Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOME OF NEW YORK'S CLAIMS FOR MEDICAID LONG-TERM HOME HEALTH CARE WAIVER PROGRAM SERVICES WERE UNALLOWABLE

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

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EXECUTIVE SUMMARY

New York claimed at least $2.6 million in Federal Medicaid reimbursement for long-term home health care program waiver services that were unallowable.

WHY WE DID THIS REVIEW

This audit is part of a series of reviews of New York's Medicaid waiver programs. During prior reviews, we determined that the State agency claimed Federal Medicaid reimbursement for home and community-based services (HCBS) under a Medicaid waiver program that did not comply with Federal requirements.

The objective of this review was to determine whether the New York State Department of Health (State agency) claimed Medicaid reimbursement for long-term home health care program (LTHHCP) waiver services that complied with certain Federal requirements.

BACKGROUND

In New York, the State agency administers the Medicaid program, including services provided under the State agency's LTHHCP waiver (an HCBS waiver program). Specifically, the State agency's Division of Long Term Care administers the program through local departments of social services (LDSS). Under the program, the State agency is allowed to claim Medicaid reimbursement on a fee-for-service basis for HCBS provided to individuals who would otherwise require nursing facility care.

Federal regulations require the State agency to conduct initial evaluations, with annual reevaluations, of Medicaid beneficiaries enrolled in the LTHHCP waiver to determine whether they require a level of care that would be provided in an institution unless they received HCBS. Further, beneficiaries' homes must be assessed as a suitable environment for their being able to safely receive all necessary health and safety needs. Federal regulations also require that HCBS be furnished under a plan of care approved by the State agency. In addition, Federal law requires providers to maintain complete and accurate records to support any services billed.

HOW WE CONDUCTED THIS REVIEW

We reviewed Medicaid payments to the State agency for LTHHCP waiver services from January 1, 2011, through December 31, 2012. For this period, the State agency claimed approximately $66 million ($33 million Federal share) for 1,817,197 LTHHCP waiver services provided during 406,135 beneficiary-months. We reviewed a random sample of 135 beneficiary-months of service. A beneficiary-month includes all LTHHCP waiver services for a beneficiary for 1 month.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some LTHHCP waiver services that did not comply with certain Federal requirements. Of the 135 beneficiary-months in our sample, the State agency properly claimed Medicaid reimbursement for all LTHHCP waiver services during 94 beneficiary-months. However, the State agency claimed Medicaid reimbursement for unallowable LTHHCP waiver services during the remaining 41 beneficiary-months.

The State agency made claims for unallowable LTHHCP waiver services because its monitoring activities did not ensure that (1) services were provided in accordance with each beneficiary's plan of care, (2) documentation supported services billed, (3) level-of-care assessments were documented timely, (4) each beneficiary's residence was a suitable environment for their receiving services, and (5) beneficiaries were eligible to receive waiver program services based on their level-of-care assessment. On the basis of our sample results, we estimated that the State agency improperly claimed at least $2,608,137 in Federal Medicaid reimbursement for unallowable LTHHCP waiver services.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $2,608,137 to the Federal Government and
- ensure that it complies with certain Federal requirements by requiring:
  - LTHHCP providers to claim reimbursement only for documented services, and
  - LDSS to ensure and document that all beneficiaries approved for LTHHCP waiver services (1) have been assessed to meet minimum level-of-care requirements, (2) are eligible for those services, and (3) are in a home environment that is suitable for their receiving services.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially agreed with our first recommendation and described actions it has taken or planned to take to address our second recommendation. Under separate cover, the State agency provided additional documentation to support services for certain sampled beneficiary-months. The State agency disagreed with 25 of the 55 sampled beneficiary-months that we questioned in our in draft report, including 6 for which we identified multiple deficiencies.

After reviewing the State agency's comments and additional documentation, we revised our findings for 14 beneficiary-months and modified our statistical estimates accordingly. The additional documentation provided decreased the number of sampled claims found in error, which decreased both the average overpayment amount and the variability of the sample and thus

increased the precision of our estimated overpayment. As a result, our estimated overpayment also increased. We maintain that our remaining findings are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

This audit is part of a series of reviews of New York's Medicaid waiver programs. During prior reviews, we determined that the State agency claimed Federal Medicaid reimbursement for home and community-based services (HCBS) under a Medicaid waiver program that did not comply with Federal requirements. For a list of related Office of Inspector General reports, see Appendix A.

