October 8, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Personal Care Services Claims Made by Providers in New York State (A-02-08-01005)

Attached, for your information, is an advance copy of our final report on personal care services claims made by providers under the New York State (the State) Medicaid program. We will issue this report to the State within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-08-01005.

Attachment

Office of Audit Services
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

October 13, 2010

Report Number: A-02-08-01005

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Daines:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Personal Care Services Claims Made by Providers in New York State.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kevin W. Smith, Audit Manager, at (518) 437-9390, extension 232, or through email at Kevin.Smith@oig.hhs.gov. Please refer to report number A-02-08-01005 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID PERSONAL CARE SERVICES CLAIMS MADE BY PROVIDERS IN NEW YORK STATE

Daniel R. Levinson
Inspector General

October 2010
A-02-08-01005

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, 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 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 State), the Department of Health (DOH) administers the Medicaid program. Within DOH, the Office of Long Term Care oversees the personal care services program. Each county's social services district is responsible for authorizing personal care services, arranging service delivery, and monitoring the personal care services program.

Pursuant to 42 CFR § 440.167, personal care services are generally furnished to individuals residing in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by the individual State. Pursuant to the State's regulations: (1) personal care services must be authorized and reauthorized based on a physician's order, nursing assessment, and social assessment; (2) a physician, physician's assistant, or nurse practitioner (medical professionals) must examine the beneficiary within 30 days before the physician's order is signed; (3) the delivery of personal care services must be supervised by a registered professional nurse; (4) personal care aides must receive the required in-service training; and (5) providers must document the time spent providing services to each patient. Examples of personal care services include cleaning, shopping, grooming, and bathing.

This review excluded personal care service claims submitted by 100 providers in New York City, which we audited separately.

OBJECTIVE

The objective of our review was to determine whether the State properly claimed Federal Medicaid reimbursement for personal care services claims submitted by 217 providers. Our audit period covered January 1, 2004, through December 31, 2006.

SUMMARY OF FINDINGS

The State improperly claimed Federal Medicaid reimbursement for some personal care services claims submitted by providers. Of the 100 claims in our random sample, 61 claims complied with Federal and State requirements, but 31 claims did not. We could not determine whether the remaining eight claims, which involved services under the State's Consumer Directed Personal Assistance Program (CDPAP), complied with Federal and State requirements and are setting aside those claims for resolution by CMS and the State.

Of the 31 noncompliant claims, 10 contained more than 1 deficiency:

- For 19 claims, there was no nursing assessment.
- For 12 claims, a medical professional did not examine the beneficiary within 30 days before the order for personal care services was signed.
- For four claims, there was no physician's order.
- For three claims, there was no nursing supervision.
- For two claims, the personal care aide did not receive in-service training.
- For one claim, the time spent providing services to the patient was not documented.

Of the 100 claims in our sample, 8 were CDPAP claims that lacked either an applicable physician's order or nursing assessment. These eight claims are being set aside for resolution by CMS and the State because it is unclear whether State requirements regarding physician's orders and nursing assessments (18 NYCRR § 505.14) apply to CDPAP claims.

These deficiencies occurred because the State did not effectively monitor the personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimate that the State improperly claimed $100,335,472 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2006, audit period. In addition, we estimate that the State claimed $15,325,689 for CDPAP claims that may not have complied with State requirements.

We conducted interviews with 55 of the 100 sampled beneficiaries or their family members. Of the 55 individuals interviewed, 38 identified quality-of-care problems with a personal care services aide, problems with the personal care services agency, or other problems. These include, but are not limited to, physical abuse or threats of physical abuse, theft, and beneficiary abandonment.

RECOMMENDATIONS

We recommend that the State:

- refund $100,335,472 to the Federal Government;
- improve its monitoring of the personal care services program to ensure compliance with Federal and State requirements;

- work with CMS to resolve the eight CDPAP claims and, if applicable, refund the estimated $15,325,689 in unallowable payments; and

- promulgate specific regulations related to claims submitted under the CDPAP.

NEW YORK STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State disagreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations. The State also disagreed with many elements of our findings. The State indicated that the claims in our sample substantially complied with regulations. Further, the State noted that it found nothing in our draft report or local social services districts' documentation to indicate that any services related to noncompliant sample claims were inappropriate, excessive, or unnecessary to maintain the beneficiary's health and safety in the community. Under separate cover from its response, the State provided additional documentation and written explanations for certain sample claims.

After reviewing the State's comments on our draft report, additional documentation, and written explanations, we revised our findings and modified our statistical estimates accordingly. The State's comments appear in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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 State's Medicaid Program

In New York State (the State), the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Medicaid Management administers the Medicaid program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims, including personal care services claims. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From January 1, 2004, to June 30, 2004, the FMAP in the State was 52.95 percent, and from July 1, 2004, through December 31, 2006, the FMAP was 50 percent.

New York State's Personal Care Services Program

The State's personal care services program is operated by DOH's Bureau of Medicaid Long Term Care. Although DOH is responsible for the program, each county's social services district is responsible for authorizing personal care services, arranging service delivery, and monitoring the personal care services program.

Title 18 § 505.14 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) defines "personal care services" as some or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions, and health-related tasks. Such services must be essential to the maintenance of the beneficiary's health and safety within his or her own home, as determined by the social services district in accordance with the regulations of DOH; ordered by the attending physician; based on an assessment of the beneficiary's needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

The State operates two levels of personal care services:

- Level I services are limited to the performance of environmental and nutritional functions, including dusting, vacuuming, dishwashing, shopping, laundry, and meal preparation, and

- Level II services include Level I services and personal care functions, such as assisting beneficiaries with bathing, grooming, and toileting.[1]

Each county's social services district oversees that county's personal care services program and provides case management.[2] Services are provided through contracts with home care/personal care agencies.

