

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEW YORK IMPROVED ITS  
MONITORING OF ITS PERSONAL CARE  
SERVICES PROGRAM BUT STILL MADE  
IMPROPER MEDICAID PAYMENTS  
OF MORE THAN \$54 MILLION**

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# *Office of Inspector General*

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## Report in Brief

Date: December 2020

Report No. A-02-19-01016



### Why OIG Did This Audit

Prior OIG audits found that New York did not effectively monitor its Medicaid personal care services program and, as a result, made more than \$375 million in Federal Medicaid payments for services that did not comply with Federal and State requirements. This audit was conducted to determine whether New York made improvements to its monitoring of the program and whether any of those improvements were effective.

Personal care services provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so they can remain in their homes and communities. Although New York oversees the program, local departments of social services (local districts) are responsible for authorizing the services and arranging service delivery with a personal care services provider.

Our objective was to determine whether New York claimed Medicaid reimbursement for personal care services that complied with Federal and State requirements.

### How OIG Did This Audit

Our audit covered 5,675,965 claims with Federal Medicaid payments totaling \$438 million for personal care services provided during calendar years 2015 through 2018 (audit period). We reviewed a stratified random sample of 140 claims and determined whether the services complied with Federal and State requirements.

## New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than \$54 Million

### What OIG Found

New York claimed Federal reimbursement for personal care services that did not comply with certain Federal and State requirements for 28 of the 100 sampled claims. Specifically, New York received reimbursement for personal care services for which there was (1) no valid nursing or social assessment, (2) no independent medical review, (3) no valid physician's order or the order was not timely, (4) no documentation of services provided, and (5) no plan of care. Additionally, for some claims, the personal care aide who provided the associated services had not undergone a timely criminal history check or did not meet training requirements.

The unallowable claims occurred because New York's monitoring of the personal care services program was not adequate to ensure that services complied with Federal and State requirements. However, we noted that in 2017, New York made some improvements to its monitoring of the program.

On the basis of our sample results, we estimated that New York improperly claimed at least \$54.5 million in Federal Medicaid reimbursement for personal care services during our audit period. In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their personal care aides had not undergone a criminal history check prior to providing personal care services or did not meet training requirements.

### What OIG Recommends and New York's Comments

We recommend that New York refund \$54.5 million to the Federal Government, continue to improve its monitoring of local districts, and reinforce with local districts and personal care services providers Medicaid requirements related to personal care services.

In written comments on our draft report, New York did not specifically indicate concurrence or nonconcurrence with our recommendations; however, it described steps that it plans to take to address them, including pursuing recovery of any payments determined to be inappropriate, reviewing each local district at least once every 2 years, reinforcing and ensuring providers comply with criminal history check and training requirements and implementing an electronic visit verification system. We commend New York for its planned steps to improve its monitoring of the personal care services program and to ensure local districts and personal care services providers comply with Medicaid requirements related to personal care services. We are also available to discuss our methodology with New York should it be necessary.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits of New York's Medicaid personal care services program found that the New York State Department of Health (State agency) did not effectively monitor the program and, as a result, made more than \$375 million in Federal Medicaid payments for personal care services provided during calendar years (CYs) 2004 through 2006 that did not comply with Federal and State requirements.<sup>1</sup> These audits identified personal care services that were not: (1) properly authorized, including services for which there were no physician orders or nursing assessments; (2) supervised by a registered nurse; and (3) provided by individuals who met State qualification requirements. In addition to recommending that the State agency refund more than \$375 million to the Federal Government, we recommended that it strengthen its monitoring of the personal care services program. This audit was conducted to determine whether the State agency made improvements to its monitoring of personal care services and whether any of those improvements were effective.

### OBJECTIVE

Our objective was to determine whether the State agency claimed Medicaid reimbursement for personal care services that complied with Federal and State requirements.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

#### New York's Medicaid Personal Care Services Program

New York's Medicaid personal care services program provides assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. Personal care services generally consist of non-medical services supporting activities of daily living, including bathing, dressing, light housework, money management, meal preparation, and transportation. Although the State agency is responsible

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<sup>1</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York City* ([A-02-07-01054](#)) June 3, 2009, and *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* ([A-02-08-01005](#)) October 8, 2010.

for overseeing the program, local departments of social services (local districts)<sup>2</sup> are responsible for authorizing personal care services and arranging service delivery with a personal care services provider.