OBJECTIVE

The objective of this review was to determine whether the New York State Department of Health (State agency) claimed Medicaid reimbursement for long-term home health care program (LTHHCP) waiver services that complied with certain Federal requirements.

BACKGROUND

The 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 program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

Section 1915(c) of the Social Security Act (the Act) authorizes HCBS waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid.

New York's Long-Term Home Health Care Program Waiver

In New York State, the State agency administers the Medicaid program, including services provided under the State agency's LTHHCP waiver (an HCBS waiver program).[1] Specifically, the State agency's Division of Long Term Care administers the program through local departments of social services (LDSS) located in all but 7 counties throughout New York.[2] Under the program, the State agency is allowed to claim Medicaid reimbursement on a fee-for-service basis for HCBS provided to individuals who would otherwise require nursing facility care.

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[1] During our audit period, services provided under the LTHHCP included case management, respite, congregate and home-delivered meals, environmental modifications, home maintenance service, medical social services, moving assistance, nutritional counseling/education services, respiratory therapy, social day care and social day care transportation.

[2] The 7 counties—Livingston, Hamilton, Schoharie, Lewis, Essex, Chenango and Schuyler—do not have a LTHHCP.

Federal regulations require the State agency to conduct initial evaluations, with annual reevaluations, of Medicaid beneficiaries enrolled in the LTHHCP waiver to determine whether they require a level of care that would be provided in an institution unless they received HCBS. Further, beneficiaries' homes must be assessed as a suitable environment for their being able to safely receive all necessary health and safety needs.[3] Under its waiver agreement with CMS, State agency assessors who perform these evaluations must complete certain training requirements.

Federal regulations also require that HCBS must be furnished under a plan of care approved by the State agency.[4] The plan of care must include an assessment of the services needed to prevent the beneficiary from requiring institutionalization and specify the services to be provided and their frequency. The plan of care must also be reviewed and approved every 60 days by the beneficiary's physician and a LTHHCP agency registered nurse.

For details on Federal requirements related to the State agency's LTHHCP waiver, see Appendix B.

HOW WE CONDUCTED THIS REVIEW

From January 1, 2011, through December 31, 2012, the State agency claimed approximately $66 million ($33 million Federal share) for 1,817,197 LTHHCP waiver services provided during 406,135 beneficiary-months. Of these claims, we reviewed a random sample of 135 beneficiary-months of service. A beneficiary-month includes all LTHHCP waiver services for a beneficiary for 1 month.

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

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

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some LTHHCP waiver services that did not comply with certain Federal requirements. Of the 135 beneficiary-months in our sample, the State agency properly claimed Medicaid reimbursement for all LTHHCP waiver services during 94 beneficiary-months. However, the State agency claimed Medicaid

[3] If a physician determines an individual cannot be safely cared for at home or the individual is assessed to need a nursing home level of care, the person may not be admitted to the LTHHCP.

[4] LDSS and LTHHCP agencies are both responsible for reviewing application packets, including eligibility decisions and plans of care, and must maintain documentation of each plan of care and level of care assessment for at least 3 years.

reimbursement for unallowable LTHHCP waiver services during the remaining 41 beneficiary-months. Of the 41 beneficiary-months during which the State agency improperly claimed Federal Medicaid reimbursement for LTHHCP waiver services, 8 contained more than 1 deficiency. Appendix F contains a summary of deficiencies, if any, identified for each sampled beneficiary-month.

SERVICES NOT PROVIDED IN ACCORDANCE WITH PLAN OF CARE

HCBS must be furnished under a written plan of care subject to approval by the State Medicaid agency (42 CFR § 441.301(b)(1)(i)). A plan of care must specify the services to be provided, their frequency, and the type of provider (section 4442.6 of CMS's *State Medicaid Manual*). In addition, New York's waiver agreement with CMS states that all LTHHCP waiver services will be furnished pursuant to a plan of care, and Federal financial participation will not be claimed for waiver services that are not included in the individual written plan of care. Further, the waiver agreement requires that the plan of care be signed by a physician.

During 24 sampled beneficiary-months, the State agency claimed reimbursement for some LTHHCP waiver services that were not provided in accordance with the beneficiary's approved plan of care. Specifically:

- Services not included in plan of care. During 19 beneficiary-months, providers claimed reimbursement for LTHHCP waiver services that were not specified in the beneficiary's plan of care.

