NEW YORK STATE
OFFICE OF THE STATE COMPTROLLER

H. Carl McCall
STATE COMPTROLLER

DEPARTMENT OF HEALTH

MEDICAID PAYMENTS FOR PERSONAL CARE SERVICES

2001-S-14

DIVISION OF MANAGEMENT AUDIT AND
STATE FINANCIAL SERVICES

OSC Management Audit reports can be accessed via the OSC Web Page:

http://www.osc.state.ny.us

If you wish your name to be deleted from our mailing list or if your address has changed,

contact the Management Audit Group at (518) 474-3271

or at the

Office of the State Comptroller

110 State Street

11th Floor

Albany, NY 12236

H. Carl McCall
STATE COMPTROLLER

Report 2001-S-14

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Novello:

The following is our report on the Department of Health's policies and procedures for monitoring Medicaid payments for personal care services.

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

April 26, 2002

EXECUTIVE SUMMARY

DEPARTMENT OF HEALTH

MEDICAID PAYMENTS FOR PERSONAL CARE SERVICES

SCOPE OF AUDIT

New York State's Medicaid program is jointly administered by the Department of Health (Health) and 58 local social services districts (local districts), which consist of 57 counties and New York City. Health oversees the local districts and also oversees the processing and payment of claims from medical service providers, while the local districts handle other aspects of program administration, such as determining eligibility for program services. These services include personal care services, which consist of dressing, feeding, housekeeping, assistance in personal hygiene and other tasks that enable the patient to live at home. For the year ended December 31, 2000, New York's Medicaid payments for personal care services totaled about $1.49 billion, and the services were provided to about 85,000 Medicaid recipients.

Our audit addressed the following question about the procedures used by Health and the local districts to monitor Medicaid reimbursements for personal care services for the period January 1, 1998 through December 31, 2000:

- Do the procedures provide adequate assurance that Medicaid payments for personal care services are appropriate?

AUDIT OBSERVATIONS AND CONCLUSIONS

Improvements are needed in the procedures used to monitor Medicaid payments for personal care services, as during our three-year audit period, at least $1.6 million was paid for services that may not have been provided or may not have been authorized.

Since personal care services are intended to help a patient live at home, a Medicaid claim for personal care services should not be paid if the services were provided to a patient during a period in which the patient was hospitalized or living in a nursing home. However, when we performed a computer match of the Medicaid claims submitted during our three-year audit period by personal care service providers, inpatient hospitals and nursing homes, we identified 21,768

personal care service claims, totaling about $1.5 million, that were paid for periods during which the Medicaid recipients were either hospitalized or living in nursing homes. Nearly 2,300 of these claims, totaling about $297,000, were submitted by one provider. We recommend that the claims be investigated by Health, and all overpayments be recovered. (See pp. 4-5)

A Medicaid claim for personal care services should not be paid unless the services have been authorized by the recipient's local district. To determine whether this prior approval process was working as intended, we selected a judgmental sample of 120 Medicaid recipients from five local districts (New York City and the counties of Erie, Nassau, Suffolk and Ulster), and compared the Medicaid claims paid for these recipients' personal care services during our three-year audit period to the services that were authorized for the recipients by their local districts. For 79 of the 120 recipients, we found that some of the reimbursed services were not provided as authorized. For example, in some instances, more hours of service were reimbursed than were authorized or the services were provided by unauthorized providers. We determined that more than $100,000 was paid to providers who were not authorized by the recipient's local district. We recommend that these payments be investigated by Health, and all overpayments be recovered. We also recommend that the prior approval process be strengthened to provide better assurance that personal care services are provided in accordance with local district authorizations. (See pp. 5-7)

Comments of Officials

Department of Health officials generally agree with the report's recommendations. With respect to recovering inappropriate Medicaid payments for personal care services, officials stated they are in the process of reviewing the Medicaid payment information provided during the audit and will seek recovery were appropriate. With respect to assessing local district practices for prior approving personal care services, officials stated they would defer any assessment until they complete their review of the inappropriate payments.

CONTENTS

INTRODUCTION

Background

In the Medicaid program, which is jointly funded by the Federal government and the states, people with low incomes receive health care services from participating medical providers. The providers are reimbursed for the services on the basis of claims submitted to the states.

In New York State, the Medicaid program is administered by the Department of Health (Health) and 58 local social services districts (local districts), which consist of 57 counties and New York City. Health, which is responsible for overall program administration, oversees New York's Medicaid Management Information System (MMIS), a computerized claims processing and payment system that is operated by a fiscal agent (Computer Sciences Corporation). The local districts determine whether individuals are eligible for Medicaid and whether Medicaid recipients are eligible for certain health care services.

Personal care services provided through New York's Medicaid program are defined by Health's Rules and Regulations (Title 18, Section 505.14) as services that provide the patient with assistance in personal hygiene, dressing, feeding, housekeeping, nutritional and environmental support, and certain other health-related tasks. To be eligible for Medicaid reimbursement, the services must be essential to the maintenance of the patient's health and safety within his or her home.