New York provides 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.
- Level II services include Level I services and personal care functions, such as assisting beneficiaries with bathing, grooming, and toileting.

Each local district oversees that district's personal care services program. Services are provided through contracts with home care/personal care agencies.

To receive personal care services, a Medicaid beneficiary must undergo a medical examination by a physician or other qualified medical professional and such services must be based on an order signed by a physician within 30 calendar days of the medical examination.<sup>3</sup> When a local 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,<sup>4</sup> and a nursing assessment.<sup>5, 6</sup> If the case involves continuous care or live-in 24-hour personal care services, the professional director,<sup>7</sup> a physician contracted by the local district, or a designee must conduct an independent medical review to authorize this level of care.<sup>8</sup> Authorizations for personal care services are required to be completed before the initiation of services.<sup>9</sup> Once authorized, personal care services must be provided in accordance with a plan of care, by a qualified person who has undergone a criminal history check and who

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<sup>2</sup> In New York State, each county is considered its own social services district, except the five counties that make up New York City, which are considered a single district.

<sup>3</sup> Section 1905(a)(24) of the Social Security Act (The Act), 42 Code of Federal Regulations (CFR) § 440.167(a)(1), and Title 18 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) §§ 505.14(b)(3) and (b)(5)(viii).

<sup>4</sup> The social assessment determines the family and community support available for the beneficiary to remain in the community.

<sup>5</sup> The nursing assessment should be based on a review of the physician's order and include development of a plan of care.

<sup>6</sup> 18 NYCRR § 505.14 (b)(2).

<sup>7</sup> The professional director is usually a medical doctor contracted by the local district.

<sup>8</sup> 18 NYCRR §§ 505.14 (b)(4)(i)(c) and (b)(5)(viii).

<sup>9</sup> 18 NYCRR § 505.14(b)(5).



is supervised by a registered professional nurse.<sup>10, 11</sup> Lastly, claims for personal care services must be supported by documentation of the time spent providing services.<sup>12</sup>

## HOW WE CONDUCTED THIS AUDIT

Our audit covered 5,675,965 claims with Medicaid payments totaling \$873,694,317 (\$438,447,759 Federal share) for personal care services provided during CYs 2015 through 2018 (audit period).<sup>13</sup> We reviewed a stratified random sample of 140 of these claims and determined whether the personal care 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

## FINDINGS

The State agency claimed Federal Medicaid reimbursement for personal care services that did not comply with certain Federal and State requirements. Specifically, 112 of the 140 sampled claims included personal care services that complied with Federal and State requirements, but 28 did not. Table 1 (next page) summarizes the deficiencies we identified.

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<sup>10</sup> Personal care services must be reauthorized at least every 12 months. The reauthorization process generally includes the same procedures as the initial authorization; however, the reauthorization of Level I services does not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged.

<sup>11</sup> Section 1905(a)(24) of The Act; 42 CFR § 440.167; New York State Plan (TN 09-47 (Attachment 3.1-A Supplement, page 3(d)(A); Attachment 3.1-B Supplement, page 3(d)(A))); 18 NYCRR §§ 505.14(a)(1), (d)(4)(v), (e), (f)(3); 10 NYCRR § 402.4.

<sup>12</sup> 18 NYCRR § 505.14 (h)(1).

<sup>13</sup> Medicaid claims for CYs 2015 through 2018 were the most current data available when we started our audit.

**Table 1: Summary of Deficiencies in Sampled Claims**

Type of Deficiency	Number of Unallowable Claims <sup>14</sup>
No Valid Nursing Assessment	10
Independent Medical Review Not Completed	9
No Valid Physician’s Order	7
Criminal History Check Not Completed Timely	4
Services Not Documented	4
Aide Did Not Meet Training Requirements	4
No Valid Social Assessment	2
Physician’s Order Not Completed and Signed Within 30 Days of Medical Exam	2
No Plan of Care	1

The unallowable claims occurred because the State agency’s monitoring of the personal care services program was not adequate to ensure that services complied with Federal and State requirements. In addition, some local districts were not aware of certain requirements. Lastly, for some claims, personal care service providers stated that they could not locate certain records or indicated that the claim was billed in error.

