

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK VERIFIED THAT MEDICAID
ASSISTED LIVING PROGRAM PROVIDERS
MET LIFE SAFETY AND EMERGENCY
PLANNING REQUIREMENTS BUT DID
NOT ALWAYS ENSURE THAT ASSISTED
LIVING PROGRAM SERVICES MET
FEDERAL AND STATE REQUIREMENTS**

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Deputy Inspector General
for Audit Services

March 2022
A-02-19-01017

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

Date: March 2022

Report No. A-02-19-01017

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



Why OIG Did This Audit

A 2018 Government Accountability Office report found that improved Centers for Medicare & Medicaid Services oversight of State monitoring of Medicaid assisted living services was needed. We audited New York's Medicaid assisted living program (ALP) to determine whether its oversight and monitoring of ALP providers was effective because we have not conducted an audit of the program since 2006.

In New York, beneficiaries receiving ALP services generally require supervision and personal care to carry out basic activities of daily living. ALP providers must meet New York's life safety and emergency planning requirements.

Our objectives were to determine whether New York verified that ALP providers met life safety and emergency planning requirements for providing Medicaid services and claimed reimbursement for ALP services in accordance with Federal and State requirements.

How OIG Did This Audit

We conducted site visits at five ALP providers to review New York's monitoring and oversight of ALP providers' compliance with life safety and emergency planning requirements. Our audit covered 195,373 beneficiary-months of ALP services with Federal Medicaid payments totaling \$244 million for calendar years 2017 through 2018 (audit period). We audited a random sample of 100 beneficiary-months of ALP services.

New York Verified That Medicaid Assisted Living Program Providers Met Life Safety and Emergency Planning Requirements But Did Not Always Ensure That Assisted Living Program Services Met Federal and State Requirements

What OIG Found

New York verified that life safety and emergency planning requirements were met at the five judgmentally selected ALP providers we visited. However, it claimed reimbursement for some unallowable ALP services during our random sample of 100 beneficiary-months. Specifically, New York properly claimed Medicaid reimbursement for all ALP services during 91 beneficiary-months and claimed reimbursement for unallowable ALP services during the remaining 9 beneficiary-months. These deficiencies occurred because New York's monitoring was not sufficient to ensure that ALP providers complied with certain Federal and State requirements for providing, documenting, and billing services. Despite New York's efforts, some ALP providers did not comply with the requirements for (1) documenting beneficiary assessments and care plans and (2) claiming reimbursement only for services in accordance with Medicaid billing requirements and beneficiary care plans.

On the basis of our sample results, we estimated that New York improperly claimed at least \$1.9 million in Federal Medicaid reimbursement for ALP services during our audit period. In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their assessments and care plans were not valid or were missing, and some nurse's aides' qualifications were not documented. As a result, beneficiaries may have (1) not received ALP services that they were entitled to, (2) received services that were not needed, or (3) received services from some nurse's aides that were not qualified to perform the services furnished.

What OIG Recommends and New York Comments

We recommend that New York refund \$1.9 million to the Federal Government. We also made a series of recommendations for New York to strengthen its oversight and monitoring of its ALP to ensure that providers comply with Federal and State requirements.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations; however, it provided additional documentation regarding some ALP services. After reviewing New York's comments and the additional documentation, we revised our findings and estimates accordingly. The State agency also stated that it currently performs oversight and monitoring of the ALPs that reflect our recommendations. We maintain that our findings, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

A 2018 Government Accountability Office (GAO) report found that improved Centers for Medicare & Medicaid Services (CMS) oversight of Medicaid assisted living services was needed.¹ We audited the New York State Department of Health's (State agency's) Medicaid assisted living program (ALP) to determine whether its oversight and monitoring of ALP providers was effective because we have not conducted an audit of the program since 2006.

OBJECTIVES

Our objectives were to determine whether the State agency verified that ALP providers met life safety and emergency planning requirements for providing Medicaid services and claimed Medicaid reimbursement for ALP services in accordance with Federal and State 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, 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, the State agency administers the Medicaid program.