To receive personal care services, a Medicaid beneficiary must have a physician's order. When a county social services district receives the physician's order, a case record is established and a caseworker is assigned to the beneficiary. An initial authorization for services is based on the physician's order, a social assessment, and a nursing assessment. Authorizations for personal care services are required to be completed before the initiation of services. The reauthorization process generally includes the same procedures as the initial authorization; however, Level I services do not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged. After completing the authorization process, a caseworker contacts a local personal care services provider so it can assign a personal care aide unless the beneficiary hires his or her own aide under the State's Consumer Directed Personal Assistance Program (CDPAP).[3]

Federal and State Requirements Related to Personal Care Services

The State and the social services districts must comply with certain Federal and State requirements in determining and redetermining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual 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.

Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A of the Circular provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

[1] The State's regulations reference three levels of service (Level I, Level II, and Level III), but the State's current personal care services program provides only Level I and Level II services.

[2] Bronx, Kings, New York, Queens, and Richmond Counties make up one social services district (New York City).

[3] Section 365-f of the New York Social Services Law established the CDPAP. Under the CDPAP, the beneficiary may hire his or her own aide, train the aide according to the beneficiary's personal preferences, supervise and direct the provision of service, and fire the aide. Although the program has been in effect since 1996, it was not defined under the State plan until Amendment 07-32 was approved by CMS on April 8, 2008, with an effective date of July 1, 2007. The State plan notes that the eligibility, assessment, and prior authorization of services mirror those of the personal care services program. The State has not promulgated specific State regulations applicable to the CDPAP.

Title 18 of NYCRR § 505.14 establishes requirements for the State's personal care services program. These requirements include that a physician, physician's assistant, or nurse practitioner (medical professionals) complete the physician's order for personal care services within 30 calendar days of conducting a medical examination and that social and nursing assessments be prepared as part of the authorization and reauthorization of personal care services. Authorization for Level I and II services must be based on an assessment of the beneficiary's appropriateness for other services that are medically necessary and that the county's social services district "reasonably expects can maintain the patient's health and safety in his or her home …."[4] In addition, the provision of services must be supported by documentation of the time spent providing services to each patient. Appendix A contains the specific Federal and State requirements related to personal care services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the State properly claimed Federal Medicaid reimbursement for personal care services claims submitted by 217 providers.

Scope

Our audit period covered January 1, 2004, through December 31, 2006. Our audit population consisted of 11,511,394 claims, totaling $1,101,392,649 ($551,500,292 Federal share), submitted by the 217 providers. Our audit population did not include claims for services submitted by 100 providers in New York City, which were audited separately.[5]

During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork at DOH's offices in Albany, New York; at the State MMIS fiscal agent in Rensselaer, New York; and at 34 county social services district offices and 61 personal care providers throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines;
- held discussions with DOH and county social service district officials to gain an understanding of the personal care services program;

[4] Some examples of these services include long-term home health services and personal emergency response services.

[5] *Review of Medicaid Personal Care Services Claims Made by Providers in New York City*, issued June 8, 2009 (A-02-07-01054).

- used providers' correspondence addresses and county codes on the MMIS, which identified 217 personal care providers, excluding those located in New York City;

- ran computer programming applications at the MMIS fiscal agent that identified 11,514,430 personal care services claims, totaling over $1.1 billion ($552 million Federal share) for the 217 providers;

- eliminated from our programming applications all personal care services claims identified in an August 2007 Office of the New York State Comptroller audit report;[6]

- determined that our revised sampling frame contained 11,511,394 claims, totaling $1,101,392,649 ($551,500,292 Federal share), made by the 217 providers;

- selected a simple random sample of 100 claims from the sampling frame of 11,511,394 claims; and

- estimated unallowable and potentially unallowable Federal Medicaid reimbursement paid in the population of 11,511,394 claims.

Appendix B contains the details of our sample design and methodology.

For each of the 100 sampled claims, we:

- reviewed the corresponding personal care provider's documentation supporting the claim;

- reviewed the corresponding county social services district's case file;

- reviewed documentation from the physician ordering the personal care services to confirm whether a medical professional had examined the beneficiary within 30 days before the order was signed; and

- visited the beneficiary or the family members, if available, associated with the claim to inquire about the personal care services received and referred all quality-of-care issues identified to our Office of Investigations.[7]

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 objective.

[6] *Medicaid Payments to Home Care Providers While Recipients Were Hospitalized*, Office of the New York State Comptroller, Division of State Government Accountability, Report 2006-S-77 (August 28, 2007).

[7] We were able to visit only 55 of the 100 beneficiaries because of various reasons (e.g., relocation, illness).

FINDINGS AND RECOMMENDATIONS

The State improperly claimed Federal Medicaid reimbursement for some personal care services claims submitted by providers. Of the 100 claims in our random sample, 61 claims complied with Federal and State requirements, but 31 claims did not. We could not determine whether the remaining eight claims, which involved services under the State's CDPAP, complied with Federal and State requirements and are setting aside those claims for resolution by CMS and the State. Of the 31 claims, 10 contained more than 1 deficiency. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[8]
No nursing assessment	19
Physician's order deficiencies	12
No physician's order	4
No nursing supervision	3
No in-service training on the part of the aide	2
No documentation	1

For eight sample claims submitted under the CDPAP, seven claims lacked applicable nursing assessments and three claims lacked applicable physician's orders.[9] We are setting aside these eight claims for resolution by CMS and the State because it is unclear whether State requirements apply to these claims.

These deficiencies occurred because the State did not effectively monitor the personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimate that the State improperly claimed $100,335,472 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2006, audit period. In addition, we estimate that the State claimed $15,325,689 for CDPAP claims that may not have complied with State requirements.

NO NURSING ASSESSMENT

Pursuant to 18 NYCRR § 505.14, authorizations for Level I and II services must include a nursing assessment prepared by a registered professional nurse.[10] For 19 of the 100 claims in our sample, the county social services district could not provide an applicable nursing assessment.

[8] The total exceeds 31 because 10 claims contained more than 1 error.

[9] The total exceeds eight because two claims contained more than one error.

[10] Reauthorization for Level I services does not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged.