- Excess units billed. During 3 beneficiary-months, providers claimed reimbursement for LTHHCP waiver services in excess of the number of units detailed in the beneficiary's plan of care.

- Plan of care not signed. During 2 beneficiary-months, providers claimed reimbursement for LTHHCP services when the beneficiary's plan of care was not signed by a physician.

SERVICES NOT DOCUMENTED

States must have agreements with providers under which providers agree to keep records that fully disclose the extent of the services provided to Medicaid beneficiaries (section 1902(a)(27) of the Act). In addition, Federal cost principles require providers to maintain documentation of services provided.[5]

During 13 sampled beneficiary-months, the State agency claimed reimbursement for some LTHHCP waiver services that were not adequately documented. Specifically:

[5] Costs must be adequately documented to be allowable under Federal awards (2 CFR § 225, App. A § C.1.j (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*)). In addition, Medicaid reimbursement is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services provided by certified providers (section 2497.1 of CMS's *State Medicaid Manual*).

- Services not supported. During 12 beneficiary-months, service documentation did not include service notes to support or document the services billed.

- Billing rate not supported. During 1 beneficiary-month, service documentation indicated that the service provided was reimbursed at a rate higher than the appropriate rate code.

LEVEL-OF-CARE ASSESSMENT NOT DOCUMENTED OR DOCUMENTED TIMELY

To be eligible for HCBS, which include LTHHCP waiver services, a beneficiary's plan of care must include a level-of-care assessment approved by a physician that includes services needed to prevent the beneficiary from requiring institutionalization.[6] The State agency uses the *New York State Long Term Placement Medical Assessment Abstract* (DMS-1 form) to assess nursing home level-of-care. To continue participation in the LTHHCP waiver, a reassessment must be done at least every 180 days. Beneficiaries must also have periodic reevaluations, at least annually, to determine whether they continue to need the level of care provided (42 CFR 441.302(c)).

During 8 sampled beneficiary-months, the State agency claimed reimbursement for waiver program services provided to beneficiaries who were not assessed to require nursing home level-of-care or whose reassessments were not completed timely.

- Level-of-care assessment not documented. During 4 beneficiary-months, the State agency claimed reimbursement for LTHHCP waiver services for beneficiaries for which a level-of-care assessment was not documented.

- Reassessment not completed timely. During 3 beneficiary-months, providers claimed reimbursement for LTHHCP waiver services for beneficiaries for which a reassessment was not documented within the required 180-day period.[7]

- No assessment covering service dates. During 1 beneficiary-month, a provider claimed reimbursement for LTHHCP waiver services before the beneficiary's initial DMS-1 form was documented.

HOME ENVIRONMENT NOT SUITABLE OR HOME ASSESSEMENT INCOMPLETE

The State agency's waiver agreement with CMS states that, to be eligible for the LTHHCP, the beneficiary's home environment must be assessed to be suitable to meet the beneficiary's functional and psychological needs. The State agency uses the *Home Assessment Abstract* (HAA form) to assess home environments. This assessment is signed by a registered nurse and LDSS representative and is used to determine the services the beneficiary requires in order to prevent institutionalization.

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[6] Section 1915(c) of the Act, 42 CFR 441.301(b)(1)(iii), and the State's LTHHCP waiver agreement with CMS.

[7] For each service, the sampled service date was after the date for which the beneficiary's level-of-care assessment was to be renewed. Reassessments were subsequently completed more than 30 days after the renewal date.

During 3 sampled beneficiary-months, the State agency claimed reimbursement for LTHHCP waiver services that were ineligible because the HAA was incomplete or the beneficiary's home environment was not assessed to be suitable to meet the beneficiary's needs. Specifically:

- Needs could not be met through home care. During 2 beneficiary-months, providers claimed reimbursement for LTHHCP waiver services for which the HAA indicated that the beneficiary's needs could not be met through home care.

- Incomplete home assessment form. During 1 beneficiary-month, a provider claimed reimbursement for LTHHCP waiver services for a beneficiary whose HAA was not completed.