New York's Medicaid Assisted Living Program Services

States provide long-term services and supports care, which includes assisted living services, under their Medicaid State plans and through Medicaid demonstrations or waivers. Medicaid may provide assisted living services to beneficiaries who are medically eligible for nursing home placement but opt for a less medically intensive, lower-cost setting. Beneficiaries receiving assisted living services are generally required to have an assessment of their support needs and capabilities.

In New York, beneficiaries receiving ALP services generally require supervision and personal care services² to enable them to maintain good personal health and hygiene, to carry out the

¹ *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed*, GAO-18-179, February 2018. Available online at: <https://www.gao.gov/products/GAO-18-179>.

² Personal care services include direction and assistance with grooming, dressing, bathing, walking, eating, and with self-administration of medications.

basic activities of daily living, and to participate in the ongoing activities of the facility they reside in and the greater community.³ For example, a beneficiary requiring services from a nurse's aide may be provided with limited medical services, such as medication administration, or non-medical services, such as grooming and bathing, to assist the beneficiary's personal care needs.

ALP services are reimbursed based on 1 of 16 daily, all-inclusive rates paid to the ALP provider. The rates are based on Resource Utilization Groups (RUGs) that identify the complexity and severity of the beneficiary's needs. RUGs are based on a beneficiary's level of care. The appropriateness of ALP services is determined by a care plan developed through beneficiary assessments. ALP providers must also meet New York's life safety and emergency planning requirements, including installing fire prevention and smoke detection systems at their facilities and developing evacuation planning measures.

HOW WE CONDUCTED THIS AUDIT

We conducted site visits at five ALP providers to review the State agency's monitoring and oversight of the providers' compliance with life safety and emergency planning requirements.⁴ Specifically, we reviewed providers' compliance with requirements related to: (1) disaster and emergency planning, (2) environmental standards, and (3) food services, including whether personnel were qualified to ensure compliance with beneficiaries' dietary requirements.⁵

Our audit also covered 195,373 beneficiary-months of ALP services with Medicaid payments totaling \$486,588,779 (\$243,840,578 Federal share) for the period January 1, 2017, through December 31, 2018 (audit period).^{6, 7} We audited a random sample of 100 beneficiary-months of ALP services during the audit period to determine whether the services complied with Federal and State requirements.

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

³ Beneficiaries may receive the following services through a licensed ALP provider: (1) personal care services, (2) home health aide services, (3) personal emergency response services, (4) nursing services, (5) physical therapy, (6) occupational therapy, (7) speech therapy, (8) medical supplies and equipment not requiring prior authorization, and (9) adult day health care.

⁴ We judgmentally selected the five providers based on the providers' geographic location and the results of State agency surveys that identified deficiencies.

⁵ We inspected beneficiary residences, common areas, kitchens, doors and exits, and the building exterior at each facility. We also reviewed building permits and certificates to ensure they were maintained and valid.

⁶ We define a beneficiary-month as all ALP services provided to a beneficiary during 1 month.

⁷ This audit period reflects the most recent data available at the start of this audit.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

FINDINGS

The State agency verified that life safety and emergency planning requirements were met at the five judgmentally selected ALP providers we visited. However, it claimed reimbursement for some unallowable ALP services during our random sample of 100 beneficiary-months. Specifically, the State agency properly claimed Medicaid reimbursement for all ALP services during 91 beneficiary-months and claimed reimbursement for some unallowable ALP services during the remaining 9 beneficiary-months. Table 1 summarizes the deficiencies noted and the number of beneficiary-months associated with each type of deficiency.⁸

Table 1: Summary of Deficiencies in Sampled Beneficiary-Months

Type of Deficiency	Beneficiary-Months Containing Deficiency
Incomplete or Missing Assessments	3
Services Not Provided	3
Nurse’s Aides’ Qualifications and Services Not Documented	3
No Valid Assessments	2
Care Plan Missing	1

These deficiencies occurred because the State agency’s monitoring was not sufficient to ensure that ALP providers complied with certain Federal and State requirements for providing, documenting, and billing services. The State agency has issued policy and billing guidance to ALP providers and conducts ALP inspections that include, among other things, reviewing providers’ admission standards, resident services, disaster and emergency planning, and records and reports. However, despite these efforts, some ALP providers did not comply with Federal and State requirements for (1) documenting beneficiary assessments and care plans, and (2) claiming reimbursement only for services in accordance with Medicaid billing requirements and beneficiary care plans.