PHYSICIAN'S ORDER DEFICIENCIES

Pursuant to 18 NYCRR § 505.14(b)(3)(i), a medical professional is required to complete the physician's order for personal care services within 30 calendar days after conducting a medical examination of the beneficiary. For 12 of the 100 claims in our sample, the required medical professional did not examine the beneficiary within 30 calendar days before the physician's order was signed.[11] If a medical professional had not examined the beneficiary within 60 calendar days before the date the physician's order was signed, we questioned the claim.

NO PHYSICIAN'S ORDER

Pursuant to section 1905(a)(24) of the Act, implementing Federal regulations (42 CFR § 440.167(a)(1)), and 18 NYCRR § 505.14, personal care services must be authorized by a physician. The physician's order is part of an authorization package that must be completed before the authorization and reauthorization of services. Of the 100 claims in our sample, 4 did not have an applicable physician's order before the authorization or reauthorization period of personal care services.

NO NURSING SUPERVISION

Pursuant to 18 NYCRR § 505.14(f), all persons providing Level I and II personal care services are subject to supervision by a registered nurse. Supervisory nursing visits must be made at least every 90 days except when the beneficiary is self-directing and his or her medical condition is not expected to change.[12] In those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months. For 3 of the 100 claims in our sample, there was no evidence that a registered nurse supervised the personal care services within the 6 months before the date of the sample service.

AIDE DID NOT RECEIVE IN-SERVICE TRAINING

Pursuant to 18 NYCRR § 505.14(e)(2)(ii), in-service training shall be provided, at a minimum, for 3 hours semiannually for each person providing personal care services (other than household functions only) to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training. For 2 of the 100 claims in our sample, there was no evidence that the personal care aide received any in-service training for the calendar year that included our sample service date.

[11] Although a medical examination date was noted on 6 of the 12 physicians' orders and none was noted on the remaining 6, we based our disallowance for this category on the fact that the underlying medical record for each claim did not support the examination date.

[12] Self-directing means that the beneficiary is capable of making choices about his or her activities of daily living, understanding the impact of the choices, and assuming responsibility for the results of the choices.

NO DOCUMENTATION

Pursuant to 18 NYCRR § 505.14(h)(1), no payments for a personal care service claim shall be made to a provider for authorized services unless the claim is supported by documentation of the time spent providing services for each patient. For 1 of the 100 claims in our sample, the provider could not document the time spent providing services.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM CLAIMS

New York Social Services Law 365-f established the CDPAP in 1996. The State has not issued specific regulations applicable to the CDPAP. Of eight CDPAP claims, seven claims lacked applicable nursing assessments and three claims lacked applicable physician's orders.[13] We are setting aside these claims because it is unclear whether State requirements regarding physician's orders and nursing assessments (18 NYCRR § 505.14) apply to CDPAP claims.

CAUSE OF UNALLOWABLE CLAIMS

The State did not effectively monitor the personal care services program. The State conducts periodic onsite monitoring visits of its social services districts to review case records for compliance with applicable State regulations but did not conduct monitoring visits at personal care providers or at the ordering physicians' offices. In some cases, reports of the State's monitoring visits at social services districts noted instances of noncompliance similar to those discussed above and recommended corrective actions. However, despite these monitoring visits and recommended corrective actions, improper claims for Federal Medicaid reimbursement were submitted.

ESTIMATIONS

Of the 100 personal care services claims sampled, 31 were not made in accordance with Federal and State requirements. Based on our sample results, we estimated that the State improperly claimed between $100,335,472 and $250,250,939 in Federal Medicaid reimbursement from January 1, 2004, through December 31, 2006. The details of our sample results and estimates are shown in Appendix C.

In addition, we could not determine whether eight sample claims submitted under CDPAP complied with State requirements. Based on our sample results, we estimated that the State potentially claimed between $15,325,689 and $84,102,826 in unallowable Federal Medicaid reimbursement. The details of our sample results and estimates are shown in Appendix C.

[13] The total exceeds eight because two claims contained more than one potential error.

RECOMMENDATIONS

We recommend that the State:

- refund $100,335,472 to the Federal Government;
- improve its monitoring of the personal care services program to ensure compliance with Federal and State requirements;
- work with CMS to resolve the eight CDPAP claims and, if applicable, refund the estimated $15,325,689 in unallowable payments; and
- promulgate specific regulations related to claims submitted under the CDPAP.

NEW YORK STATE COMMENTS

In its comments on our draft report, the State disagreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations. The State also disagreed with many elements of our findings. The State indicated that the claims in our sample substantially complied with regulations and that it found nothing in our draft report or local social services districts' documentation to indicate that any services related to noncompliant sample claims were inappropriate, excessive, or unnecessary to maintain the beneficiary's health and safety in the community.

Further, in its response, the State provided specific reasons for disagreeing with our determinations on six of these claims. Specifically, the State indicated that for four claims for which a medical professional had not examined the beneficiary within 60 calendar days before the date the physician's order was signed, the corresponding beneficiary's condition "clearly established the ongoing need for services." The State also indicated that for one claim for which there was no physician's order, the claim "is an Adult Protective Services case for which discontinuing service would have resulted in health and safety issues." Finally, for one claim that lacked documentation of services, the State described the claim as an anomaly because the provider maintained timesheets for all other days during the week that services were delivered. Under separate cover from its response, the State provided additional documentation and written explanations for 42 sample claims, including the 6 mentioned above.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State's comments on our draft report, additional documentation, and written explanations, we revised our findings by accepting 4 of 35 claims that we had questioned and modified our statistical estimates accordingly. The State's comments appear in their entirety as Appendix D.

We did not revise our treatment of the six claims discussed individually in the State's response. Regarding the four claims for which a medical professional had not examined the beneficiary within 60 calendar days before the date the physician's order was signed, we maintain that these

claims were unallowable. Our determination for each of these claims was based on a review of the beneficiaries' medical records—not on their medical conditions. Regarding the one claim related to an Adult Protective Services case, we maintain that such claims are not exempt from the requirement that personal care services require a timely physician's order. For the one claim that the State described as an anomaly, we maintain that the provider cannot provide documentation to support the claim; therefore, the claim is unallowable.

