					
S2-30					
S2-31					
S2-32					
S2-33					
S2-34					
S2-35					
S2-36				X	1
S2-37	X				1
S2-38					
S2-39					
S2-40					
S3-1					
S3-2					
S3-3					
S3-4					
S3-5					
S3-6					
S3-7					
S3-8	X				1
S3-9	X				1
S3-10					
S3-11					
S3-12					
S3-13					
S3-14		X			1
S3-15					
S3-16			X		1
S3-17					
S3-18					

Sample Number	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S3-19	X	X			2
S3-20		X			1
S3-21					
S3-22					
S3-23	X				1
S3-24			X		1
S3-25					
S3-26					
S3-27	X				1
S3-28					
S3-29					
S3-30					
S3-31		X			1
S3-32					
S3-33		X			1
S3-34					
S3-35	X				1
S3-36					
S3-37					
S3-38					
S3-39					
S3-40					
Totals	**14**	**7**	**4**	**3**	**28** [b]

[b] One claim contained more than one deficiency.

APPENDIX E: STATE AGENCY COMMENTS

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

March 5, 2018

Ms. Brenda Tierney
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-02-16-01026

Dear Ms. Tierney:

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-02-16-01026 entitled, "New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance Services That Did Not Meet Medicaid Requirements."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
Dennis Rosen
Erin Ives
Brian Kiernan
Timothy Brown
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New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-16-01026 entitled
"New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance Services That Did Not Meet Medicaid Requirements"

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-02-16-01026 entitled, "New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance Services That Did Not Meet Medicaid Requirements."

Background:

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

General Comments:

The Consumer Directed Personal Assistance Program (CDPAP) began as a demonstration called the Patient Managed Home Care Program (PMHCP). In 1995, it was elevated to program status and renamed CDPAP. That same year, the legislature passed Social Services Law 365-f establishing the CDPAP to permit chronically ill and/or physically disabled individuals receiving home care under the medical assistance program greater flexibility and freedom of choice in obtaining such services. The CDPAP is operated in New York State as a Medicaid State Plan service and the local service district must follow all applicable CDPAP assessment and authorization processes and policies. The scope of services that may be authorized under CDPAP include the tasks that may be provided by a Personal Care Aide, Home Health Aide, Licensed Practical Nurse or Registered Professional Nurse.

Social Services Law Section 365-f authorizes the provision of the CDPAP and the regulatory authority is located at 18 NYCRR § 505.28. These regulations include a description of the program; eligibility requirements; the assessment/reassessment process; guidelines for the local social services districts to determine an applicant's eligibility and appropriateness for participation in the program. The regulation also delineates roles and responsibilities of program participants, local districts and the fiscal intermediary that acts as the employer of record on behalf of the consumer.

Methodology:

The audit period selected by OIG was characterized by high levels of change across the Medicaid program, and covers the entire roll out of mandatory enrollment into Mainstream Managed Care and Managed Long-Term Care in New York State (2012 to 2015). The sample design does not account for the significant change over time this caused in the volume of CDPAP services provided through local districts. Such a change could affect the validity of OIG's estimation based on the current sample.

Recommendation #1:

Refund $139,803,214 to the Federal Government.

Response #1

The draft report states that 77 of the 120 random sampled claims were properly claimed for reimbursement by the State and 43 were improperly claimed. In conjunction with the Department, OMIG has conducted an in-depth review of the 43 claims that were identified as improper. From this review, the Department and OMIG disagree with the OIG's findings concerning 24 claims * because there is supporting documentation to demonstrate that those claims were properly reimbursed. This documentation was provided to the OIG to refute deficiencies noted in this report. The results of the State's analysis, warrants another review of the identified claims by OIG. The Department and OMIG anticipate this documentation will have a significant impact on the amount OIG is requesting that the State refund to the Federal Government.

For the remaining 19 claims, the Department agrees that inadequate documentation exists to demonstrate that the services were properly performed. The Department will resolve any issues identified in these claims through follow-up efforts, primarily through the completion of a corrective action plan (CAP) and routine audits of the local departments of social services (LDSS). Audits are currently underway, and the Department intends to issue guidance and policies that clarify how to authorize CDPAP and the timeframes associated with the assessment and authorization process.

