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April 29, 1998

Barbara A. DeBuono, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 98-F-2

Dear Dr. DeBuono:

Pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law, we have reviewed the actions taken by the Department of Health (Health) as of January 26, 1998, to implement the recommendations contained in our prior audit report 95-S-136. The report, issued February 19, 1997, reviewed the management controls established by Health and the Department of Social Services to monitor the costs of the Long Term Home Health Care program (LTHHC or Program).

Background

In 1978, the Federal Health Care Financing Administration (HCFA) granted Health and the Department of Social Services (Social Services) a waiver to create and operate the Program. Under the Program waiver, physically and mentally impaired Medicaid recipients can obtain health and related social support services in their own homes, rather than in more costly nursing homes.

Social Services Law (Law) and Social Services and Health regulations require that the cost of care for Program recipients, with the exception of AIDS cases, be less than the cost of nursing home care at a level that meets an individual's specific care needs. Health administers the Program through local social services districts (districts). Districts are responsible for assessing the care needs of Program applicants and for determining that the cost of care for Program recipients does not exceed the cost of nursing home care, the regulatory cost limit. Health is also responsible for developing medical standards, monitoring the quality of care provided, and setting reimbursement rates for the Program. For the Federal fiscal year ended September 30, 1997, Health officials reported that Medicaid paid Program providers about $307 million for services to 23,188 recipients.

During our prior audit period, Social Services administered New York's Medicaid program, and used the Medicaid Management Information System (MMIS) to process Medicaid claims and make payments to health care providers for services rendered to recipients. After October 1, 1996, Health was responsible for administering Medicaid and MMIS.

Summary Conclusion

In our prior audit, we found there was no mechanism to monitor expenses for Program recipients, and the cost of services for a significant number of recipients exceeded the regulatory limit. Thus, Health and Social Services were not ensuring the Program met its legislative intent of providing home care services at a lower cost than nursing home care. In addition, with the development of other home care programs in New York State, Health needed to assess whether the Program is providing the most essential home care services to Medicaid recipients in the most cost effective manner. In our follow-up review, we found that Health officials implemented one of our prior four audit recommendations.

Summary of Status of Prior Audit Recommendations

Of the four recommendations in our prior report, Health officials have fully implemented one recommendation and have not implemented the other three recommendations. The officials stated that they plan to implement one of the other three recommendations.

Follow-up Observations

Recommendation 1

Perform regular monitoring of the cost of program services for each LTHHC recipient to ensure compliance with the program's regulatory cost limits.

Status - Not implemented

Agency Action - In the prior audit, this recommendation was addressed to Social Services. In their 90-day responses to our report submitted pursuant to Section 170 of the Executive Law, neither Social Services nor Health addressed this recommendation. During our follow-up review, we found no indication that Health officials have taken any new actions regarding this recommendation. Health officials monitor the Program's average cost per recipient. They determine Program cost-effectiveness by whether this average cost is less than the average cost of nursing home care, and report this information to HCFA. Health officials agree that monitoring costs for each Program recipient should be done, but they stated this is still a district responsibility. Health officials stated their belief that, if the average cost per Program recipient is less than the average nursing home recipient cost, then the districts' monitoring is adequate. There is no formal reporting from the districts to Health regarding their monitoring of individual recipients' Program costs. Health officials stated this is not required under mandate relief.

Auditors' Comments - Because the Law and Social Services and Health regulations apply to individual recipient costs and not average Program costs, we believe Health must monitor the cost of services for each Program recipient to ensure compliance with the regulatory cost limits.

Recommendation 2

Research alternatives that can provide the most essential home care services in the most cost effective manner and address the following issues:

- *the need for Medicaid to continue to pay for waiver services;*

- *the reasons Program providers receive higher payment than providers in other programs for delivering similar home care services; and*

- *the disparities in Medicaid financial eligibility for home care services.*

Status - Fully Implemented

Agency Action - Health is going to research the shifting of home health care from a fee-for-service basis to managed care, with monthly capitation rates for provider payments. There is legislation to establish 24 managed long term care demonstration projects throughout the State, including long term home health care. The legislation is intended to evaluate whether managed care can provide cost-effective, quality services to long term health care recipients. Health has developed a schedule of steps to accomplish implementing the legislation and establishing the managed long term care projects. Health is required to report the results of these projects to the Governor and the Legislature in years 2003 and 2006.

Another alternative in place is the New York State Partnership Plan for Long Term Care (Plan), which combines private health insurance policies for health care (including home health care) with Medicaid. Medicaid is deferred until the private insurance benefits are exhausted. For home health care, private insurance pays benefits for six years, after which Medicaid pays for the services. Delaying the onset of Medicaid coverage is intended to produce savings of Medicaid expenditures incurred for recipients who participate in the Plan.

Recommendation 3

Modify current financial reports to require providers to identify case management as a separate category of expense.

Status - Not implemented

Agency Action - In their 90-day response to the prior audit, Health officials disagreed with this recommendation because of the length of time needed to collect case management cost data, evaluate it, and institute any regulatory or legislative changes, and because of the uncertainty as to whether collecting the data will produce answers as to whether case management is a variable that is increasing the Program's cost. Also, Health is evaluating the delivery of long

term home health care services through managed care programs that will pay providers a monthly capitation. In our follow-up review, Health officials stated they have not changed this position.

Auditors' Comments - We recognize there may be changes in the delivery of home health care services through long term managed care programs. However, because such changes may not take place on a widespread basis until after the long term managed care demonstration projects are evaluated in year 2006, and because Health currently calculates all providers' Medicaid rates, Health officials should know what constitutes providers' case management expense. Case management will remain a significant component of a capitated rate and will still need to be identified and its reasonableness determined.

Recommendation 4

Audit LTHHC providers' financial data to ensure compliance with Health's regulations. When instances of noncompliance are identified, develop measures to adjust rates and recover inappropriate MMIS payments.

Status - Not implemented

Agency Action - Health's Division of Quality Assurance and Audit (QA&A) has not done any of the recommended audits since our prior audit report was issued. QA&A officials stated the transition of QA&A to Health from Social Services has impeded audit planning and implementation. They stated they plan to do such recommended audits in the future, but not on an annual cycle.

Auditors' Comments - Recent audits of home care providers conducted by the Federal government have uncovered several instances of illegal acts among health care providers. Although New York State providers were not included in these audits, the Federal audit results determined that home care providers sometimes claim inappropriate expenses as a cost of doing business. We believe Health needs to perform compliance audits to monitor providers and ensure they comply with Health's regulations concerning the Program's allowable costs. Therefore, we encourage QA&A officials to monitor the Program through the audit process.

Major contributors to this report were Donald Paupini and Lawrence Julien.

We would appreciate receiving your response to this report within 30 days, indicating any action planned or taken to address the unresolved matters discussed in this report. We wish to thank your staff for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Robert L. King