⁸ The total exceeds nine because two beneficiary-months contained more than one deficiency. Also, two beneficiary-months did not impact the unallowable Medicaid reimbursement amount because other allowable services were performed under the all-inclusive daily rate.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$1,943,190 in Federal Medicaid reimbursement for ALP services during our audit period.⁹ In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their assessments and care plans were not valid or were missing, and some nurse's aides' qualifications were not documented. As a result, beneficiaries may have (1) not received ALP services that they were entitled to, (2) received services that were not needed, or (3) received services from some nurse's aides that were not qualified to perform the services furnished.

NEW YORK VERIFIED THAT ASSISTED LIVING PROGRAM PROVIDERS MET LIFE SAFETY AND EMERGENCY PLANNING REQUIREMENTS FOR PROVIDING MEDICAID SERVICES

ALP providers are required to maintain disaster and emergency planning procedures for the proper protection of residents and staff in the event an emergency or disaster interrupts normal service. Providers must also ensure that their facilities are clean and in good repair.¹⁰

We determined that the State agency verified that ALP providers met life safety and emergency planning requirements for providing Medicaid services. Specifically, we did not identify any issues related to disaster and emergency planning, environmental standards, or food services at the five ALP providers we visited.

NEW YORK CLAIMED FEDERAL REIMBURSEMENT FOR ASSISTED LIVING PROGRAM SERVICES THAT DID NOT COMPLY WITH MEDICAID REQUIREMENTS

Incomplete or Missing Assessments

New York requires ALP providers to conduct an initial assessment and a reassessment of beneficiaries' nursing, social, and functional needs before a provider may begin or continue providing services for which payment will be made.¹¹

During three beneficiary-months, the State agency claimed Federal Medicaid reimbursement for ALP services for which the beneficiary's assessments were incomplete or missing. Specifically, for services provided during one beneficiary-month, a portion of the beneficiary's reassessment was included in the beneficiary's record but lacked supporting documentation that the beneficiary's nursing and social reassessments were conducted. For another beneficiary-month, the beneficiary's reassessment was missing from the beneficiary's record.

⁹ 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 are designed to be less than the actual overpayment total 95 percent of the time.

¹⁰ Title 18 §§ 505.35(c), 487.11-487.12, and 488.11-488.12 of the New York Compilation of Codes, Rules, & Regulations (NYCRR).

¹¹ 18 NYCRR §§ 505.35(h), 494.4(g)(3) and 494.4(h).

For the remaining beneficiary-month, the beneficiary's initial assessment was not completed before the beneficiary began receiving services during the beneficiary-month.¹²

Services Not Provided

ALP providers must keep such records as are necessary to fully disclose the extent of services provided and are required to submit claims for payment only for services furnished. Payments for ALP services must not be made when a beneficiary is absent from the facility or hospitalized.¹³

During three beneficiary-months, the State agency claimed Federal Medicaid reimbursement for ALP services that were not provided.¹⁴ Specifically, during two beneficiary-months, ALP providers each billed for 1 day of services during which the associated beneficiary was absent from the assisted living facility. During another beneficiary-month, the ALP provider billed for 2 days of services during which the beneficiary was hospitalized.

Nurse's Aides' Qualifications And Services Not Documented

ALP providers are required to maintain records to document the extent of services provided to Medicaid beneficiaries and that those services are performed by trained qualified staff.¹⁵

During three beneficiary-months, the State agency claimed Federal Medicaid reimbursement for ALP services for which the provider did not provide documentation of the associated nurse's aide's qualifications. In addition, for one of the three beneficiary-months, the ALP provider billed for services for which it did not provide documentation to support the services the nurse's aides performed.¹⁶

¹² The beneficiary's initial assessment was conducted on June 25, 2018. Accordingly, we recommended a partial disallowance for this beneficiary-month because the assessment did not cover services performed from June 1 through June 24, 2018.

