

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK STATE IMPROPERLY
CLAIMED MEDICAID
REIMBURSEMENT FOR SOME HOME
HEALTH SERVICES CLAIMS
SUBMITTED BY CERTIFIED HOME
HEALTH AGENCIES**

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



Daniel R. Levinson
Inspector General

September 2013
A-02-11-01008

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage, which varies depending on a State's relative per capita income.

In New York State, the Department of Health (State agency) administers Medicaid. The home health services program is operated by the State agency's Office of Long Term Care. Under the program, Certified Home Health Agencies (CHHAs) provide preventive, therapeutic, and/or rehabilitative services to Medicaid beneficiaries.

Pursuant to Federal regulations, home health services are provided to a beneficiary at the beneficiary's place of residence and on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days. Many providers use Form CMS-485, Home Health Certification and Plan of Care, as the required plan of care to document physicians' orders for home health services. Pursuant to State requirements, home health aides must complete a basic training program in home health aide services or an equivalent exam approved by the State agency.

This review excluded service claims submitted by CHHAs in New York City that we previously audited (A-02-10-01022).

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for selected State plan home health services claims submitted by CHHAs in the State in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency claimed Federal Medicaid reimbursement for some home health services claims submitted by CHHAs in the State that were not in accordance with Federal and State requirements. Of the 100 claims in our random sample, 85 claims complied with Federal and State requirements, but 15 claims did not. Specifically:

- For 10 claims, the physician did not review the plan of care.

- For two claims, there was no plan of care.
- For one claim, the CHHA could not provide documentation to support the service.
- For one claim, the CHHA did not provide the service in the beneficiary's place of residence.
- For one claim, the home health aide did not complete a basic training program.

These deficiencies occurred because some CHHAs in the State did not comply with Federal and State requirements.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$31,482,913 in Federal Medicaid reimbursement during our January 1, 2007, through December 31, 2009, audit period.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$31,482,913 to the Federal Government and
- issue guidance to CHHAs in the State on Federal and State requirements for physicians' orders and plans of care.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate either concurrence or nonconcurrence with our two recommendations. Regarding our recommended financial disallowance, the State agency stated that its Office of the Medicaid Inspector General (OMIG) found additional documentation to support one claim and provided the documentation under separate cover. The State agency also asked that CMS waive collection of the recommended disallowance in lieu of corrective action being taken by OMIG. Regarding our recommendation that it issue guidance to CHHAs, the State agency stated that CHHAs are on notice to comply with Federal conditions of participation, particularly as they relate to plans of care. In addition, plan of care requirements have also been included in guidance issued to providers and in audit protocols posted on OMIG's Web site. The State agency stated that it will evaluate whether additional guidance is needed.

After reviewing the State agency's comments and additional documentation related to one claim, we revised our findings and modified our statistical estimates accordingly.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on a State's relative per capita income.

New York State's Medicaid Program

In New York State (the State), the Department of Health (State agency) administers Medicaid. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. From January 1, 2007, through September 30, 2008, the FMAP in the State was 50 percent. From October 1, 2008, through December 31, 2009, the FMAP in the State varied from 58.78 percent to 61.59 percent.

New York State's Home Health Services Program

Within the State agency, the Office of Long Term Care operates the home health services program. Under the program, Certified Home Health Agencies (CHHAs) provide preventive, therapeutic, and/or rehabilitative services to Medicaid beneficiaries.¹ CHHAs may contract with Licensed Home Care Services Agencies (LHCSAs) to provide home health services.² Most CHHAs provide nursing care directly to beneficiaries and contract with one or more LHCSAs to provide other home health services, such as physical therapy and occupational therapy.

Reimbursement under Medicaid is available for home health services provided by CHHAs certified by the State agency. According to State regulations at Title 10 § 763.3(a) of the New York Compilation of Codes, Rules, & Regulations (NYCRR), a CHHA must be able to provide, directly or through contractual arrangement, a minimum of four services: nursing, home health aide, medical supplies/equipment/appliances, and at least one optional service (e.g., physical therapy or occupational therapy).

¹ Medicaid beneficiaries who receive home health service may be acutely or chronically ill with conditions requiring skilled nursing services or conditions requiring only maintenance and supervision. The level of need may range from total dependence to virtual independence.

² LHCSAs are not-for-profit or proprietary organizations and are generally not qualified to participate as CHHAs.