INELIGIBLE BENEFICIARY

The State agency's waiver agreement with CMS states that, to be eligible for the LTHHCP waiver, a beneficiary must be assessed to need nursing facility level-of-care. The State agency uses the DMS-1 form, which assigns a numerical score based on answers to specific questions, for this assessment. The form is also used to assess whether the beneficiary is eligible for home care. A score of 60 or higher or a physician's override of the assessment tool is considered evidence that the beneficiary meets nursing facility eligibility criteria.

During 2 sampled beneficiary-months, the State agency claimed reimbursement for program waiver services provided to beneficiaries whose DMS-1 forms indicated that they were not assessed to be eligible for nursing facility level-of-care or home care. Specifically:

- Beneficiary not assessed to be eligible for nursing facility level-of-care. During 1 beneficiary-month, a provider claimed reimbursement for LTHHCP waiver services for a beneficiary whose DMS-1 scores were lower than 60 and for whom a physician did not override the assessment.

- Beneficiary not assessed to be eligible for home care. During 1 beneficiary-month, a provider claimed reimbursement for LTHHCP waiver services for a beneficiary whose DMS-1 form indicated that they were not eligible for home care.

CONCLUSION

On the basis of our sample results, we estimated that the State agency improperly claimed at least $2,608,137 in Federal Medicaid reimbursement for unallowable LTHHCP waiver services that did not comply with Federal requirements.[8]

The State agency made claims for unallowable LTHHCP waiver services because its monitoring activities did not ensure that (1) services were provided in accordance with each beneficiary's approved plan of care, (2) documentation supported services billed, (3) level-of-care assessments

[8] 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 at least 95 percent of the time.

were documented timely, (4) each beneficiary's residence was a suitable environment for receiving services, and (5) beneficiaries were eligible to receive waiver program services based on their level-of-care assessment.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,608,137 to the Federal Government and
- ensure that it complies with certain Federal requirements by requiring:
  - LTHHCP providers to claim reimbursement only for documented services and
  - LDSS to ensure and document that all beneficiaries approved for LTHHCP waiver services (1) have been assessed to meet minimum level-of-care requirements, (2) are eligible for those services, and (3) are in a home environment that is suitable for their receiving services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially agreed with our first recommendation and described actions it has taken or planned to take to address our second recommendation. Under separate cover, the State agency provided additional documentation to support services for certain sampled beneficiary-months. The State agency disagreed with 25 of the 55 sampled beneficiary-months that we questioned in our in draft report, including 6 for which we identified multiple deficiencies.

The State agency's comments appear as Appendix G.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and additional documentation, we revised our findings for 14 beneficiary-months and modified our statistical estimates accordingly. The additional documentation provided decreased the number of sampled claims found in error which decreased both the average overpayment amount and the variability of the sample and, thus increased the precision of our estimated overpayment. As a result, our estimated overpayment also increased. We maintain that our remaining findings are valid.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Some of New York's Claims for Medicaid Supported Employment Services were Unallowable	A-02-13-01004	9/29/2014
New York Claimed Unallowable Room-and-Board Costs Under Its Developmental Disabilities Waiver Program	A-02-12-01031	5/6/2014
New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements	A-02-10-01043	5/21/2013
Review of Medicaid Payments for Services Under New Jersey's Section 1915(c) Community Care Waiver Program	A-02-10-01029	4/23/2012
Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services - Manhattan LTHHCP	A-02-10-01002	4/20/2012
Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Bancroft NeuroHealth	A-02-09-01034	3/22/2012
Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Elwyn New Jersey	A-02-09-01033	7/28/2011
Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver at Venture Forthe, Inc.	A-02-09-01005	5/25/2011

APPENDIX B: FEDERAL REQUIREMENTS RELATED TO LONG-TERM HOME HEALTH CARE PROGRAM WAIVER

Section 1915(c) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(iii)) provide that HCBS may be provided only to beneficiaries who have been determined would, in the absence of such services, require the Medicaid covered level of care provided in a hospital, nursing facility, or intermediate care facility for seniors and persons with physical disabilities.

Federal regulations (42 CFR § 441.302(c)) require a State agency to provide for an initial evaluation of the beneficiary's need for the level of care that would be provided in an institution unless the individual receives HCBS. The regulations further require at least annual reevaluations of each beneficiary receiving HCBS.

Section 4442.6 of CMS's *State Medicaid Manual* requires an assessment of the individual to determine the services needed to prevent institutionalization be included in the plan of care. In addition, the plan of care must specify the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available under a section 1915(c) waiver for HCBS furnished without a written plan of care.