OTHER MATTER: BENEFICIARY-IDENTIFIED PROBLEMS WITH PERSONAL CARE SERVICES

We interviewed 55 of the 100 sampled beneficiaries or their family members to determine (1) whether quality-of-care issues existed, (2) the service type and frequency, and (3) whether any service-related problems existed. We did not interview the remaining 45 sampled beneficiaries because the beneficiaries were deceased, had moved out of the State, or could not be located. Of the 55 individuals interviewed, 38 identified quality-of-care problems with a personal care services aide, problems with the personal care services agency, or other problems.[14] Table 2 summarizes the problems identified and the number of beneficiaries who encountered each type of problem.[15]

Table 2: Problems Identified in Beneficiary Interviews

Type of Problem	Number of Beneficiaries[16]
Problems with the personal care agency	12
Theft of property by the personal care aide	11
Personal care aide engaged in unrelated activities	7
Plan of care not received by the beneficiary	6
Physical abuse/threats by the personal care aide	5
Plan of care not followed by the personal care aide	3
Beneficiary abandonment by the personal care aide	2
Other (e.g., personal care aide was intoxicated, personal care aide asked for money)	25

[14] We were unable to determine if any of the identified problems occurred on the specific service date drawn in our sample. For some beneficiaries, we were able to determine that the problems identified occurred during our audit period or that the aide on duty on the service date we reviewed was the cause of the beneficiary's problems. Not all of the identified problems occurred during our 3-year audit period.

[15] We referred all quality-of-care issues identified by the 38 beneficiaries to our Office of Investigations.

[16] The total exceeds 55 because 18 beneficiaries identified more than 1 problem.

Below are examples of some of the problems identified in our interviews.

THEFT OF PROPERTY

Of the 55 individuals we interviewed, 11 indicated that a personal care services aide stole property from them. For example, the father of an adult beneficiary in the CDPAP alleged that his son's aide stole $47,688 between June and November 2006 from a joint bank account held by the father and son for the son's care. The mother of a second adult beneficiary alleged that her daughter's aide stole her newly issued credit card, activated it, and used it.[17] The mother stated that she was unaware of this until her credit card company contacted her about suspicious activity on her account. The mother further stated that she contacted local law enforcement but did not file a complaint for fear of retaliation by the aide. Among the other items allegedly stolen from other beneficiaries were cash, diamonds, $400 worth of coins, and jewelry. One beneficiary stated that an aide stole her birth certificate.

PHYSICAL ABUSE OR THREATS OF PHYSICAL ABUSE

Of the 55 individuals we interviewed, 5 indicated that a personal care services aide abused or threatened to abuse the beneficiary. For example, the mother of an adult beneficiary alleged that her daughter's aide attempted to smother the beneficiary with a pillow.[18] The mother stated that the aide said "Let's play dead" to the beneficiary and placed a pillow over the beneficiary's face, preventing her from breathing. The mother stated that she contacted the personal care agency about the incident and, afterward, the aide confessed to the incident in front of an agency nurse. In a second example, the daughter of a beneficiary stated that her mother's aide verbally and physically abused her mother.[19] The daughter stated that she overheard the aide through a baby monitor verbally abusing her mother about a diaper change. When the daughter entered the room, she stated that she saw the aide grabbing and shoving the beneficiary. Local law enforcement was contacted and removed the aide from the home. Other examples of abuse alleged by beneficiaries included verbal abuse and inappropriate touching.

BENEFICIARY ABANDONMENT

Of the 55 individuals we interviewed, 2 indicated that a personal care services aide abandoned the beneficiary. One beneficiary indicated that her aide abandoned her outside of a store while the aide shopped for approximately 1 hour. A second beneficiary indicated that, on several occasions, his aide would not show up for scheduled services, thereby leaving him unattended at home.

[17] The mother lives with the beneficiary, whose physical condition does not allow her to easily communicate.

[18] The mother lives with the beneficiary, whose physical condition does not allow her to easily communicate.

[19] The beneficiary is bedridden and lives with her daughter.

APPENDIXES

APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO PERSONAL CARE SERVICES

- Section 1905(a)(24) of the Social Security Act and implementing Federal regulations (42 CFR § 440.167) permit States to elect, as an optional Medicaid benefit, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease. The statute specifies that personal care services must be: (1) authorized for an individual by a physician within a plan of treatment or in accordance with a service plan approved by a 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 other location.

- Federal regulations (42 CFR § 440.167(a)(1)) and Title 18 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) § 505.14 specify that personal care services must be authorized by a physician. The physician's order is part of an authorization package that is required to be completed before the initial authorization and reauthorization of services.

- Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A of the Circular provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

- Medical professionals must complete the physician's order for personal care services within 30 calendar days after conducting a medical examination of the beneficiary (18 NYCRR § 505.14(b)(3)(i)). A physician must sign the physician's order and certify that the recipient can be cared for at home.

- All persons providing Level I and II personal care services must be subject to nursing supervision (18 NYCRR § 505.14(f)). This supervision must ensure that the beneficiary's needs are appropriately met by the case management agency's (county social services district) authorization for the level, amount, frequency, and duration of services and that the person providing services is competent and safely performing the tasks specified in the plan of care. Supervisory nursing visits must be made at least every 90 days except when the beneficiary is self-directing and his or her medical condition is not expected to change. In those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months.

- The initial authorization for Level I and II services must include a nursing assessment prepared by a registered professional nurse (18 NYCRR § 505.14(b)(2)(iii)). Reauthorization for Level I services does not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged (18 NYCRR § 505.14(b)(3)(ix)(a)). The nursing assessment shall include the following: (1) a review and interpretation of the physician's order, (2) the primary diagnosis code, (3) an evaluation of the functions and tasks required by the beneficiary, (4) the degree of assistance required,

(5) the development of a plan of care, and (6) recommendations for authorization of services (18 NYCRR § 505.14(b)(3)(iii)(b)).