The local districts are responsible for authorizing all personal care services, arranging for service delivery, and monitoring the services in accordance with guidelines developed by Health. Health is responsible for monitoring the services to ensure that the local districts are complying with regulations and guidelines. Health is also responsible for ensuring that the payments made by the MMIS are appropriate. For the year ended December 31, 2000, the payments for personal care services totaled about $1.49 billion, and the services were provided to about 85,000 Medicaid recipients.

Audit Scope, Objective and Methodology

We audited the procedures used by Health and the local districts to monitor Medicaid reimbursements for personal care services during the period January 1, 1998 through December 31, 2000. The objective of our performance audit was to evaluate the adequacy of these procedures in ensuring that Medicaid payments to personal care service providers are appropriate.

To accomplish our audit objective, we interviewed officials from Health and five local districts: New York City and the counties of Erie, Nassau, Suffolk and Ulster. We also reviewed the policies and procedures used by Health and the local districts to monitor Medicaid payments for personal care services. In addition, we reviewed MMIS edits to identify the controls used to prevent inappropriate payments for personal care services, and we used computer assisted auditing techniques to identify potentially inappropriate payments made by the MMIS during our audit period. These techniques included: (1) a computer match of the Medicaid claims submitted during our three-year audit period by personal care service providers, inpatient hospitals and nursing homes, and (2) the identification of all the personal care service claims that met certain criteria indicative of potentially inappropriate payments (these claims related to Medicaid recipients who received more than 24 hours of personal care services in a single day; recipients who received personal care services from more than one provider on the same day; and recipients who received personal care services and hospital/nursing home services on the same day). We selected for further review the potentially inappropriate claims relating to 120 recipients, whom we judgmentally selected from the five local districts with the most such claims during our audit period.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess the operations of Health that are included in our audit scope. Further, these standards require that we understand Health's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures

as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Health Officials to Audit

Draft copies of this report were provided to Health officials for their review and comment. Their comments were considered in preparing this report and are included as Appendix B.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

MEDICAID PAYMENTS FOR PERSONAL CARE SERVICES

Health has established a prior approval process and a system of computerized edits to help ensure the appropriateness of Medicaid payments for personal care services. However, improvements are needed in Health's controls over these payments, as we determined that at least $1.6 million in potentially inappropriate Medicaid payments were made for personal care services during our three-year audit period. In these instances, payments were made for services that may not have been provided, and services that may have been provided but may not have been authorized. To avoid such inappropriate payments in the future, Health should resume its routine post payment reviews of personal care services and assess the local districts' practices for controlling and monitoring the prior approval process for these services. We also identified other weaknesses in the prior approval process for these services, as a result of which there is less assurance that the services are always provided in the manner authorized.

Services Claimed When Recipients in Hospitals or Nursing Homes

Personal care services can be reimbursed by Medicaid only when the services help a patient live at home. Therefore, a Medicaid claim for personal care services should not be paid if the services were provided to a patient during a period in which the patient was hospitalized or living in a nursing home. To determine whether any personal care service claims were paid for periods during which the Medicaid recipients were hospitalized, we performed a computer match of the personal care service claims and inpatient hospital claims submitted to the MMIS for the period January 1, 1998 through December 31, 2000. We identified 19,168 personal care service claims, totaling more than $1.3 million, that were paid for periods during which the Medicaid recipients were hospitalized. Since the claims indicated that the services were provided at the same time that the patients were hospitalized, the claims should not have been paid.

We further determined that 2,298 of these claims, totaling about $297,000, were submitted by a single provider. The claims submitted by this provider included:

- 53 claims, totaling more than $15,000, for one recipient that coincided with eight different hospital stays by the recipient; on each claim, the provider billed 24 hours of personal care services a day, even though the recipient was in the hospital on the days that were billed, and

- 148 claims, totaling more than $21,000, for one recipient that coincided with a hospital stay by the recipient that lasted from September 11, 1999 through March 12, 2000; on each claim, the provider billed 12 hours of personal care services a day.

To determine whether any personal care service claims were paid for periods during which the Medicaid recipients were living in nursing homes, we performed a computer match of the personal care service claims and nursing home claims submitted to the MMIS for the period January 1, 1998 through December 31, 2000. We identified 2,600 personal care service claims, totaling almost $200,000, that were paid for periods during which the Medicaid recipients were living in nursing homes. Since the claims indicated that the services were provided at the same time that the patients were in nursing homes, the claims should not have been paid.

In the past, Health performed routine post payment reviews involving computer matches to identify personal care service claims paid for periods during which the recipients were in hospitals or nursing homes. However, these routine reviews have not been performed since 1997. We recommend that these reviews be resumed.