In response to our prior audits, the State agency stated that it had improved its monitoring of the personal care services program by increasing the number of monitoring visits of local districts and by revising its procedures for conducting those visits. However, we found that the State agency did not conduct any monitoring visits from 2009 to 2017, a period that included the first 2 years of our audit period (2015 and 2016). In 2017, the State agency began monitoring visits of local districts but has only visited 29 of New York’s 58 local districts since that time, and most of those visits did not focus on personal care services. Rather, according to State agency officials, most were more focused on the consumer-directed personal assistance program.<sup>15</sup> Further, the State agency’s monitoring visits do not include reviews of the local districts’ compliance with independent medical review requirements related to continuous care or live-in 24-hour personal care services. In 2019, subsequent to our audit period, the State agency further revised its monitoring procedures to ensure a more representative sample of personal care services are reviewed during its monitoring visits.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$54,456,563 in Federal Medicaid reimbursement for personal care services during our

<sup>14</sup> The total exceeds 28 because 10 claims contained more than 1 deficiency.

<sup>15</sup> The consumer-directed personal assistance program allows beneficiaries flexibility and freedom in choosing, training, and supervising their personal care services providers.

audit period.<sup>16</sup> In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their personal care aides did not meet training requirements or had not undergone a criminal history check prior to providing personal care services.

## **NO VALID NURSING ASSESSMENT**

Authorizations for Level I and II services must include a nursing assessment prepared by a registered nurse.<sup>17</sup> The nursing assessment should be based on a review of the applicable physician's order, include development of a plan of care, and be completed prior to the initiation of services.<sup>18</sup>

For 10 sample claims, there was no valid nursing assessment.<sup>19</sup> Specifically, for five claims, the nursing assessments were completed *before* the physician's order, and therefore not based on a review of the physician's order, as required. For another three claims, the nursing assessments were completed after the initiation of services and 7 to 79 days after the sampled service date. Additionally, for one claim, there was no evidence that the nursing assessment was completed by a registered nurse, as required.<sup>20</sup> Lastly, for the remaining claim, the local district did not provide a nursing assessment.

## **INDEPENDENT MEDICAL REVIEW NOT COMPLETED**

Authorizations involving continuous or live-in 24-hour personal care services are required to have an independent medical review conducted by the professional director, a physician contracted by the local district, or a designee and be completed prior to the initiation of services.<sup>21</sup>

For nine sample claims involving continuous or live-in 24-hour personal care services, an independent medical review was not completed prior to the initiation of services. Specifically, for eight claims, no independent medical review was performed, and for one claim, the review

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<sup>16</sup> 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.

<sup>17</sup> 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.

<sup>18</sup> 18 NYCRR §§ 505.14 (b)(2)(iii), (b)(3)(iii) and (b)(5)(viii).

<sup>19</sup> All 10 sample claims involved the reauthorization of Level II services.

<sup>20</sup> Specifically, the section of the nursing assessment that identifies who performed the assessment was blank; and therefore, we could not determine who completed the assessment. Further, the local district could not provide any other evidence to show that a registered nurse had prepared the nursing assessment.

<sup>21</sup> 18 NYCRR §§ 505.14 (b)(4)(i)(c) and (b)(5)(viii).

was completed 48 days after personal care services commenced and 12 days after the sampled service date. Most of these errors occurred because local districts were not aware of the State requirements related to independent medical review for continuous or live-in 24-hour personal care services.

### **NO VALID PHYSICIAN'S ORDER**

Personal care services are required to be authorized based on a physician's order completed by a physician or other qualified medical professional after conducting a medical exam of the beneficiary.<sup>22</sup> This physician's order must be signed by a physician prior to the initiation of services.<sup>23</sup>

For seven sample claims, a valid physician's order was not completed and signed prior to the initiation of personal care services. Specifically, for three claims, the physician's order was signed 32 to 141 days after the sampled service date. For two other claims, the physician's order was signed by a registered nurse—not by a physician, as required. For the remaining two claims, the local district did not provide a physician's order.

### **CRIMINAL HISTORY CHECK NOT COMPLETED TIMELY**

Personal care services providers must ensure that each person providing personal care services undergoes a timely criminal history check.<sup>24</sup>

For four sample claims, a criminal history check of the personal care aide who provided the sampled services was not completed timely.<sup>25</sup> Specifically, for 3 claims, checks on these aides were completed 412 to 980 days after the sampled service date, and for one claim, the personal care services provider did not provide any evidence that a criminal history check was completed. The personal care services providers associated with these claims were unable to explain why the checks were not timely.

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<sup>22</sup> A physician's assistant, nurse practitioner, or other approved specialist may complete the physician's order; however, a physician must sign the physician's order for it to be valid.