- In-service training shall be provided, at a minimum, for 3 hours semiannually for each person providing personal care services (other than household functions only) to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training (18 NYCRR § 505.14(e)(2)(ii)).

- No payments to the provider shall be made for authorized services unless the claim is supported by documentation of the time spent in provision of services for each individual patient (18 NYCRR § 505.14(h)(1)).

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

Population

The population was personal care services claim lines submitted by 217 providers in New York State (the State) during our January 1, 2004, through December 31, 2006, audit period that were claimed for Federal Medicaid reimbursement by the State.

Sampling Frame

The sampling frame was a computer file containing 11,511,394 detailed claim lines for personal care services submitted by 217 providers during our audit period. The total Medicaid reimbursement for the 11,511,394 claim lines was $1,101,392,649 ($551,500,292 Federal share). The Medicaid claim lines were extracted from the paid claims' files maintained at the Medicaid Management Information System fiscal agent.

Sampling Unit

The sampling unit was an individual Federal Medicaid personal care claim line.

Sample Design

We used a simple random sample to evaluate the population of Federal Medicaid personal care claim lines.

Sample Size

We selected a sample size of 100 claim lines.

Source of Random Numbers

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical software, RAT-STATS. We used its random number generator for selecting our random sample items

Method for Selecting Sample Items

We sequentially numbered the 11,511,394 detailed claim lines. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

Estimation Methodology

We used RAT-STATS to calculate our estimates. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the improper claim lines.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Unallowable Claims: 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)
11,511,394	$551,500,292	100	$4,727	31	$1,523

Unallowable Claims: Estimates (Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Unallowable Costs
Point Estimate	$175,293,206
Lower Limit	$100,335,472
Upper Limit	$250,250,939

Potentially Unallowable Claims:[1] Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Potentially Unallowable Claims	Value of Potentially Unallowable Claims (Federal Share)
11,511,394	$551,500,292	100	$4,727	8	$432

Potentially Unallowable Claims: Estimates (Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Potentially Unallowable Costs
Point Estimate	$49,714,257
Lower Limit	$15,325,689
Upper Limit	$84,102,826

[1] These are State's Consumer Directed Personal Assistance Program claims.

APPENDIX D: NEW YORK STATE COMMENTS

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 25, 2010

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-02-08-01005

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-08-01005 on "Review of Medicaid Personal Care Services Claims Made By Providers in New York State."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: Robert W. Reed
Donna Frescatore
Mark L. Kissinger
James Sheehan
Diane Christensen
Nicholas Meister
Stephen Abbott
Irene Myron
Ronald Farrell
Mary Elwell
Lynn Oliver

New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-08-01005 on
"Review of Medicaid Personal Care Services Claims Made by Providers in New York State"

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's draft audit report A-02-08-001005 on "Review of Medicaid Personal Care Service Claims Made by Providers in New York State."

BACKGROUND

New York State's 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. New York State 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.

In Olmstead v. Zimring 527 U.S. 581 (1999), the United States Supreme Court held that the Americans with Disabilities Act requires States to place disabled patients in integrated settings (that is, in community settings) when they are medically cleared for such settings. The Court held that "the State generally may rely upon the reasonable assessments of its own professionals in determining whether an individual meets the essential eligibility requirements. . ." (for placement in a community-based treatment setting).

In response to the Supreme Court's issuance of the Olmstead Decision, CMS directed states to take necessary measures to assure that beneficiaries are provided the opportunity to receive services in the least restrictive setting appropriate to their needs. Since that directive was issued, New York State has partnered with CMS on several grant initiatives to promote home and community-based care and delay/prevent unnecessary institutionalization of individuals with disabilities. PCSP is a critical component of New York State's home care system, assuring the least restrictive setting to the beneficiary and lowest cost to the system. In working with CMS on these issues, New York has, as Olmstead states, relied upon the reasonable assessments of its licensed, Medicaid participating, physicians to determine the need for provision and continuation of these services.

OIG DRAFT REPORT

The OIG audit focused on personal care services claims submitted by one hundred (100) providers outside of the New York City area (which was separately audited) for the three years ended December 31, 2006. OIG sampled one hundred (100) randomly selected claims from a universe of 11,511,394 claims. Of the 100 sample selection, 57 were determined by OIG to be in compliance with documentation and billing regulation. OIG has, on a preliminary basis, identified 35 claims which it believes to be in error and 8 claims requiring further analysis. Of the 35 claims, OIG found 13 with more than one deficiency. Summarized below are the numbers of deficiencies, by type:

1. NO NURSING ASSESSMENT	19
2. MEDICAL PROFESSIONAL DID NOT EXAMINE THE BENIFICIARY WITHIN 30 DAYS BEFORE THE ORDER FOR PERSONAL CARE SERVICES WAS SIGNED	17
3. NO PHYSICIAN'S ORDER	4
4. NO NURSING SUPERVISION	4
5. THE PERSONAL CARE AIDE DID NOT RECEIVE IN-SERVICE TRAINING	2
6. THE PROVIDER DID NOT OBTAIN A CRIMINAL HISTORY CHECK FOR THE PERSONAL CARE AIDE	1
7. TIME SPENT PROVIDING SERVICES TO THE PATIENT WAS NOT DOCUMENTED	1
TOTAL	48

Based on the above, OIG contends New York State improperly claimed $120,441,703 in Federal Medicaid reimbursement.

OIG RECOMMENDATIONS

Detailed below for the OIG's review and consideration is the Department's response to each OIG recommendation.

OIG Recommendation #1:

The State should refund $120,441,703 to the Federal Government.

Department Response #1:

OIG's draft report indicates that 35 of the 100 claims in the audit sample did not comply with Federal and State requirements, with the 35 claims containing 48 deficiencies, and that, as a result, the State improperly claimed $120,441,702 in Federal Medicaid reimbursement.