¹³ The Act § 1902(a)(27); 18 NYCRR §§ 504.3(e) and 505.35(h)(7).

¹⁴ A disallowance was only taken for the day(s) the beneficiary was not in the assisted living facility.

¹⁵ The Act § 1902(a)(27); 18 NYCRR §§ 494.6, 504.3, and 505.14.

¹⁶ New York's ALP pays providers a daily, all-inclusive rate for all services provided to beneficiaries, in accordance with their care plan. Therefore, we allowed Medicaid reimbursement for the beneficiary-months that lacked documentation for nurse's aides' qualifications or lacked documentation supporting the services the aides performed because we identified other allowable services that were performed in accordance with the beneficiary's care plan.

No Valid Assessments

ALP services must be provided to beneficiaries in accordance with a care plan based on an initial assessment and periodic reassessments by an ALP provider, either directly or through contract with a long-term home health care program. Providers must conduct an initial assessment of beneficiaries' overall needs for the initial admission into an assisted living facility and reassessments every 6 months thereafter, before beginning or continuing services for which payment will be made.¹⁷

During two beneficiary-months, the State agency claimed Federal Medicaid reimbursement for ALP services for which the associated beneficiary's care plan or assessment was conducted after the required 6-month timeframe or before an initial assessment. Specifically, for ALP services provided during 1 beneficiary-month, the associated beneficiary's care plan was conducted 120 days after it was due for renewal. For another beneficiary-month, the care plan was developed prior to the beneficiary's initial assessment.

Care Plan Missing

Prior to accepting a Medicaid beneficiary for healthcare services, ALP providers must develop a care plan and ensure that the beneficiary's services are provided in accordance with the care plan.^{18, 19}

During one beneficiary-month, the State agency claimed Federal Medicaid reimbursement for ALP services for which the beneficiary's care plan was not documented.

Conclusion

These deficiencies occurred because the State agency's monitoring was not sufficient to ensure that ALP providers complied with certain Federal and State requirements for providing, documenting, and billing services. The State agency has issued policy and billing guidance to ALP providers and conducts ALP inspections that include, among other things, reviewing providers' admission standards, resident services, disaster and emergency planning, and records and reports. However, despite these efforts, some ALP providers did not comply with Federal and State requirements for (1) documenting beneficiary assessments and care plans, and (2) claiming reimbursement only for services in accordance with Medicaid billing requirements and beneficiary care plans.

¹⁷ New York Social Services Law § 461-L(2)(d)(iii); 18 NYCRR §§ 505.35(h), 494.4(c), and 494.4(h).

¹⁸ New York State Plan Amendment #09-0023-B; 18 NYCRR §§ 505.35(d) and 494.4(c).

¹⁹ The care plan is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, need for palliative care, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations, and rehabilitation potential.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$1,943,190 in Federal Medicaid reimbursement for ALP services during our audit period. In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their assessments and care plans were not valid or were missing, and some nurse's aides' qualifications were not documented. As a result, beneficiaries may have (1) not received ALP services that they were entitled to, (2) received services that were not needed, or (3) received services from some nurse's aides that were not qualified to perform the services furnished.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund \$1,943,190 to the Federal Government and
- strengthen its oversight and monitoring of ALP providers to ensure that the providers 1) conduct timely and valid assessments, including nursing and social assessments; 2) bill only for services provided; 3) maintain required documentation; and 4) provide services only under a valid care plan.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. Regarding our first recommendation, the State agency stated that its Office of the Medicaid Inspector General (OMIG) obtained and reviewed documentation from providers associated with our sampled beneficiary-months and determined that some of the providers were appropriately paid. Also, the State agency stated that its OMIG initiated audits of ALP providers that overlap with the scope of this audit and will refund any identified overpayments to the Federal Government.²⁰

Under separate cover, the State agency provided additional documentation for four sampled beneficiary-months that we identified in our draft report as having deficiencies. After reviewing the additional documentation, we revised our determinations for 3 of the sampled beneficiary-months, which reduced the total number of sampled beneficiary-months with unallowable ALP services from 11 to 9, and revised our estimates accordingly.²¹

²⁰ According to the State agency, its OMIG maintains audit protocols which include, but are not limited to, reviewing beneficiary's records for valid assessments, documentation of services provided, and care plans.