<sup>23</sup> Section 1905(a)(24) of The Act, 42 CFR § 440.167(a)(1), and 18 NYCRR §§ 505.14(b)(3) and (b)(5)(viii).

<sup>24</sup> New York State Plan (TN 09-47 (Attachment 3.1-A Supplement, page 3(d)(A) and Attachment 3.1-B Supplement, page 3(d)(A))), 18 NYCRR § 505.14 (d)(4)(v), and 10 NYCRR § 402.4.

<sup>25</sup> For these four claims, we only questioned the services provided by the aides who did not undergo a timely criminal history check. This resulted in two claims being questioned in their entirety and two claims being partially questioned.

## SERVICES NOT DOCUMENTED

No payment for personal care services will be made unless there is documentation of the time spent providing services for each beneficiary.<sup>26</sup>

For four sample claims, the personal care services provider did not provide documentation supporting the time spent providing services. Specifically, for three claims, the provider did not provide any record of time spent providing services on the sampled service date and, for the other claim, the hours billed exceeded the hours documented on the aide's timesheet for the sampled service date.<sup>27</sup>

## AIDE DID NOT MEET TRAINING REQUIREMENTS

Personal care services must be provided by a qualified individual. In this respect, New York requires each person performing personal care services (other than household functions only) to complete an initial 40-hour basic training course prior to performing any service. In addition, on a semiannual basis, each person providing personal care services (other than household functions only) must receive at least 3 hours of in-service training to develop specialized skills or knowledge not included in the basic training or to review or expand skills or knowledge included in the basic training.<sup>28</sup>

For four sample claims, there was no documentation to support that the aide met training requirements. Specifically, the personal care services provider did not provide documentation to support that the aide associated with the claim received the required initial basic training (one claim) or the required in-service training for the calendar year that included the sample service date (all four claims).<sup>29, 30</sup>

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<sup>26</sup> 18 NYCRR § 505.14 (h)(1).

<sup>27</sup> The one claim where the hours billed exceeded the hours documented was questioned in its entirety for other reasons.

<sup>28</sup> New York State Plan (TN 09-47 (Attachment 3.1-A Supplement, page 3(d)(A); Attachment 3.1-B Supplement, page 3(d)(A))); 42 CFR § 440.167(a)(2); and 18 NYCRR §§ 505.14 (e)(2)(i)(b), (e)(2)(ii), (e)(3), (e)(7), and (e)(9).

<sup>29</sup> For these four claims, we only questioned the services provided by the aides who did not meet training requirements. This resulted in two claims being questioned in their entirety and two claims being partially questioned.

<sup>30</sup> The total exceeds four because one aide did not meet both training requirements.

## **NO VALID SOCIAL ASSESSMENT**

A social assessment must be completed prior to each authorization and reauthorization period.<sup>31</sup>

For two sample claims, a valid social assessment was not completed prior to the sampled service date. Specifically, for one claim, the local district did not provide a social assessment. For the other claim, the social assessment was completed 79 days after the sampled service date.

## **PHYSICIAN'S ORDER NOT COMPLETED AND SIGNED WITHIN 30 DAYS OF MEDICAL EXAM**

A medical professional must complete and sign the physician's orders for personal care services within 30 calendar days after conducting a medical exam of the beneficiary.<sup>32</sup>

For two sample claims, the documentation provided by the local district did not support the physician's order being completed and signed within 30 calendar days of the medical exam. Specifically, for one claim, the date of the medical exam was not documented in the medical record; therefore, we could not determine if the physician's order occurred within 30 days of the medical exam. For the other claim, the physician's order was completed 61 days after the medical exam.

## **NO PLAN OF CARE**

Personal care services must be provided in accordance with a plan of care.<sup>33</sup>

For one claim, the local district could not locate the plan of care for the associated beneficiary.

## **CONCLUSION**

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$54,456,563 in Federal Medicaid reimbursement for personal care services during our audit period. In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their personal care aides did not meet training requirements or had not undergone a criminal history check prior to providing personal care services.

The unallowable claims occurred because the State agency's monitoring of the personal care services program was not adequate to ensure that services complied with Federal and State requirements. As of the date of this report, the State agency has not conducted monitoring

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<sup>31</sup> 18 NYCRR §§ 505.14 (b)(2)(ii), (b)(3)(ii), and (b)(5)(viii).