OIG extrapolated the $1,704 aggregate Federal share for the 35 claims as the basis for the $120,441,702 overclaim. The Department has reviewed the OIG workpapers furnished with respect to the 35 specific claims. It additionally consulted with the local social services districts ("local districts") responsible for the cases associated with these claims, interviewing staff and inspecting files and supporting documentation maintained by the districts. The Department found nothing in the OIG report or the local districts' documentation that would indicate that any of the services provided were ultimately found to be inappropriate, excessive or unnecessary to maintain the patient's health and safety in the community. Furthermore, the Department was able to gather additional documentation that, if inspected by OIG, the Department believes will have a material impact on the estimated overpayment amount. Since the data includes beneficiary-specific information, it is not specifically addressed in the Department's comments herein but will be separately provided to the OIG.

Summarized below are the results of the Department's follow-up by area of deficiency cited in the OIG report.

1. **NO NURSING ASSESSMENT**

OIG Findings:

"Pursuant to 18 NYCRR § 505.14, authorizations for Level I and II services must include a nursing assessment prepared by a registered professional nurse. For 19 of the 100 claims in our sample, the county social services district could not provide an applicable nursing assessment."

Department Follow-up:

Of the 19 claims which OIG determined to be non-compliant due to lack of evidence of an applicable nursing assessment, 17 were determined to be acceptable through Department review for a number of reasons which are included in explanations accompanying the supporting documentation that will be separately provided to OIG. Local districts are responsible for assuring that patients are maintained in the least restrictive setting appropriate to meet their needs, and they made diligent effort to provide needed services and adhere to regulation.

2. **PHYSICIAN'S ORDERS DEFICIENCIES (MEDICAL PROFESSIONAL DID NOT EXAMINE THE BENIFICIARY WITHIN 30 DAYS BEFORE THE ORDER FOR PERSONAL CARE SERVICES WAS SIGNED)**

OIG Findings:

"Pursuant to 18 NYCRR § 505.14(b)(3)(i), a medical professional is required to complete the physician's order for personal care services within 30 calendar days after conducting a medical examination of the beneficiary. For 17 of the 100 claims in our sample, the required medical professional did not examine the beneficiary within 30 calendar days before the physician's order was signed. If a medical professional had not examined the beneficiary within 60 calendar days before the date the physician's order was signed, we questioned the claim."

Department Follow-up:

Of the 17 claims which OIG determined to be non-compliant due to physician's orders' deficiencies, 7 were determined to be acceptable through Department review for reasons included in explanations accompanying the supporting documentation that will be separately provided to OIG. In addition, the documentation will demonstrate for 4 other claims that the specifics of the patients' conditions clearly established the ongoing need for services, which is the regulatory intent of the examination requirement.

Furthermore, it is common healthcare industry practice for health care providers to rely on the accuracy of signed and dated physician orders. It would be impractical and costly for healthcare providers to routinely verify the accuracy of physician orders with the physician before services are rendered to eligible beneficiaries. The Department's review of Federal and State laws, rules and regulations did not identify any requirement for a provider to routinely verify signed and dated physician orders before services are rendered.

The OIG findings suggest that local districts should review physician claims to confirm that the physician's order is based on a same day examination office visit *before* services are prior authorized. This is not practical as physician claims can be submitted to the state's eMedNY claim processing system months after the actual service was provided. Nor is it feasible to contact each physician by electronic means or by on-site visit to verify that each and every physician's order received by the local district is based on a same day physical as indicated by the ordering physician. In addition to being administratively cumbersome and cost-prohibitive, completion of such onerous requirements would delay provision of immediately needed services. Hospital and nursing home patients whose discharge plan is dependent on the availability of home care services would have to remain institutionalized pending confirmation activities. Beneficiaries already living in the community, but whose health and safety is at risk absent services, may be faced with costly, disruptive and unnecessary institutionalization pending validation of the physician's order. Physicians are state-licensed medical professionals, obligated to practice in accordance with accepted standards of conduct. Health insurance programs, including Medicaid and Medicare, that require a physician's order based on current patient status, rely on such standards of practice and accept physician orders for services and equipment in good faith. The Department would be amenable to reviewing any other states' pre-service physician order verification system that the OIG is aware of for potential application in New York State.

The mechanisms employed by the Department and the local districts to assure compliance with Federal and State physician order requirements are more cost-effective and more appropriately assure the timely provision of services to eligible beneficiaries in need of home care services.

3. NO PHYSICIAN'S ORDER

OIG Findings:

"Pursuant to § 1905(a)(24) of the Act, implementing Federal regulations (42 CFR §440.167(a)(1)), and 18 NYCRR § 505.14, personal care services must be authorized by a physician. The physician's order is part of an authorization package that must be

completed before the authorization and reauthorization of services. Of the 100 claims in our sample, 4 did not have an applicable physician's order before the authorization or reauthorization period of personal care services."

Department Follow-up:

Of the 4 claims which OIG determined to be non-compliant due to the lack of physician's orders documentation, 2 were determined to be acceptable through Department review for reasons included in explanations accompanying the supporting documentation that will be separately provided to OIG. In addition, the documentation will demonstrate that one other claim is an Adult Protective Services case for which discontinuing services would have resulted in health and safety issues.

4. **NO NURSING SUPERVISION**

OIG Findings:

"Pursuant to 18 NYCRR § 505.14(f), all persons providing Level I and II personal care services are subject to supervision by a registered nurse. Supervisory nursing visits must be made at least every 90 days except when the beneficiary is self-directing and his or her medical condition is not expected to change. In those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months. For 4 of the 100 claims in our sample, there was no evidence that a registered nurse supervised the personal care services within the 6 months before the date of the sample service."

Department Follow-up:

Of the 4 claims which OIG determined to be non-compliant due to the lack of nursing supervision documentation, 3 were determined to be acceptable through Department review for reasons included in explanations accompanying the supporting documentation that will be separately provided to OIG.