New York's waiver agreement with CMS states that to be eligible for the LTHHCP waiver program, a beneficiary must be assessed to need nursing facility level of care as determined by the *New York State Long Term Placement Medical Assessment Abstract* (DMS-1). The DMS-1 assigns patients a numerical score based on individual medical needs. To meet the requirements for nursing home level of care, a minimum DMS-1 score of 60 is required unless a physician determines the individual's score does not reflect the person's true medical or functional status. If such a case, a physician may provide an override so that the individual can obtain necessary services.

New York State's waiver agreement with CMS states that all waiver services will be furnished pursuant to a written plan of care, and Federal financial participation will not be claimed for waiver services that are not included in the individual written plan of care.

Section 1902(a)(27) of the Act, 42 U.S.C. § 1396a(a)(27), mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under a State plan.

The Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), requires that costs be adequately documented to be allowable under Federal awards.

Federal financial participation is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services rendered by certified providers (section 2497.1 of CMS's *State Medicaid Manual*). Expenditures are allowable only to the extent that, when a claim is filed, the provider has adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid payments to the State agency for LTHHCP waiver services from January 1, 2011, through December 31, 2012. For the period, the State agency claimed approximately $66 million ($33 million Federal share) for 1,817,197 LTHHCP waiver services provided during 406,135 beneficiary-months. We reviewed a random sample of 135 beneficiary-months of service. A beneficiary-month includes all LTHHCP waiver services for a beneficiary for 1 month.

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for LTHHCP waiver services claimed for reimbursement. 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 objective. We reviewed the providers' and the LDSS's internal controls for documenting LTHHCP waiver services billed and claimed for reimbursement. We did not assess the appropriateness of HCBS payment rates.

We performed our fieldwork at 50 providers' offices throughout New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- met with CMS financial and program management officials to gain an understanding of the HCBS waiver approval, administration, and assessment processes;
- met with State agency officials to discuss the State agency's administration and monitoring of the LTHHCP;
- interviewed providers' regarding their LTHHCP policies and procedures;
- obtained from New York's Medicaid Management Information System (MMIS) a sampling frame of 406,136 beneficiary-months with LTHHCP waiver services for which the State agency claimed reimbursement totaling $65,804,840 ($32,902,881 Federal share) during calendar years 2011 through 2012;
- reconciled the LTHHCP waiver services that the State agency claimed for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the sampling frame of all payments for LTHHCP waiver services to providers statewide obtained from New York's MMIS for calendar years 2011 through 2012;

- removed from our sampling frame 1 beneficiary-month totaling $240 ($120 Federal Share) for a provider reviewed by New York's Office of Medicaid Inspector General;

- determined that our revised sampling frame consisted of 406,135 beneficiary-months totaling $65,804,600 ($32,902,761 Federal share) during calendar years 2011 through 2012;

- selected a stratified random sample of 135 beneficiary-months and for each beneficiary-month:

    - determined whether the beneficiary was assessed by a certified individual to be eligible to participate in the LTHHCP,

    - determined whether the beneficiary's home environment was assessed to be appropriate for necessary services,

    - determined whether LTHHCP waiver services were provided in accordance with an approved plan of care,

    - determined whether documentation supported LTHHCP waiver services billed,

    - determined whether the staff members who provided the LTHHCP waiver services met qualification requirements, and

    - identified LTHHCP waiver services that were not provided or documented in accordance with Federal requirements;

- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 406,135 beneficiary-months; and

- discussed the results of the review with State agency officials.

See Appendix D for the details of our statistical sampling methodology and Appendix E 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 D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of beneficiary-months of service provided under New York's LTHHCP waiver for which the State agency received Medicaid reimbursement during calendar years 2011 through 2012. A beneficiary-month is defined as all LTHHCP waiver services for one beneficiary for 1 month.

SAMPLING FRAME

The sampling frame was an Access file containing 406,135 beneficiary-months of service totaling $65,804,600 ($32,902,761 Federal share) for which the State agency received Medicaid reimbursement from January 1, 2011 through December 31, 2012. We eliminated from the sampling frame all LTHHCP waiver services for one provider reviewed by New York's Office of Medicaid Inspector General. We extracted the data for these beneficiary months from New York's MMIS.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a stratified random sample. To accomplish this, we separated the sampling frame into two strata, as follows:

- Stratum 1: beneficiary-months with total payments for LTHHCP waiver services totaling $3,000 or less—406,100 beneficiary-months totaling $65,518,398 ($32,759,660 Federal share).