<sup>32</sup> 18 NYCRR §§ 505.14 (b)(3)(i)(a)(1) and (b)(5)(viii).

<sup>33</sup> 18 NYCRR § 505.14 (a)(1), 42 CFR § 440.167, and § 1905(a)(24) of The Act.

visits of all local districts on a continual basis. In addition, while the State agency has revised some of its monitoring procedures, they still do not include a review of local districts' compliance with the independent medical review requirements related to continuous care or live-in 24-hour personal care services. We also found that some local districts were not even aware of those requirements. Lastly, for some claims, personal care service providers stated that they could not locate certain records or indicated that the claim was billed in error.

## **RECOMMENDATIONS**

We recommend that the New York State Department of Health:

- refund \$54,456,563 to the Federal Government;
- continue to improve its monitoring of local districts by ensuring that:
  - each local district is monitored on a continuing basis;
  - monitoring visits include a review of local districts' compliance with independent medical review requirements; and
- reinforce with the local districts and personal care services providers Medicaid requirements related to personal care services to ensure:
  - local districts conduct all required assessments and examinations in a timely manner and that they maintain documentation related to the authorization and reauthorization of services;
  - local districts are aware of requirements related to conducting independent medical review;
  - personal care service providers conduct criminal history checks on all aides and verify that all aides meet training requirements prior to providing Medicaid services; and
  - personal care services providers document time spent providing services.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency did not specifically indicate concurrence or nonconcurrence with our recommendations; however, it described steps that it plans to take to address them. Specifically, regarding our first recommendation, the State agency indicated that its Office of Medicaid Inspector General will pursue recovery of any payments determined to be inappropriate as a result of its analysis of our audit methodology

and rate codes. Regarding our second recommendation, the State agency stated that it will review each local district at least once every 2 years. The review process will include reviews of local districts' compliance with independent medical review requirements related to continuous care or live-in 24-hour personal care services, as well as other Medicaid personal care services requirements. In addition, the State agency described recent statutory changes related to the assessment, reassessment, and authorization of personal care services that it believes will fully address our third recommendation. The State agency also detailed steps it plans to take to reinforce and ensure personal care services providers comply with criminal history check and training requirements. Lastly, the State agency stated that it is working with providers to implement an electronic visit verification system that will collect service delivery information and ensure time spent providing personal care services is accurately documented. The State agency's comments are included in their entirety as Appendix D.

We commend the State agency for its planned steps to improve its monitoring of the personal care services program and to ensure local districts and personal care services providers comply with Medicaid requirements. We are also available to discuss our methodology with State agency officials should it be necessary.



## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 5,675,965 claims with Medicaid payments totaling \$873,694,317 (\$438,447,759 Federal Share) for personal care services provided during calendar years 2015 through 2018 (audit period). We reviewed a stratified random sample of 140 of these claims to determine whether personal care 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 Medicaid Management Information System (MMIS)<sup>34</sup> for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State agency's claims for reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures (CMS-64).

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

We performed fieldwork at the State agency's office in Albany, New York; the MMIS fiscal agent in Rensselaer, New York; 17 local district offices; and 71 personal care services providers throughout New York.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid requirements;
- met with officials from the State agency, local districts, and personal care services providers to gain an understanding of the personal care services program and the procedures each have in place to ensure compliance with Federal and State requirements;
- obtained from New York's MMIS, a sampling frame of 5,675,965 claims for personal care services provided during the audit period, totaling \$873,694,317 (\$438,447,759 Federal Share) in Medicaid reimbursement;
- reconciled the State agency's CMS-64 covering our audit period with the data obtained from the MMIS;

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<sup>34</sup> The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

- selected a stratified random sample of 140 claims from the sampling frame, and for each of the 140 claims, obtained and reviewed supporting documentation from the associated local district and personal care services provider and the personnel record of the aide associated with the claim;
- estimated the total amount of improper Federal Medicaid reimbursement made to the State agency for personal care services claims; and
- discussed our results with State agency officials.

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

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

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of 8 Access databases containing 5,675,965 claims with Medicaid payments totaling \$873,694,317 (\$438,447,759 Federal share), for personal care services claimed by the State agency for calendar years 2015 through 2018. We extracted these claims from the New York MMIS.

### SAMPLE UNIT

The sample unit was a Medicaid claim for personal care services.

