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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

June 24, 2004

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

Re: Long Term Home Health Care Program
Report 2002-S-43

Dear Dr. Novello:

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, we audited the applicable controls at the Department of Health (Department) for ensuring that Medicaid expenditures for the Long Term Home Health Care Program (LTHHCP) did not exceed nursing home costs. Our audit covered the two-year period October 1, 2000 through September 30, 2002.

A. Background

The Department administers the State's Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the federal Social Security Act to provide medical assistance to needy people. The Department's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System, a computerized payment and information reporting system, to process Medicaid claims and pay providers for medical services they render to eligible Medicaid recipients. In New York, the federal, State and local governments jointly fund the Medicaid program.

In 1978, New York State authorized the LTHHCP. The LTHHCP is a coordinated plan of care and services provided at home to invalid, infirm, or disabled persons who are medically eligible for placement in a hospital or skilled nursing facility. Certified home health agencies, nursing homes or hospitals may provide LTHHCP services in the person's home, the home of a responsible relative or other adult, or in a congregate care setting, such as a retirement community residence. The intent of the LTHHCP is to prevent premature hospital or nursing home placement of individuals who

could be cared for at home. According to Department officials, in practice the LTHHCP is used exclusively to divert people from nursing home placement.

New York State law and regulations require that persons getting long term care at home receive services that are comparable to those that would be provided in a nursing home, as appropriate. LTHHCP providers are required to provide: nursing services; medical social services; home health aide services; medical supplies and equipment; physical therapy; speech therapy; respiratory therapy; nutritional counseling; and personal care services including homemaker and housekeeper. Providers may also render waived services, which include: home maintenance tasks; home improvement services; respite care; social day care; social transportation; home-delivered meals; and moving assistance. Waived services are services not normally covered under New York State's Medicaid program, but the LTHHCP providers may offer these services and be reimbursed for them, under federal waivers and State law. Care for LTHHCP recipients also includes ancillary services, such as: physician services; medical equipment; pharmacy; inpatient; medical-related transportation; laboratory; and adult day care.

New York State Social Services Law and regulations also require that the annual cost of care for each LTHHCP recipient be no more than 75 percent of the average annual cost of nursing home care in the recipient's local social services district (local district). State law and regulations stipulate two exceptions to this cost limit: 1) expenditures for recipients with AIDS, who are in an AIDS home care program, are unlimited; and, 2) expenditures for recipients designated as persons with special needs are limited to 100 percent of the average annual cost of nursing home care in the recipients' local district. Persons with special needs are defined as those whose care needs include respiratory therapy, tube feeding, skin wound care or insulin therapy that cannot be provided through personal care services, or who have one or more of the following conditions: a mental disability; AIDS; or dementia, including Alzheimer's disease.

Throughout New York State, 58 local districts, including the Home Care Services Program (HCSP) within New York City's Human Resources Administration (HRA), administer the LTHHCP, under the Department's supervision. The local districts' responsibilities include: assessing the care needs of LTHHCP applicants jointly with nurses from the LTHHCP providers; and, determining whether the LTHHCP can provide essential services at a cost that is less than the cost of nursing home care.

For the period October 1, 2000 through September 30, 2002, Medicaid paid $915.6 million for LTHHCP, other home health care and ancillary services provided to nearly 27,700 recipients.

B. Audit Scope, Objective and Methodology

We audited the applicable controls at the Department for maintaining LTHHCP expenditures within statutory limits during the two-year period October 1, 2000 through September 30, 2002. The objective of our performance audit was to determine whether the Department and the local districts limited Medicaid costs for recipients in the LTHHCP to less than the cost of comparable nursing home care, i.e., less than 75 percent or 100 percent of average nursing home costs. We did not include LTHHCP recipients with AIDS in our scope.

To accomplish our objective, we interviewed officials at the Department and at selected local districts (Nassau, Suffolk and Westchester departments of social services (DSS) and the HCSP); used computer-assisted audit techniques to identify about 15.1 million Medicaid claims for LTHHCP, other home health care and ancillary services provided to nearly 27,700 recipients, and compared the cost of all services for each recipient to the regulatory cost limits; and visited HCSP offices and reviewed documentation that authorized the placement of a judgmental sample of 18 New York City recipients in LTHHCP, as well as documentation that demonstrated the extent of the HCSP's oversight of these 18 recipients' cost of long term home health care.

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 the Department that are within our audit scope. Further, these standards require that we understand the Department'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 our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities for audit. This approach focuses our audit efforts on those operations that we have identified through a preliminary survey as having the greatest probability of needing improvement. Consequently, by design, we use our finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under Generally Accepted Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance

C. Results of Audit

State law and regulations require that expenses for each LTHHCP recipient be no more than the cost of nursing home care. For most recipients, State statute sets the cost of care limit at 75 percent of the average cost of nursing home care in the recipients' local district. If a recipient is classified as having special needs, the cost of care is limited to 100 percent of the average cost of nursing home care in the recipient's local district.