²¹ We removed deficiencies for two beneficiary-months for which the State agency provided valid assessments. For a third beneficiary-month, we reduced the number of unallowable days billed from 4 to 2. The State agency also provided documentation (a beneficiary reassessment) related to a fourth beneficiary-month. However, we maintain that this beneficiary-month was billed in error because it lacked documentation to support that the beneficiary's nursing and social reassessments were conducted.

The State agency also indicated that it currently performs oversight and monitoring of ALP providers that reflect our recommendations. Specifically, the State agency stated that it performs surveillance of ALP providers and monitors licensed home care services agencies that are either operated or contracted by ALP providers. These activities include reviews of beneficiaries' medical records for completeness and ALP providers' personnel records, which include professional licensure, qualifications, trainings, and other required documentation.

Further, the State agency plans to issue guidance to ALP providers reminding them to follow appropriate program protocols, especially with regard to: 1) conducting timely and valid assessments, including nursing and social assessments; 2) billing only for services provided; 3) maintaining required documentation; and 4) providing services only under a valid care plan. The guidance will also remind ALP providers that all paraprofessional staff must have their eligibility confirmed via a State agency registry prior to being assigned to beneficiaries receiving ALP services.

The State agency also provided technical comments, which we addressed as appropriate. The State agency's comments, excluding the technical comments, are included in their entirety as Appendix D.

After reviewing the State agency's comments, we maintain that our findings and recommendations, as revised, are valid. In addition, we acknowledge the State agency's continuing efforts to ensure that ALP providers comply with Federal and State requirements and to recover improper payments made to these providers.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 195,373 beneficiary-months with Medicaid payments totaling \$486,588,779 (\$243,840,578 Federal share) for ALP services provided during the period January 1, 2017, through December 31, 2018 (audit period). We audited a random sample of 100 beneficiary-months of ALP services to determine whether the services complied with Federal and State requirements.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the State agency's Medicaid Management Information System (MMIS) for our audit period.²² We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State agency's claims for reimbursement on the CMS-64, Quarterly Medicaid Statement of Expenditures and the Management and Administrative Reporting Subsystem reports.

During our audit, we did not assess the State agency's overall internal control structure. Rather, we limited our review to the State agency's internal controls for monitoring ALP providers for compliance with life safety and emergency planning requirements, and requirements for providing, documenting, and billing ALP services.

We performed fieldwork at the State agency's offices in Albany, New York; New York City's Human Resources Administration offices in New York, New York; and at five assisted living providers located throughout New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid requirements;
- met with CMS financial and program management officials to gain an understanding of and obtain documentation on CMS's oversight and administration of New York's ALP;
- met with State agency officials to gain an understanding of the State agency's administration and oversight of the ALP;
- obtained from the State agency's MMIS, a database containing all payments for which the State agency claimed Medicaid reimbursement for ALP services during the audit period;