### SAMPLE DESIGN

We used a stratified sample as shown in Table 2 below:

**Table 2: Sample Design**

<b>Stratum Number</b>	<b>Location</b>	<b>Strata Bounds</b>	<b>Frame Federal Share Paid Amount</b>	<b>Frame Count</b>	<b>Sample Size</b>
1	New York City	> \$0 and ≤ \$70.14	\$70,265,785	1,507,602	20
2	New York City	> \$70.14 and ≤ \$117.60	\$70,994,239	792,183	20
3	New York City	> \$117.60 and ≤ \$144.95	\$67,978,444	534,890	20
4	New York City	> \$144.95	\$71,697,176	350,933	20
5	Rest of State	> \$0 and ≤ \$52.63	\$39,379,676	1,439,616	15
6	Rest of State	> \$52.63 and ≤ \$104.94	\$39,377,219	520,108	15
7	Rest of State	> \$104.94 and ≤ \$137.16	\$39,411,405	326,996	15
8	Rest of State	> \$137.16	\$39,343,815	203,637	15
<b>Total</b>			<b>\$438,447,759</b>	<b>5,675,965</b>	<b>140</b>

### SAMPLE SIZE

We selected a sample of 140 claims for personal care services as described above in Table 2.

### SOURCE OF RANDOM NUMBERS

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

## **METHOD FOR SELECTING SAMPLE ITEMS**

We consecutively numbered the claims in each of the eight strata. After generating random numbers for each stratum, we selected the corresponding frame items.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of improper Medicaid payments made for unallowable personal care 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 improper payment 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**

<b>Stratum Number</b>	<b>Claims in Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Claims With Unallowable Services</b>	<b>Value of Claims With Unallowable Services (Federal Share)</b>
1	1,507,602	\$70,265,785	20	\$845	1	\$39
2	792,183	70,994,239	20	1,802	1	76
3	534,890	67,978,444	20	2,485	2	257
4	350,933	71,697,176	20	4,263	3	478
5	1,439,616	39,379,676	15	493	3	129
6	520,108	39,377,219	15	1,111	4	272
7	326,996	39,411,405	15	1,818	6	768
8	203,637	39,343,815	15	2,923	8	1,255
<b>Total</b>	<b>5,675,965</b>	<b>\$438,447,759</b>	<b>140</b>	<b>\$15,739<sup>‡</sup></b>	<b>28</b>	<b>\$3,274</b>

<sup>‡</sup> Individual stratum values do not add up to the total amount due to rounding.

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

Point estimate	\$76,821,665
Lower limit	54,456,563
Upper limit	99,186,767

## APPENDIX D: STATE AGENCY COMMENTS



ANDREW M. CUOMO  
Governor

Department  
of Health

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

LISA J. PINO, M.A., J.D.  
Executive Deputy Commissioner

November 12, 2020

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-02-19-01016**

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-02-19-01016 entitled, "**New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than \$54 Million.**"

Thank you for the opportunity to comment.

Sincerely,

Lisa J. Pino, M.A., J.D.  
Executive Deputy Commissioner

Enclosure

cc: Diane Christensen  
Theresa Egan  
Brett Friedman  
Geza Hrazdina  
Dan Duffy  
Erin Ives  
Timothy Brown  
Amber Rowan  
Brian Kiernan  
Jonah Bruno  
Jill Montag  
Michael Spitz  
James DeMatteo  
James Cataldo  
Robert Schmidt  
Lori Conway  
OHIP Audit SM

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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-02-19-01016  
entitled, "New York Improved Its Monitoring of Its Personal Care  
Services Program But Still Made Improper Medicaid Payments  
of More Than \$54 Million"**

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The following are the responses from New York State Department of Health to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-19-01016 entitled, "New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than \$54 Million."

**Recommendation #1:**

Refund \$54,456,563 to the Federal Government.

**Response #1:**

The Office of the Medicaid Inspector General (OMIG) has audit protocols which address the findings in this OIG draft audit report, including but not limited to reviewing for valid nursing assessments, independent medical reviews, physician's orders, documentation of services provided, and plans of care. OMIG has previously performed audits of the personal care services program. For this audit, OMIG is analyzing the methodology and rate codes recently provided by OIG and is initiating the audit process to pursue recovery of any payments determined to be inappropriate as a result of that analysis. Any recoveries are subject to the provider's right to due process.