Federal Requirements for Home Health Services

Section 1905(a)(7) of the Act authorizes home health services. Pursuant to 42 CFR § 440.70(a), “home health services” are services provided to a beneficiary at the beneficiary’s place of residence and “[o]n his or her physician’s orders as part of a written care plan that the physician reviews every 60 days” Many providers use Form CMS-485, Home Health Certification and Plan of Care, as the required plan of care to document physicians’ orders for home health services.³ Line 3 of Form CMS-485 is entitled “Certification Period” and includes spaces for providers to enter “From” and “To” dates for valid home health services. The certification period represents the 60-day period during which the plan of care is valid. Physician review is required at the end of each certification period. (See Appendix A for the CMS form.)

Principles and standards for determining allowable costs incurred by State and local governments under Federal awards are established by 2 CFR pt. 225 (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). Pursuant to 2 CFR § App. A, C.1.c, to be allowable, costs must be authorized or not prohibited by State or local laws and regulations.

State Requirements for Home Health Services

New York’s approved State Medicaid plan—SPA 07-13—provides that home health care services are medically necessary services (physician order required) that a CHHA provides to individuals in the home and community. State regulations for home health services covered under the State plan are in 18 NYCRR § 505.23.⁴ Pursuant to 10 NYCRR § 700.2(b)(9), home health aides must complete a basic training program in home health aide services or an equivalent exam approved by the State agency.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for selected State plan home health services claims submitted by CHHAs in the State in accordance with Federal and State requirements.

Scope

Our audit period covered January 1, 2007, through December 31, 2009. Our review covered 5,720,894 claim lines, totaling \$684,816,530 (\$342,425,306 Federal share), submitted by CHHAs in the State. (In this report, we refer to these lines as “claims.”) Our audit population

³ Form CMS-485 is not a required form. CHHAs may submit any document that: (1) has a physician’s signature and date, (2) has all of the Form’s data elements, and (3) is in accordance with the current rules governing the home health plan of care.

⁴ All citations to 18 NYCRR § 505.23 are to the 2009 edition of the NYCRR, which is applicable to our entire audit period. The section was amended in November 2010.

did not include State plan home health services submitted by CHHAs in New York City, which we audited separately.⁵

We limited our review to claims for the following State plan services: home health aide, nursing, occupational therapy, physical therapy, audiology, speech therapy, and speech pathology.⁶

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

We performed fieldwork at the State agency's offices in Albany, New York; at the MMIS fiscal agent in Rensselaer, New York; and at 57 CHHAs and 15 LHCSAs throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- held discussions with State agency officials and county officials throughout the State to gain an understanding of the home health services program;
- identified a sampling frame of 5,720,894 selected State plan home health services claims, totaling \$684,816,530 (\$342,425,306 Federal share), submitted by CHHAs in the State;⁷
- selected a simple random sample of 100 claims⁸ from the sampling frame of 5,720,894 claims; and for each of these 100 claims we:
 - reviewed the CHHA's and contracted LHCSA's (if applicable) documentation supporting the claim and
 - reviewed the personnel file of the corresponding home health aide or medical professional for training documentation and certifications; and

⁵ *New York Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies in New York City (A-02-10-01022, issued November 29, 2012).*

⁶ Our audit population did not include home health services covered under a waiver to the State plan.

⁷ We used CHHAs' correspondence addresses and county codes on the MMIS to identify those located in the State but outside of the five counties that make up New York City. In addition, the sampling frame did not include claims submitted by 16 CHHAs audited by the New York State Office of Medicaid Inspector General (OMIG) during our audit period.

⁸ The 100 sampled claims comprised 48 home health aide services, 29 nursing services, 13 physical therapy services, 6 occupational therapy services, and 4 speech therapy services.

- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 5,720,894 claims.

Our sample design and methodology are in Appendix B.

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.

FINDINGS AND RECOMMENDATIONS

The State agency claimed Federal Medicaid reimbursement for some home health services claims submitted by CHHAs in the State that were not in accordance with Federal and State requirements. Of the 100 claims in our random sample, 85 claims complied with Federal and State requirements, but 15 claims did not. The following table lists the type of deficiencies and the number of claims for each type:

Summary of Deficiencies in Sampled Claims

Deficiency	Unallowable Claims
Plan of care not reviewed	10
No plan of care	2
Service not documented	1
Service not furnished in place of residence	1
Aide did not receive basic training	1

These deficiencies occurred because some CHHAs in the State did not comply with Federal and State requirements.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$31,482,913 in Federal Medicaid reimbursement during our January 1, 2007, through December 31, 2009, audit period.