- Stratum 2: beneficiary-months with total payments for LTHHCP waiver services greater than $3,000—35 beneficiary-months, totaling $286,202 ($143,101 Federal share).

SAMPLE SIZE

We selected a sample of 135 beneficiary-months:

- 100 beneficiary-months from stratum 1 and

- 35 beneficiary-months from stratum 2.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample items in the first stratum. After generating 100 random numbers for this stratum, we selected the corresponding frame items. We selected for review all 35 beneficiary-months in stratum 2.

ESTIMATION METHODOLOGY

We used OAS statistical software to appraise our sample results. We estimated the overpayment associated with the unallowable LTHHCP waiver services in the beneficiary-months at the lower limit of the 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum	Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months With Unallowable Services	Value of Unallowable Services (Federal Share)
1	406,100	$32,759,660	100	$8,863	25	$1,048
2	35	143,101	35	143,101	16	$44,040
Total	**406,135**	**$32,902,761**	**135**	**$151,964**	**41**	**$45,088**

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

Point estimate	$4,301,714
Lower limit	$2,608,137
Upper limit	$5,995,291

APPENDIX F: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED BENEFICIARY-MONTH

Legend

Deficiency	Description
1	Services Not Provided in Accordance With Plan of Care
2	Services Not Documented
3	Level-of-Care Assessment Not Documented or Documented Timely
4	Home Environment Not Suitable or Home Assessment Incomplete
5	Ineligible Beneficiary

Office of Inspector General Review Determinations for the 135 Sampled Beneficiary-Months

Sample Beneficiary-Month[9]	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-1	X					1
S1-2						0
S1-3					X	1
S1-4						0
S1-5						0
S1-6						0
S1-7						0
S1-8						0
S1-9		X				1
S1-10	X					1
S1-11						0
S1-12						0
S1-13						0
S1-14	X	X		X		3
S1-15	X					1
S1-16						0
S1-17						0
S1-18	X					1
S1-19						0
S1-20						0

[9] S1 and S2 indicate stratum 1 and 2, respectively.

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-21			X			1
S1-22						0
S1-23						0
S1-24		X				1
S1-25						0
S1-26						0
S1-27						0
S1-28						0
S1-29						0
S1-30						0
S1-31			X			1
S1-32	X	X				2
S1-33		X		X		2
S1-34						0
S1-35				X		1
S1-36						0
S1-37						0
S1-38						0
S1-39						0
S1-40						0
S1-41						0
S1-42						0
S1-43						0
S1-44						0
S1-45						0
S1-46						0
S1-47						0
S1-48						0
S1-49			X			1
S1-50						0
S1-51						0
S1-52						0

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-53						0
S1-54						0
S1-55			X			1
S1-56						0
S1-57						0
S1-58	X					1
S1-59		X	X			2
S1-60						0
S1-61						0
S1-62						0
S1-63						0
S1-64						0
S1-65		X				1
S1-66						0
S1-67						0
S1-68						0
S1-69						0
S1-70	X					1
S1-71						0
S1-72						0
S1-73	X	X				2
S1-74	X					1
S1-75						0
S1-76						0
S1-77						0
S1-78						0
S1-79						0
S1-80						0
S1-81						0
S1-82						0
S1-83						0
S1-84						0
S1-85						0

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-86						0
S1-87		X	X			2
S1-88					X	1
S1-89	X					1
S1-90						0
S1-91						0
S1-92			X			1
S1-93						0
S1-94						0
S1-95						0
S1-96						0
S1-97						0
S1-98						0
S1-99						0
S1-100						0
S2-1	X					1
S2-2						0
S2-3						0
S2-4	X					1
S2-5						0
S2-6		X				1
S2-7		X				1
S2-8	X					1
S2-9			X			1
S2-10	X	X				2
S2-11	X					1
S2-12	X					1
S2-13	X					1
S2-14						0
S2-15						0
S2-16						0
S2-17						0
S2-18						0