Recommendation #2:

Reinforce guidance to the social services districts and providers related to CDPAP documentation and billing requirements.

Response #2

The audit period covers January 2012 through June 2016. The Department has issued many policies and guidance materials both during and since the audit period occurred, to reinforce compliance with CDPAP requirements. The Department has attached a detailed listing of all the policies and guidance materials on CDPAP. (See Attachment I)

Recommendation #3:

Improve its monitoring of the CDPAP to ensure that social services districts and providers comply with CDPAP requirements.

* **Office of Inspector General Note**: In its written comments, the State agency said that documentation was provided for 24 of the 43 claims, however, the State agency actually sent documentation related to 39 of the 43 claims.

Response #3

The Department has issued many policies and guidance materials both during and since the audit period occurred to reinforce our monitoring of the CDPAP and the LDSS compliance with CDPAP requirements. Additionally, the Department continues to provide guidance on an as needed basis through routine auditing of the LDSSs.

Conclusion:

The Department concludes the following:

1. For the claims identified within the scope of this audit, the Department has issued guidance to LDSSs on CDPAP authorizations, which may not exceed a 12-month period. The Department continues to release and respond to questions related to the overall programmatic guidelines of the CDPAP to the LDSSs and the fiscal intermediaries that facilitate the program. Since the implementation of the Mainstream Managed Care and Managed Long-Term Care mandatory transition from Fee-for-Service (FFS) care, there is a significant decrease in the number of CDPAP FFS cases being served, decreasing the effort required to monitor the program.

2. The draft report states that 77 of the 120 random sampled claims were properly claimed for reimbursement by the State, and 43 were improperly claimed. The State conducted an in-depth review of the 43 claims that were identified as improper. From this review, the State identified 24 claims that have supportive documentation to demonstrate that those claims were reimbursed properly. The results of the State's analysis warrant another review of the identified claims by OIG.

3. The draft report states that 18 of the 120 sampled claims did not have an Assessment and/or a Physician's Order in the case record. While the state recognizes that a physician's order must be in place prior to the assessment of need, it is imperative – in instances 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 CDPAP.