PLAN OF CARE NOT REVIEWED

Pursuant to 42 CFR § 440.70(a)(2), home health services mean services provided to a beneficiary on his or her physician’s orders as part of a written plan of care that the physician reviews every 60 days. All of the CHHAs in our sample used Form CMS-485 to document both the certification period based on a physician’s review every 60 days and a plan of care for each Medicaid beneficiary.

For 10 of the 100 claims in our sample, a physician did not review the corresponding plan of care within the 60-day certification period indicated on the corresponding Form CMS-485. For these claims, the physician reviewed Form CMS-485 an average of 118 days after the certification period ended. The CHHA officials that we interviewed stated that these unallowable claims

occurred because it was difficult to coordinate plan of care reviews with beneficiaries' physicians within the required 60-day period.

NO PLAN OF CARE

Pursuant to 42 CFR § 440.70(a)(2), home health services mean services provided to a beneficiary on his or her physician's orders as part of a written plan of care.

For 2 of the 100 claims in our sample, the CHHA could not provide a plan of care for the beneficiary that covered the service date.⁹

SERVICE NOT DOCUMENTED

Pursuant to 42 CFR § 433.32, services claimed for Federal Medicaid reimbursement must be documented. Pursuant to 18 NYCRR § 505.23(e)(1), payments for home health services are prohibited unless the claims for payment are supported by documentation of the time spent providing services.

For 1 of the 100 claims in our sample, the CHHA could not document that services were provided for 4 of the 24 hours billed on our service date.

SERVICE NOT FURNISHED IN PLACE OF RESIDENCE

Pursuant to 42 CFR § 440.70(a), home health services are services provided to a beneficiary at the beneficiary's place of residence. Pursuant to 42 CFR § 440.70(c), a beneficiary's place of residence does not include a hospital, nursing facility, or intermediate care facility.

For 1 of the 100 claims in our sample, the service was provided in a hospital, as part of an outpatient physical therapy service.

AIDE DID NOT RECEIVE BASIC TRAINING

Pursuant to 18 NYCRR § 505.23(a)(2)(iii), home health aide services must be provided by a home health aide who meets the State agency's training requirements. Pursuant to 10 NYCRR § 700.2, home health aides must successfully complete a basic training program in home health aide services or an equivalent exam approved by the State agency.

For 1 of the 100 claims in our sample, services were provided by an individual who had not completed a basic training program in home health aide services.¹⁰

⁹ For these two sampled claims, the CHHAs billed for home health services but were actually providing personal care services.

¹⁰ We noted that on our service date, the individual had a personal care services certification, which is less stringent than a home health certification.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 home health services claims that we sampled, 15 were not made in accordance with Federal and State requirements. On the basis of our sample results, we estimated that the State improperly claimed at least \$31,482,913 in Federal Medicaid reimbursement from January 1, 2007, through December 31, 2009, for selected State plan home health services claims that CHHAs in the State submitted. Our sample results and estimates are in Appendix C.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$31,482,913 to the Federal Government and
- issue guidance to CHHAs in the State on Federal and State requirements for physicians' orders and plans of care.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate either concurrence or nonconcurrence with our two recommendations.¹¹ Regarding our recommended financial disallowance, the State agency stated that its OMIG found additional documentation to support one claim (sampled claim number 6) and provided the documentation under separate cover. The State agency also asked that CMS waive collection of the recommended disallowance in lieu of corrective action being taken by OMIG.¹² Regarding our recommendation that it issue guidance to CHHAs, the State agency stated that CHHAs are on notice to comply with Federal conditions of participation, particularly as they relate to plans of care. In addition, plan of care requirements have also been included in guidance issued to providers and in audit protocols posted on OMIG's Web site. The State agency stated that it will evaluate whether additional guidance is needed.

After reviewing the State agency's comments and additional documentation related to sampled claim number 6, we revised our findings and modified our statistical estimates accordingly. The State agency's comments appear in their entirety as Appendix D.

¹¹ In its comments, the State agency also provided a detailed description of recent reforms to its Medicaid program, including a new methodology to reimburse CHHAs for Medicaid services. These reforms were implemented after our audit period.

¹² The State agency did not specify what corrective action it has taken or plans to take at providers. Rather, the State agency stated that OMIG visited 8 providers associated with 11 total claims that we determined to be unallowable.