Authorization of Payments by the Local Districts

Personal care services should not be reimbursed by Medicaid unless they have been authorized by the recipient's local district. When a local district receives a request for personal care services, it determines whether the recipient is eligible for the services by reviewing the physician's order for the services and conducting its own social and nursing assessments. The

local district determines what types of personal care services should be provided, and how frequently they should be provided. The local district also arranges for the delivery of the services from one of the providers under contract with the local district. Every six months, the local district is required to reassess the services needed by the recipient, and update its authorization for those services.

The local district's authorization, or prior approval, of personal care services is a critical part of the process used to control and monitor Medicaid payments to personal care providers. As part of the prior approval process, the local district indicates the rate code to be used by the provider on its reimbursement claims, the total number of service units (in hours or quarter hours) approved for the entire authorization period, and the daily or weekly units approved. Every prior approval is assigned a unique identification number. The claims submitted by the provider must use this identification number to receive payment from the MMIS. During its processing of personal care service claims, the MMIS verifies that the prior approval number is still active, the units of service provided do not exceed the units approved, and the rate code matches the code authorized by the local district.

To determine whether the prior approval process was working as intended, we selected a judgmental sample of 120 recipients who received personal care services during the three years ended December 31, 2000, and compared the Medicaid claims paid for such services to the services that were authorized for the recipients by their local districts. As is explained in the section of this report entitled *Audit Scope, Objective and Methodology*, we selected these 120 recipients because some of their claims met certain criteria indicative of potentially inappropriate payments.

We determined that, for 79 of the 120 recipients, payments were made for personal care services that were not consistent with the services authorized by the local districts, as follows:

- Six of the 120 recipients received personal care services from providers that were not authorized by their local district. A total of more than $100,000 was paid for these services during the three-year period. In all these instances, more than one personal care service provider

billed Medicaid for the same date of service, but one of the providers was not authorized by the local district.

- For 42 of the 120 recipients, personal care service providers billed and were paid for more than 24 hours of service in a single day, even though the recipients were not authorized to receive more than 24 hours of service in a day. The payments for these unauthorized hours totaled more than $24,000.

- A total of 31 of the 120 recipients received services in a manner that was not consistent with the authorizations given by their local districts. For example, the number of hours of service provided in a day or week exceeded the number authorized, or services were not provided on dates that had been authorized for service.

If the prior approval process was working as intended, these claims would not have been paid. We therefore conclude that improvements are needed if the process is to work as intended. We note that Health relies on each local district to develop and implement its own system of controlling and monitoring the prior approval process. We found that, in the five local districts addressed by our audit, these control and monitoring practices varied considerably. For example, one of the districts continually updates its prior approvals to account for changes in service providers. In particular, this district identifies dates when services are to be provided by a contractor other than the contractor originally authorized for those dates. Other districts do not make such updates, even though the recipients in the districts are often served by more than one provider. As a result, in these districts, inappropriate billings from different providers are less likely to be detected.

Recommendations

1. Investigate the $1.6 million in potentially inappropriate Medicaid payments identified in this report, and take steps to recover all overpayments.

2. Resume the performance of routine post payment reviews involving computer matches to identify personal are service claims that were paid for periods during which the recipients were in hospitals or nursing homes.

3. Assess local district practices for controlling and monitoring the prior approval process, and help the districts identify and implement the best controlling and monitoring practices.

MAJOR CONTRIBUTORS TO THIS REPORT

Kevin McClune

Ken Shulman

William Clynes

Don Paupini

Sharon Whitmore

Claudia Christodoulou

Julie DeRubertis

David Amedio

Dana Newhouse

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 5, 2002

Kevin M. McClune
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2001-S-14, entitled "Medicaid Payments for Personal Care Services".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix B

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2001-S-14 Entitled
"Medicaid Payments for Personal Care Services"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2001-S-14 entitled "Medicaid Payments for Personal Care Services".

Recommendation #1:

Investigate the $1.6 million in potentially inappropriate Medicaid payments identified in this report and take steps to recover the overpayments.

Recommendation #2:

Resume the performance of routine post payment reviews involving computer matches to identify personal care service claims that were paid for periods during which the recipients were in hospitals or nursing homes.

Responses #1 & #2:

The Department will continue, as it always has, to aggressively recoup inappropriate Medicaid payments, once identified. Office of Medicaid Management (OMM) staff is in the process of reviewing Medicaid payment information recently provided by OSC to verify its audit conclusions. Until that review has been completed, recovery of potential overpayments or resumption of post payment reviews cannot be made.

Recommendation #3:

Assess local district practices for controlling and monitoring the prior approval process, and help the districts identify and implement the best controlling and monitoring practices.

Response #3:

If the Department's review of cases identified by OSC confirms problems with some districts' control and monitoring of the prior authorization process, the Department will help districts identify and implement best practices. However, that activity has been deferred pending the review of the cases identified, to determine whether the deficiencies are regional or statewide in nature, limited to certain program populations, or whether there are variables (e.g. size of the district's PCSP caseload, etc.) which need to be considered when selecting best practices.