5. **AIDE DID NOT RECEIVE IN-SERVICE TRAINING**

"Pursuant to 18 NYCRR § 505.14(e)(2)(ii), in-service training shall be provided, at a minimum, for 3 hours semiannually for each person providing personal care services (other than household functions only) to develop specialized skills or knowledge not included in basic training. For 2 of the 100 claims in our sample, there was no evidence that the personal care aide received any in-service training for the calendar year that included our sample service date."

Department Follow-up:

Both claims which OIG determined to be non-compliant due to insufficient documentation to demonstrate the personal care aide received in-service training were determined to be acceptable through Department review for reasons included in explanations accompanying the supporting documentation that will be separately provided to OIG.

6. **PROVIDER DID NOT PERFORM CRIMINAL HISTORY RECORD CHECK ON AIDE**

"Pursuant to 18 NYCRR § 505.14(d)4)(v), the minimum criteria for selection of all persons providing personal care services shall include, but are not limited to, a criminal history record check to the extent required by 10 NYCRR § 400.23. Pursuant to 10 NYCRR § 400.23, the operator of a personal car services agency shall obtain a criminal record history check from the United States Attorney General to the extent provided for under Federal law. This authorizes the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal records. For 1 of the 100 claims in our sample, the provider did not obtain a criminal record check in accordance with the above requirements."

Department Follow-up:

The claim which OIG determined non-compliant due to lack of evidence that the provider obtained a criminal record check was determined to be acceptable through Department review for reasons included in explanations accompanying the supporting documentation that will be separately provided to OIG.

7. **LACK OF DOCUMENTATION (TIME SPENT PROVIDING SERVICES TO THE PATIENT WAS NOT DOCUMENTED)**

Department Follow-up:

Department follow-up determined that the home health agency was able to produce signed timesheets for all days during the week that service was delivered except the OIG audit sample date. It appears this particular date was an anomaly and is therefore not representative of the overall claims universe. Furthermore, the agency refunded payment for the date in question prior to issuance of the OIG draft report.

OIG Recommendation #2:

The State should improve its monitoring of the personal care services program to ensure compliance with Federal and State requirements.

Department Response #2:

The Department has implemented significant improvements in monitoring local district administration of the program since the January 2004 - December 2006 audit time period:

- In 2007, the Department established the Office of Long Term Care and within that office, the Division of Home and Community-Based Services. The allocation of additional staffing resources has afforded the Department greater opportunities for providing technical assistance and best practices information to newly hired and existing local district staff. It has additionally allowed for increased on-site Department reviews of local districts' program records, enhanced monitoring of local administrative protocols and improved feedback to local districts in the form of a program Monitoring Report.

Local districts are required to submit corrective action plans that address how cited deficiencies will be rectified, as necessary, with follow-up conducted by Department staff to ensure compliance.

- The Department conducted a site visit to each local district during 2008 to monitor program compliance. At the conclusion of each visit, staff discussed their findings with local officials and made recommendations for improved local program administration, as appropriate. Additionally, in 2009, the Department conducted site visits at 80 percent of the districts, monitoring program compliance and following-up on the findings and recommendations from the prior visit. Information on each site visit is tracked utilizing numerous tools developed by Department staff and analyzed against established benchmarks for compliance, with additional follow-up conducted as needed.

- The Department now collects case record information electronically and downloads it into a central database, collectively providing information from a Statewide perspective on current PCSP recipient demographics including, but not limited to, functional abilities, primary diagnoses and correlating service authorizations. Identified trends and issues are utilized for evaluating current program requirements and to support future policy and program planning.

- The Department also collects annual data on local districts' administration of the program, utilizing a standardized data collection form that is electronically forwarded to each local district for completion. The data collected tracks local district arrangements/contracts for social and nursing assessment completion and furnishes feedback on the issues and obstacles impacting service availability in the district (e.g., aide shortages). Individual district information is consolidated into a central database and utilized to analyze local, regional and Statewide trends.

- The Department historically disseminated policy and regulatory changes via issuance of Administrative Directives, Local Commissioner's Memorandums, Medicaid Update publications and General Information System releases. However, State and local district staff attrition, exacerbated by baby boomer retirements, has eroded the PCSP knowledge base. To ensure access to up-to-date program information, the Department developed and released a program training and reference guide for local district staff which includes a cross-walk between regulatory requirements and Department-issued administrative protocols, helping to ensure consistency in services Statewide.

- The Department presented a workshop on The Personal Care Services Program at the 2008 winter conference of the New York State Public Welfare Association (NYSPWA). This workshop focused on adherence to program regulations and conducting quality assessments of care needs. Another workshop on Quality Assurance Mechanisms to be Utilized in the Administration of the PCSP is planned for NYSPWA's summer 2010 conference.

- The Department revised the Physician's Order form and distributed it to all local districts via a Local Commissioner's Memorandum. Besides generating consistency across all local districts, the changes clearly reiterate physicians' responsibility for assuring that the examination date and signatory comply with regulatory requirements. Furthermore, unresolved issues involving completion and submission of forms will result in referrals,

as appropriate, to the Department's Office of Professional Medical Conduct and/or the State Education Department which is responsible for the licensure of medical professionals.

- The Department has begun work on another Local Commissioner's Memorandum as part of a Best Practices initiative. Local districts will be encouraged to create, distribute and collect annual consumer satisfaction questionnaires, and to utilize the data to identify emerging patterns regarding specific agencies and/or individual providers. At a minimum, compilation and use of the information obtained through the questionnaires will be monitored during the Department's annual site visit to each local district.

- The Department has initiated development of a process to notify local districts of reported complaints regarding any provider agency under contract with the local district for the provision of personal care services. Local districts will be required to follow-up on each complaint and ensure appropriate resolution.

- The Department developed and maintains a database of frequently asked questions as a reference for local districts, helping to ensure consistency in program direction and information.

OIG Recommendation #3:

The State should work with CMS to resolve the eight CDPAP claims and, if applicable, refund the estimated $15,325,689 in unallowable payments.

Department Response #3:

The Department is available to work with CMS on any issues of concern related to the eight CDPAP claims reviewed by OIG.