APPENDIXES

APPENDIX A: FORM CMS-485, HOME HEALTH CERTIFICATION AND PLAN OF CARE

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
8. Date of Birth		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD-9-CM	Principal Diagnosis	Date			
12. ICD-9-CM	Surgical Procedure	Date			
13. ICD-9-CM	Other Pertinent Diagnoses	Date			
14. DME and Supplies			15. Safety Measures:		
16. Nutritional Req.			17. Allergies:		
18.A. Functional Limitations			18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Care	D <input type="checkbox"/> Other (Specify)
			5 <input type="checkbox"/> Exercises Prescribed		
19. Mental Status:			5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated	
	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
20. Prognosis:			1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT
24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was State plan home health claim lines (claims) submitted by Certified Home Health Agencies (CHHAs) in New York State during our January 1, 2007, through December 31, 2009, audit period that New York State claimed for Federal Medicaid reimbursement. The population did not include State plan home health services submitted by CHHAs in New York City, which we audited separately.

SAMPLING FRAME

The sampling frame was a computer file containing 5,720,894 detailed paid claims for selected State plan home health services submitted by CHHAs in the State during our audit period.¹ The total Medicaid reimbursement for the 5,720,894 claims was \$684,816,530 (\$342,425,306 Federal share). The Medicaid claims were extracted from the claim files maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample to evaluate the population of Federal Medicaid claims.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the 5,720,894 detailed claims. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit at a 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

¹ We limited our review to claims for the following State plan services: home health aide, nursing, occupational therapy, physical therapy, audiology, speech therapy, and speech pathology.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
5,720,894	\$342,425,306	100	\$6,106	15	\$950

Estimated Unallowable Costs (Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$54,346,205
Lower limit	\$31,482,913
Upper limit	\$77,209,496

APPENDIX D: STATE AGENCY COMMENTS



Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 24, 2013

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Ref. No. A-02-11-01008

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General draft audit report number A-02-11-01008 entitled, "New York State Improperly Claimed Medicaid Reimbursement For Some Home Health Services Claims Submitted By Certified Home Health Agencies."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Nazarko", written over a horizontal line.

Michael J. Nazarko
Deputy Commissioner
for Administration

Enclosure

cc: Nirav R. Shah, M.D., M.P.H.
Jason A. Helgeson
James C. Cox
Michael J. Nazarko
Robert W. LoCicero, Esq.
Diane Christensen
Dennis Wendell
Stephen F. LaCasse
Ronald Farrell
OHIP BML

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-11-01008 entitled
New York State Improperly Claimed Medicaid
Reimbursement For Some Home Health Services
Claims Submitted By Certified Home Health Agencies**

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-02-11-01008 entitled, "New York State Improperly Claimed Medicaid Reimbursement For Some Home Health Services Claims Submitted By Certified Home Health Agencies."

Recommendation #1:

Refund \$32,591,967 to the Federal Government.

Response #1:

The OIG's audit sample consisted of 100 randomly-selected claims from among the 5,720,894 claims totaling \$342,425,306 in federal share (FS) reimbursements over the January 1, 2007 through December 31, 2009 audit period. OIG disallowed 16 of the 100 claims in the audit sample, and extrapolated the \$969. in FS reimbursements relative to these 16 claims across the more than 5.7 million claims universe to calculate the \$32,591,967 recommended refund amount.

The OMIG, concentrating on the finding, "Plan of Care Not Reviewed," visited 8 providers representing 11 claims disallowed by the OIG audit. The OMIG found documentation supporting one claim, submitted by Clinton DOH LTHHCP CO, (provider [REDACTED]). A plan of care (POC) was found for OIG Case #6, date of service 1/27/08, which was properly signed and dated within the certification period. It appears this POC was misfiled and a second POC was sent to the physician for review and that one was signed late, and later reviewed by OIG. The documentation obtained from the provider is available for review.

CMS is respectfully requested to waive collection of OIG's recommended disallowance which is based on an extrapolation of \$969. in disallowed claims, in lieu of the OMIG continuing to take corrective action on a provider-by-provider basis within the statute of limitations. If CMS will not waive collection of the entire OIG amount, it is requested that the findings attributed to the claim of Clinton DOH LTHHCP CO be eliminated for the reason stated above.

Governor Cuomo established the Medicaid Redesign Team (MRT) by Executive Order upon taking office in January 2011, bringing together stakeholders and experts from throughout the state to work cooperatively to reform the health care system and reduce costs.

Office of Inspector General Note: We redacted a portion of the State agency's comments that included personally identifiable information.