**Recommendation #2:**

Continue to improve its monitoring of local districts by ensuring that:

- each local district is monitored on a continuing basis;
- monitoring visits include a review of local districts' compliance with independent medical review requirements

**Response #2:**

The Department is working on implementing a more streamlined electronic desk review process, whereby each personal care services program operated by Local District of Social Services (LDSS) will be reviewed at least every other year. This process will reinforce and ensure LDSS compliance with Medicaid program and billing requirements. It will include a review of the LDSS compliance with independent medical reviews related to continuous care or live-in 24-hour personal care services, as well as other personal care services program requirements that are currently reviewed. LDSS found to be noncompliant will be required to provide an acceptable corrective action plan to the Department, which will be subject to monitoring by the Department and re-audit if warranted.

**Recommendation #3:**

Reinforce with the local districts and personal care services providers Medicaid requirements related to personal care services to ensure:

- local districts conduct all required assessments and examinations in a timely manner and that they maintain documentation related to the authorization and reauthorization of services;
- local districts are aware of requirements related to conducting independent medical review;
- personal care service providers conduct criminal history checks on all aides and verify that all aides meet training requirements prior to providing Medicaid services; and
- personal care services providers document time spent providing services.

**Response #3:**

In addition to implementing the Department's response #2, which will reinforce and ensure LDSS comply with Medicaid requirements related to personal care services, recent statutory changes resulting from recommendations of the Medicaid Redesign Team II and as adopted in the State Fiscal Year 2020-21 Enacted Budget will address OIG's recommendations. Specifically, the following statutory changes will result in the Department exercising additional oversight and centralized management, in place of local districts, regarding the assessment, reassessment and authorization of personal care services:

- Contracting with an "independent assessor" to perform all required community health assessments for community-based long-term care services, including personal care services. This will obviate the need for local districts to conduct these assessments, and through which the Department can exercise oversight regarding the timeliness of assessments and reassessments, as well as the preservation of clinical documentation;
- Requiring that physician orders for personal care services are issued by physicians who are a part of an independent physician panel, rather than from any community based providers. This will help streamline the independent medical examinations of Medicaid recipients and ensure that the physician orders are generated and retained centrally;
- Conducting an additional clinical review by an independent review panel composed of independent physicians and other practitioners for Medicaid recipients who are assessed to require, on average, more than 12 hours of personal care services a day. This ensures that personal care service authorizations for these individuals are sufficient and individuals can remain safe in the community; and
- Reducing the frequency of routine reassessments from semi-annual to annual, except when there is a significant change in condition. This will avoid unnecessary reassessments of Medicaid recipients and enable these individuals to continue accessing personal care services without change.

These recommendations from the Medicaid Redesign Team and the resulting statutory enactments, including the assumption of responsibilities by the independent assessor of functions and responsibilities previously performed by LDSS for Medicaid fee-for-service beneficiaries, will eliminate the need for any further reinforcement of these responsibilities with local districts. These initiatives will fully address these OIG recommendations through centralized oversight and management of these processes and control practices.

These recommendations and statutory enactments are also reflective of a larger focus by the Medicaid Redesign Team II and New York State I in implementing processes and controls that will focus on potentially excessive spending on long-term care services that have been growing at an unsustainable rate. Therefore, reforming the way in which Medicaid authorizes and



reimburses for personal care services, including the centralization of functions from local districts, was the area with the largest number of enacted proposals resulting from Medicaid Redesign Team II recommendations. Importantly, and with these principles in mind, the Department will now contract directly for the services of the independent assessor, which in turn will engage the independent physician panel and independent review panel, with the terms of such contract incorporating applicable Federal and State legal requirements, including the timely completion of the required assessments and maintenance of appropriate clinical documentation.

Additionally, to reinforce and ensure personal care service providers comply with criminal history checks and training requirements, the Department's Office of Primary Care and Health Systems Management (OPCHSM) will take the following steps:

- Develop a webinar for licensed home care services agencies that employ or contract with individuals who furnish personal care services; and,
- Issue a "Dear Administrator Letter" to all licensed home care services agencies reminding them of the requirement to perform the required Criminal History Record Check for new aides and to verify training through the Home Care Registry.

In addition, OPCHSM has reached out to the home care trade associations and advised them of the need to educate their members with respect to employing home care aides and the requirements for the Criminal History Record Check and that training and certification must be confirmed through the Home Care Registry.

The Department is currently working with applicable providers to implement, by January 1, 2021, an electronic visit verification system in which the Department will electronically collect service delivery information including the begin and end times of services. This will serve to ensure providers are accurately documenting the time spent providing personal care services.