²² The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

- reconciled the State agency’s CMS-64 covering our audit period with the data obtained from the MMIS;
- created a sampling frame of 195,373 beneficiary-months with Medicaid payments totaling \$486,588,779 (\$243,840,578 Federal share);²³
- selected a statistical sample of 100 beneficiary-months of ALP services provided during the audit period, and for each of the 100 beneficiary-months, obtained and reviewed supporting documentation from the associated ALP provider;
- met with State agency officials and officials from New York City’s local department of social services (LDSS), and sent questionnaires to officials from LDSSs throughout New York to gain an understanding of the officials’ roles in the administration and monitoring of New York’s ALP;²⁴
- judgmentally selected five ALP providers based on the providers’ geographic location and the results of State agency surveys that identified deficiencies and, during site visits at each of the providers:
 - interviewed personnel to gain an understanding of their policies and procedures, including their procedures for assessing and enrolling beneficiaries, preparing plans of care and assessments, and documenting ALP services;
 - inspected the provider’s facilities to determine whether they complied with life safety and emergency planning requirements; specifically, we:
 - determined whether the provider sufficiently addressed deficiencies identified during State agency surveys;
 - reviewed operating certificates to determine whether facilities were appropriately licensed to conduct ALP services and if building permits and operating certificates were valid;
 - reviewed policies and procedures for evacuating beneficiaries;
 - determined whether fire alarms, sprinkler systems, fire extinguishers,

²³ The sampling frame included beneficiary-month payments totaling \$100 or more for ALP services.

²⁴ We sent questionnaires to 25 LDSS officials beginning March 2020; however, we were unable to obtain responses from 10 county health officials due to the onset of COVID-19 public health emergency. For the 15 county health officials that responded to our questionnaire, we noted that each indicated their local district was not involved in the administration or oversight of the ALP and confirmed that these functions were the State agency’s responsibility.

elevators, and heating systems were inspected or tested by a service company at least once every 12 months;

- determined whether evacuation drills, including full evacuation and shelter-in-place planned activities, were performed;
 - determined whether equipment and furnishings used by beneficiaries were clean and appropriately maintained; and
 - determined whether doors were not blocked and exits were closely monitored (e.g., through the use of video cameras);
- estimated the total amount of unallowable Federal Medicaid reimbursement made to the State agency for ALP services; and
 - discussed our results with State agency officials.

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

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame was an Access database containing 195,373 beneficiary-months with Medicaid payments totaling \$486,588,779 (\$243,840,578 Federal share), for ALP services claimed by the State agency during the audit period. The sampling frame included beneficiary-month payments totaling \$100 or more for ALP services.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 beneficiary-months.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the beneficiary-months within the sampling frame. After generating 100 random numbers, we selected the corresponding frame items for audit.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicaid beneficiary-month overpayments made for unallowable ALP services at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time. We also used this software to calculate the corresponding point estimate and upper limit.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Beneficiary-Months with Unallowable ALP Services in the Sample	Value of Unallowable ALP Payments in the Sample (Federal Share)
195,373	\$243,840,578	100	\$125,045	9*	\$5,425

* Seven of these nine beneficiary-months had errors that affected Medicaid reimbursement because, for two beneficiary-months, other allowable services were performed under the all-inclusive daily rate.

Estimated Value of Unallowable ALP Payments in the Sampling Frame (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$10,599,728
Lower limit	1,943,190
Upper limit	\$19,256,265

APPENDIX D: STATE AGENCY COMMENTS



KATHY HOCHUL
Governor

**Department
of Health**

MARY T. BASSETT, M.D., M.P.H.
Acting Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

December 22, 2021

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

Ref. No: A-02-19-01017

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-19-01017 entitled, "New York Verified that Medicaid Assisted Living Program Providers Met Life Safety and Emergency Planning Requirements but Did Not Always Ensure that Assisted Living Program Services Met Federal and State Requirements".

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Frank Walsh
Brett Friedman
Amir Bassiri
Geza Hrazdina
Daniel Duffy
Erin Ives
Timothy Brown
Amber Rohan
Brian Kiernan
Jill Montag
James DeMatteo
James Cataldo
Collin Gulczynski
Melissa Fiore
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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-02-19-01017 entitled,
“New York Verified That Medicaid Assisted Living Program Providers
Met Life Safety and Emergency Planning Requirements But Did Not
Always Ensure That Assisted Living Program Services Met Federal and
State Requirements.”**

The following are the responses from the New York State Department of Health (Department) to Draft Audit Report A-02-19-01017 entitled, “New York Verified That Medicaid Assisted Living Program Providers Met Life Safety and Emergency Planning Requirements But Did Not Always Ensure That Assisted Living Program Services Met Federal and State Requirements” by the Department of Health and Human Services, Office of Inspector General (OIG).