ATTACHMENT I

New York State Master Policy List-CDPAP

Policy Name	Policy Link	Effective Start Date
Personal Home Care Manual Policy Guidelines	https://www.emedny.org/ProviderManuals/PersonalCare/PDFS/PersonalCareManual-Policy.pdf	2005
GIS 06 MA/027 - Personal Care Services Contracts	http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/06ma027.pdf	10/31/2006
09OLTC005 - District Authorization of Personal Care Services Program (PCSP) and Consumer Directed Personal Assistance Program (CDPAP) Services for Traumatic Brain Injury (TBI) Waiver Participants	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/09oltc005.pdf	4/29/2009
GIS 10 LTC 005 - Consumer Directed Personal Assistance Program (CDPAP) Documents	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/10oltc-005.pdf	8/25/2010
Consumer Directed Personal Assistance Program (CDPAP) Documents	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/10oltc-005.pdf	8/25/2010
11LTC004 - Consumer Directed Personal Assistance Program (CDPAP) Services Provided Out of State	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/11oltc004.pdf	4/13/2011
11LTC007 - New State Law Requiring Automatic Change To No More than 8 Hours Per Week of Nutritional and Environmental Support Functions (Level I) 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/qis/11oltc007.pdf	6/3/2011
Attachment 1	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/11oltc007att1.pdf	6/3/2011
Attachment 2	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/11oltc007att2.pdf	6/3/2011
2011 OLCM-1 - Personal Care Services Program Assessment Protocols	http://www.health.ny.gov/health_care/medicaid/publications/docs/olcm/oltclcm-1.pdf	8/25/2011
Attachment 1	http://www.health.ny.gov/health_care/medicaid/publications/docs/olcm/oltclcm-1att1.pdf	8/25/2011
Attachment 2	http://www.health.ny.gov/health_care/medicaid/publications/docs/olcm/oltclcm-1att2.pdf	8/25/2011
Consumer Directed Personal Assistance Program (CDPAP) Scope and Procedures	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6.pdf	9/12/2011
Attachment 1	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att1.pdf	9/12/2011
Attachment 2	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att2.pdf	9/12/2011
Attachment 3	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att3.pdf	9/12/2011
Attachment 4	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att4.pdf	9/12/2011
Attachment 5	http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/11adm-6att5.pdf	9/12/2011
Consumer Directed Personal Assistance Program Provider Manual	https://www.emedny.org/ProviderManuals/CDPAP/PDFS/CDPAP_Policy_Manual.pdf	12/22/2011
New York State UB04 Billing Guidelines - CDPAP	https://www.emedny.org/ProviderManuals/PersonalCare/PDFS/PersonalCare_Billing_Guidelines_UB04.pdf	1/4/2012
Changes to Personal Care Services Program and Consumer Directed Personal Assistance Regulations Resulting From MRT #4652	http://health.state.nyenet/docs/2012adm/12adm1.pdf	4/9/2012
Availability of 24-Hour Split-Shift Personal Care Services	http://www.health.ny.gov/health_care/medicaid/publications/docs/qis/12ma026.pdf	10/3/2012
GIS 13 MA/014: Level I Personal Care Services and Consumer Directed Personal Assistance Services in Managed Long Term Care	https://www.health.ny.gov/health_care/medicaid/publications/gis/13ma014.htm	7/11/2013
GIS 14 MA/001:Medicaid Eligibility Determinations for Immediate Medical Needs	https://www.health.ny.gov/health_care/medicaid/publications/gis/14ma001.htm	1/3/2014
GIS 14 MA/04: Expansion of Mandatory Managed Long Term Care	https://www.health.ny.gov/health_care/medicaid/publications/gis/14ma004.htm	2/3/2014
GIS 15 MA/011: Reminder of Expedited Authorization Process for Medicaid Recipients with Immediate Need for Personal Care Services	https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma011.htm	7/20/2015
GIS 15 MA/017: Personal Care/Consumer Directed Services Authorization Process for Medicaid Recipients Assessed for Participation in the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Waivers	https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma017.htm	9/16/2015

New York State Master Policy List-CDPAP

GIS 15 MA/024: Changes to the Regulations for the Personal Care Services Program (PCS) and the Consumer Directed Personal Assistance Program (CDPAP)	https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma024.htm	12/31/2015
Attachment 1 - Notice of Adoption	https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/15manotice.pdf	12/23/2015
Attachment 2 - Scope of the CDPAP Benefit	https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/15mastouchcdpap.pdf	12/23/2015
Attachment 3 - Scope of the Personal Care Services Benefit	https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/15mastouchpcs.pdf	12/23/2015
GIS 16 MA/006: Changes to the Statute for the Consumer Directed Personal Assistance Program (CDPAP)	https://www.health.ny.gov/health_care/medicaid/publications/gis/16ma006.htm	4/1/2016
16ADM-02 - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services	https://www.health.ny.gov/health_care/medicaid/publications/adm/16adm2.htm	7/6/2016
Attachment 1 - Informational Notice and Attestation Form	https://www.health.ny.gov/health_care/medicaid/publications/adm/16adm2att.pdf	7/6/2016
GIS 17 MA/006: Consumer Directed Personal Assistance Program (CDPAP) Provided Out of State	https://www.health.ny.gov/health_care/medicaid/publications/gis/17ma006.htm	5/11/2017
Medicaid Update: Consumer Directed Personal Assistance Program - Fiscal Intermediary Authorization	https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-08.htm#cdpap	17-Aug
Medicaid Update: Implementation of the Consumer-Directed Fiscal Intermediary Authorization Process	https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-10.htm#consumer	17-Oct
Consumer Directed Personal Assistance Services Program (CDPAP) - Fiscal Intermediary (FI) Authorization FAQ	https://www.health.ny.gov/health_care/medicaid/redesign/mrt10003/faq.htm	11/28/2017