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S2-19						0
S2-20						0
S2-21						0
S2-22						0
S2-23	X					1
S2-24	X					1
S2-25						0
S2-26						0
S2-27	X	X				2
S2-28						0
S2-29						0
S2-30	X					1
S2-31						0
S2-32						0
S2-33						0
S2-34	X					1
S2-35	X					1
Category Totals	**24**	**13**	**8**	**3**	**2**	**50**
41 Beneficiary-Months in Error						

APPENDIX G: 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

September 29, 2015

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

Ref. No: A-02-13-01030

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-13-01030 entitled, "Some of New York's Claims for Medicaid Long-Term Home Health Care Program Waiver Services Were Unallowable."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

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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-02-13-01030 entitled Some of New York's Claims for Medicaid Long-Term Home Health Care Program Waiver Services Were Unallowable

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-02-13-01030 entitled, "Some of New York's Claims for Medicaid Long-Term Home Health Care Program Waiver Services Were Unallowable."

Recommendation #1:

Refund $1,522,351 to the Federal Government.

Response #1

The Department conducted its own independent review and was able to secure documentation from Long Term Home Health Care Program (LTHHCP) providers and Local Districts of Social Services (LDSS) that support service provision. It is the Department's position that not all of the alleged deficiencies identified within this audit warrant a refund and a number of deficiencies are in dispute and should be reversed.

Deficiency Description:

1. Services Not Provided in Accordance With Plan of Care (POC) - (32 Deficiencies noted)

    - Services not included in POC – 27
    - Excess units billed – 3
    - POC not signed – 2

Of the 32 deficiencies noted in the audit report, the Department was able to secure documentation on four (4) claims from Stratum 1 and nine (9) claims from Stratum 2 that support the provision of services in accordance with the POC, totaling $339.15 and $62,167.78, respectively.

2. Services Not Documented - (17 Deficiencies noted)

    - Services not supported – 16
    - Billing rate not supported – 1

Of the 17 deficiencies noted in the audit report, the Department was able to secure supporting documentation of services on five (5) claims from Stratum 1 and four (4) claims from Stratum 2 totaling $158.08 and $294.90, respectively.

3. Level-of-Care Assessment Not Documented or Documented Timely – (10 Deficiencies noted)

    - Level-of-Care assessment not documented – 6
    - Reassessment not completed timely – 3

- No assessment covering service dates – 1

Of the ten (10) deficiencies noted in the audit report, the Department was able to secure Level-of-Care assessment documentation on three (3) claims from Stratum 2 totaling $34,787.34.

4. Home Environment Not Suitable or Home Assessment Incomplete – (6 Deficiencies noted)

   - Needs could not be met through home care – 4
   - Incomplete home assessment form – 1
   - Home assessment form not signed – 1

Of the six (6) deficiencies noted in the audit report, the Department was able to secure documentation on four (4) claims from Stratum 1 that support provision of care in the home environment, totaling $509.51.

5. Ineligible Beneficiary – (4 Deficiencies noted)

   - Beneficiary not assessed to be eligible for nursing facility Level-of-Care – 2
   - Beneficiary not assessed to be eligible for home care – 2

Of the four (4) deficiencies noted in the audit report, the Department was able to secure documentation on one (1) claim each from Stratum 1 and Stratum 2 to support beneficiary eligibility, totaling $143.76 and $6,380.00, respectively.

Recommendation #2:

Ensure that it complies with certain Federal requirements by requiring:

- LTHHCP providers to claim reimbursement only for documented services, and

- LDSS to ensure and document that all beneficiaries approved for LTHHCP waiver services (1) have been assessed to meet minimum level-of-care requirements, (2) are eligible for those services, and (3) are in a home environment that is suitable for their receiving services.

Response #2

As of July 3, 2015, all New York State counties have been approved for transition of participants from the LTHHCP to Managed Care. Therefore, the LTHHCP is no longer a program option for individuals needing home care. The current LTHHCP expired August 31, 2015; however, the Centers for Medicare and Medicaid Services granted the Department a temporary extension, through November 29, 2015, to allow the LTHHCP waiver to continue operating while approximately 700 individuals remaining in the program transition to Managed Care or other waiver programs.

Until such time as the waiver is terminated, the Department will continue to monitor the administration of the LTHHCP by the LDSS and the provider agencies, through case record review, ensuring that all participants remaining in the program continue to meet level-of-care requirements, are eligible for the services they are receiving, and that the home environment is suitable for receiving such services.