Recommendation #1:

Refund \$5,223,336 to the Federal Government.

Response #1:

The Office of the Medicaid Inspector General (OMIG) obtained and reviewed documentation from providers included in the sample and has determined that multiple samples were in fact paid appropriately. OMIG will submit this documentation to OIG under separate cover. If OIG agrees with OMIG’s determinations, then the amount OIG recommends to be refunded to the Federal government would decrease.

OMIG has initiated assisted living program audits that overlap with the OIG audit scope and will continue its reviews in this area. The federal share of any identified overpayments will be refunded to the Federal government. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider’s right to due process.

Recommendation #2:

Strengthen its oversight and monitoring of Assisted Living Program (ALP) providers to ensure that the providers 1) conduct timely and valid assessments, including nursing and social assessments; 2) bill only for services provided; 3) maintain required documentation; and 4) provide services only under a valid care plan.

Response #2:

The Department currently performs the following oversight and monitoring of ALP that reflects OIG’s recommendations:

1. Department staff perform surveillance of adult care facility/assisted living facilities. Upon inspection of an adult care facility with ALP licensure, depending on the type of inspection being performed (e.g., complaint, recertification/complete), the surveyor obtains a list of current residents then includes a sample of ALP participants in the request for resident records. The ALP participant medical record is reviewed to determine whether it contains the ALP medical evaluation which constitutes the medical order for the ALP services. The surveyor reviews the evaluation for completeness. The record must also include the plan of care, reviewed for completeness, and then compared against other documentation in the medical record, to support that the services detailed on the plan of care coincide with the

recorded services provided. Lack of complete documentation may result in expanded survey scope and/or referral to other regulatory authorities, including but not limited to OMIG for the recovery of any resulting overpayments.

2. Department staff monitor the Licensed Home Care Services Agencies (LHCSAs) that are either operated or contracted by ALPs for the provision of paraprofessional services. Surveyors pull a roster of all aides and validate the names of these against the Home Care Registry to ensure that paraprofessional staff assigned to ALP have completed the required training. Surveyors also review the agency list of all staff by discipline. In addition, the surveyors determine compliance with 10 NYCRR Section 766.11, and select a sample of five percent of the personnel from the list of active LHCSA personnel and review documentation to determine that their personnel records contain:

- Professional licensure and current registration or certificate of approved training
- Verification of qualifications
- Two references
- Record of planned orientation
- Form of personal identification
- Current record of participation in in-service training including number of hours
- Evidence of HIV confidentiality in-service at time of employment and yearly thereafter
- Evidence of pre-employment health examination
- Evidence of a health reassessment performed within the past year for persons employed for more than one year
- Evidence of immunization for measles, rubella, and TB
- Current performance evaluation
- Signed and dated employment application

Additionally, OMIG maintains audit protocols, which address the recommendations advanced by OIG in the draft audit report, including but not limited to reviewing for valid assessments, documentation of services provided, and plans of care. For this audit, OMIG is analyzing the claim documentation provided by OIG and is initiating the audit process to pursue recovery of any payments determined to be inappropriate based on incomplete documentation. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Based on the foregoing, the Department and OMIG have sufficient protocols in place for the surveillance and oversight of ALPs; however, the Department agrees that reinforcement of ALP compliance obligations, as evidenced by OIG's recommendations, can help ensure that ALPs are following all applicable regulations and requirements. To that end, the Department is issuing a Dear Administrator Letter (DAL) to ALP providers reminding them to follow the appropriate program protocols, especially with regard to: 1) conducting timely and valid assessments, including nursing and social assessments; 2) billing only for services provided; 3) maintaining required documentation; and 4) providing services only under a valid care plan. The DAL will also remind the ALPs that all paraprofessional staff employed by any affiliated or contracted LHCSA with the ALP must be checked against the Home Care Registry to confirm eligibility to be assigned to ALP cases.