In May of 2012, the Department submitted an Amended Partnership Plan Medicaid Section 1115 Demonstration waiver to the Centers for Medicare and Medicaid Services (CMS) for approval to require all dual-eligible individuals (persons in receipt of both Medicare and Medicaid) who are aged 21 or older and are in need of community-based long term care services for more than 120 days to be enrolled into Managed Long Term Care Plans (MLTCPs) or Care Coordination Models (CCMs). This approval was granted in August 2012.

As a component of a fully integrated care management system, Medicaid Redesign Team Proposal #90 and 2011 budget legislation required the mandatory transition and enrollment of certain community based long term care services recipients into Managed Long Term Care Plans (MLTCPs) or Care Coordination Models (CCMs). To meet the goals of MRT #90, MLTCP applications were expeditiously reviewed and approved as additional capacity was needed to accommodate the influx of MLTCP enrollments migrating from fee-for-service long term care service programs such as the Personal Care Program, the Long Term Home Health Care Program (LTHHCP) and individuals moving from long term Certified Home Health Agency (CHHA) care. New York State recognizes three models of MLTCPs: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus Plans; and, partially capitated Managed Long Term Care Plans (PCMLTCP). Partially capitated Managed Long Term Care Plans provide long-term (personal care, home health) and ancillary (transportation, dental, rehabilitative therapies) health care services with an integrated care management component; PACE (Program of All-Inclusive Care for the Elderly) provides comprehensive primary, acute and long-term care in a day center setting and in the home; Medicaid Advantage Plus Plans, with enrollment in a companion Medicare Advantage Plan, include comprehensive acute, primary and long-term care services.

The mandatory enrollment initiative impacts Dual Eligible recipients (individuals who are eligible for both Medicaid and Medicare), aged 21 and over, who are in need of community based long term care services for over 120 days. Community based long term care services include home health care, personal care, adult day health care and private duty nursing; these populations have successfully initiated transition into MLTC.

As of June 2013, approximately 50,000 consumers have moved from the fee-for-service environment into a MLTC plan in the last year, with the State's MLTC enrollees numbering more than 100,000 consumers, controlling the long term care population's health care costs while providing comprehensive care coordination and quality health services. Of these approximately 2,500 CHHA recipients have transitioned in 2013 as we initiate the home health transition process for qualifying consumers.

Additionally, MRT # 5 established a new Episodic Payment System (EPS) reimbursement methodology to reimburse CHHA home health providers for services provided to Medicaid patients. The EPS is based on a price for 60-day episodes of care which will be adjusted by patient acuity and regional wage differences. The EPS is designed to address the issue of rapid growth in Medicaid costs per patient by better aligning payments with needed services and is part of a broad effort to promote the development of care management arrangements for Medicaid recipients. It too has resulted in significant Medicaid savings and directed additional consumers into MLTC plans.

New York State continues to implement our multi-year action plan that is improving health outcomes for more than five million New Yorkers as well as bending the state's Medicaid cost curve by saving \$300 million in Medicaid expenditures since 2010. Significant federal savings have already been realized through New York's MRT process and substantial savings will continue to accrue as part of the MLTC transition plan. The use of MLTC has allowed the State to provide efficient and effective community based long term care services to its consumers of long term health care. The transition to MLTC has created an atmosphere of rebalancing, aligning with the Olmstead decision, by continuing to support repatriation of consumers from both nursing facilities and adult care facilities to the most integrated setting in the community. New York continues to move forward on the path of "care management for all" to bring community based long term care services to its citizens that is efficient, cost effective, comprehensive and coordinated.

Recommendation #2:

Issue guidance to CHHAs in the State on Federal and State requirements for physicians' orders and plans of care.

Response #2:

Certified home health agencies (CHHAs) in New York State are on notice to comply with the federal conditions of participation generally, and in relation to plans of care in particular. Department regulations specifically state all CHHAs must comply with the federal conditions of participation (18 NYCRR Part 505.23), and regulations have been issued regarding plans of care in 10 NYCRR Part 763. The plan of care requirements have additionally been the subject of guidance in NYS Medicaid Policy Manuals issued for home health services. These have been issued in successive years, including in 2007, which coincides with part of the OIG's audit period. OMIG staff has made yearly presentations at CHHA association meetings where requirements for the plans of care have been a topic. In addition, OMIG has posted audit protocols on its website highlighting the requirements of the providers concerning the plans of care with Federal and State regulatory references. Nonetheless, the Department will evaluate whether additional guidance reiterating the existing standards is needed.