OIG Recommendation #4:

The State should promulgate specific regulations related to claims submitted under the CDPAP.

Department Response #4:

The Department agrees with this OIG recommendation. New York State initially withheld promulgating discrete CDPAP regulations pending release of federal guidance on state plan option consumer directed programs. CDPAP regulations have now been drafted by the Department's Office of Counsel, released for comment by stakeholders in 2009, revised as appropriate and forwarded to the Governor's Office of Regulatory Reform for release for public comment.

OIG QUALITY OF CARE ISSUES

OIG reports it conducted interviews with 55 of the 100 sampled beneficiaries or their family members, and that 38 of the 55 individuals interviewed identified quality of care issues regarding service provision. However, OIG did not furnish detailed information identifying these concerns for Department follow-up. Quality of care is the Department's priority. The ability for the

Department and local districts to follow up fully on these issues is of significant concern. The Department therefore respectfully requests OIG to furnish a complete copy of its file documentation with respect to this matter.

Quality assurance is a vital and essential component of New York's Medicaid home care system. Multiple mechanisms exist at the State and local level to assure that consumers receive appropriate services from qualified providers. When these standards are not met, consumers have access to multiple reporting systems that collaborate as needed, to assure quality of care and consumer protection.

State Quality Assurance Processes

In 1984, Chapter 959 of the Laws of 1984 was enacted in New York State. These laws required the Department's licensure of home care services agencies providing nursing, home health or personal care services.

Pursuant to this legislation, the Department issued regulations (Title 10, Part 766) regarding licensed home care services agency operating requirements. The intent of the licensure regulations was to make licensed home care services agencies responsible for the quality and appropriateness of care provided, whether provided directly or through contractual arrangement.

The licensure regulations and Department of Health policy Memorandums subsequently issued identified home care agency operating requirements including comprehensive personnel requirements of individuals providing personal care services. Such requirements have been expanded over time and include, but are not limited to:

- criminal history record check requirements for employees of direct care;
- employee health requirements;
- aide training requirements, including basic training, in-service training, on-the job training and overall job performance;
- supervision requirements;
- personnel record documentation requirements.

The Department conducts a pre-opening survey prior to issuance of a home care agency license and periodic surveys for licensure compliance periodically thereafter. Identified deficiencies must be satisfactorily addressed within a specified time period as a condition of continued licensure approval.

The Department also maintains a toll-free home care consumer hotline. Complaints are investigated by Department staff located in regional offices throughout the state. On initial home visits, licensed home care services agencies provide recipients with patient rights information which includes the phone number of the regional Department office for reporting quality of care issues. Department program staff also investigate and respond to verbal and written complaints received from recipients, advocates and other stakeholders. The Department has also established a home care worker registry that provides consumers and home care agencies access to a listing

of individuals qualified to provide personal care aide and home health aide services in New York State.

Furthermore, the New York State Attorney General's Office also operates a Healthcare Bureau that protects and advocates for the rights of healthcare consumers. The Bureau operates a toll-free Helpline and collaborates with the Department as necessary on consumer complaints received.

Local Quality Assurance Processes

Local districts employ a number of methods to assure the delivery of quality services:

- 18 NYCRR 505.14 requires all local districts to conduct an annual on-site visit to each agency with which it is contracted to furnish program services. Department staff monitor compliance with this regulation during on-site visits.

- No fewer than 15 local districts undertake client satisfaction surveys annually; more than a dozen discuss client satisfaction during the six-month reassessment; and at least 10 others have initiated, within the past two years, a complaint process with their provider agencies.

- A minimum of 45 local districts meet annually with provider agencies to discuss the provision of service.

- Six local districts indicated that district staff participate on contracted agencies' local Quality Assurance Committee. These Committees are required by licensure regulation.

- The majority of local districts monitor time and attendance records and review nursing supervision reports on an ongoing basis. Many districts also monitor personal care aide training classes and in some cases present sessions on the program including the role of the local district.

Department staff matched the names in the OIG audit sample with the Department's Complaint Tracking System to identify any service issues reported, and found only a single match for which the individual's complaint was reviewed, investigated and resolved. No other complaints were reported to the system by any other individuals in the sample, even though each was provided the Hotline number to call when service issues are encountered.

CONCLUSION

The Department believes that the 35 claims upon which the $120,441,703 audit findings amount is based, substantially comply with the regulations. It found nothing in the OIG report or amongst the local districts' documentation that would indicate that any of the services provided were ultimately found to be inappropriate, excessive or unnecessary to maintain the patient's health and safety in the community. The audit deficiencies are based on a review of isolated portions of the PCSP regulations as opposed to the totality of the intent of the regulations which is to provide support to individuals in the community in the most integrated setting as directed by the Supreme Court's Olmstead Decision. The State's regulations are comprehensive and detailed, and contain numerous standards and requirements which the state and local districts

diligently strive to achieve. They also contain many procedural checks and balances to assure appropriate services are provided to qualified individuals when circumstances preclude strict adherence to procedural standards set forth in the regulations. A failure to comply 100 percent with a procedural requirement does not negate the validity of the program benefit or the beneficiary's dire need for the services. When a Medicaid beneficiary has an immediate need for services in order to remain in his or her home, a local district may have to choose between strict regulatory procedural compliance or patient health and safety. The Department hopes in such situations that the federal government will agree that patient health and safety takes priority over procedural compliance. If the OIG asserts that strict adherence to procedural requirements contained in the State's regulations is the essential criteria upon which federal funding is based, New York and other states may be forced to re-evaluate their home and community-based program/services regulations.

The Department strongly encourages OIG to eliminate the draft recommended financial recoveries from the final audit report. Perhaps alternative recommendations could focus on requirements for the Department to: review current regulatory required assessment/prior authorization requirements; promulgate assessment/prior authorization regulations that assure provision of appropriate services to eligible recipients; and conduct statewide local district training in required assessment and prior authorization requirements. Such alternative recommendations would be consistent with OIG recommendations in other audits.