The Department has delegated to local districts the responsibility for ensuring that the cost of care for LTHHCP recipients does not exceed the regulatory limits. Local districts authorize recipients' placement into the LTHHCP, as well as the use and frequency of services, after determining the recipients are eligible for the program and can receive care at a cost within the limits.

We analyzed LTHHCP expenses for each recipient and found, overall, that the Department and the local districts kept the LTHHCP expenses for most recipients at less than the regulatory cost limits during the audit period. However, we also found that for 152 recipients, their cost of care exceeded the 75 percent limit during the entire two-year audit period by about $4.4 million. Seventy-three (48 percent) of these 152 recipients were in New York City and the cost of their care exceeded the 75 percent limit by about $2.7 million. If these 152 recipients had been classified as having special needs, then the cost of care for 33 of them would have exceeded the 100 percent limit during the audit period by nearly $1.25 million. Fifteen (45.5 percent) of these 33 recipients were in New York City. The cost of their care exceeded the 100 percent limit by nearly $785,000. Consequently, in some cases, the LTHHCP is not meeting its legal and regulatory requirement to provide home care to each recipient at a cost lower than or equal to nursing home care.

As explained below, we identified certain factors that caused the cost of care for LTHHCP recipients to exceed the regulatory limits.

1. New York City's Mandate Relief Demonstration Project

Under State laws and regulations, local district case managers assess LTHHCP recipient's care needs and living situations jointly with LTHHCP provider nurses, upon initial referral and every 120 days thereafter. Local district case managers authorize the recipients' initial and continuing LTHHCP participation and the provision of services, based on the assessment results. However, because of fiscal constraints and limited staff resources in New York City, HCSP and LTHHCP providers jointly developed a different process for evaluating cases for initial LTHHCP eligibility and continuation of services. This process, known as the Mandate Relief Demonstration Project (Project), was approved by the Department in January 1999 and began operating in September 1999.

Under the Project, LTHHCP providers conduct initial home visits and assessments, conduct reassessments every 120 days, and prepare the recipients' plans of care and LTHHCP cost budgets. Most LTHHCP recipients are placed into the program through alternate entry. Under alternate entry, providers identify potential LTHHCP recipients and begin providing services to the recipients, prior to receiving HCSP authorization. HCSP case managers are responsible for processing the initial case documentation and reassessment documentation. HCSP case managers are required to decide whether to authorize the recipient's LTHHCP placement and services within 30 days of receiving the case documentation from the provider. If HCSP case managers do not approve a recipient's placement into the LTHHCP or disapprove the use or frequency of certain services, the provider would be financially responsible for the cost of unauthorized services provided to the recipient.

However, under alternate entry there is no requirement for the provider to submit documentation to the local district within a specific timeframe. In addition, there is no mechanism

for the Department to be aware of a lack of local district approval and then prevent Medicaid from paying provider claims for unauthorized services. As a result, LTHHCP providers are able to bill Medicaid for services without local district authorization.

We reviewed a judgmental sample of 18 LTHHCP cases at HCSP, which we selected based on the dollar amount by which they exceeded the cost limits. We selected these cases from the 73 New York City LTHHCP recipients whose total cost of care exceeded the 75 percent cost limit during the audit period, and from the 15 New York City LTHHCP recipients whose total cost of care exceeded the 100 percent cost limit during the audit period.

In all 18 cases, we found instances in which Medicaid paid providers before HCSP authorized the services. For example, from October 2000 through September 2001, Medicaid paid about $103,840 for LTHHCP services provided to one recipient. However, we found no LTHHCP cost budgets or assessment documents in either the HCSP case file or the provider's records for that period. There was no evidence that HCSP was aware of these services and had authorized them.

For another recipient where a provider was paid before HCSP authorized the services, Medicaid paid about $23,700 to the LTHHCP provider during the months of January through September 2002. The provider prepared three 120-day LTHHCP budgets and reassessments during this interval:

- For the reassessment period January 4-May 4, 2002, the provider prepared the case documents on January 14, 2002 and transmitted them to the HCSP on March 6, 2002. HCSP received the documents on March 25, 2002 and approved the budget and services on April 10, 2002.

- For the reassessment period May 4-September 4, 2002, the provider prepared case documentation on May 9, 2002 and transmitted it to HCSP on June 24, 2002. HCSP approved the case on July 26, 2002.

- For the reassessment period September 4, 2002-January 4, 2003, the provider prepared case documents on October 3, 2002 and transmitted them to HCSP on November 27, 2002. HCSP received the documents and approved the case on December 2, 2002.

In all 18 cases reviewed, we found instances in which the actual cost of a service exceeded the authorized budget amount for the service. For example, during the service period December 5, 2000 – April 4, 2001, the authorized budget was $270 per month for a recipient's prescription drugs. However, for the months of December 2000, January 2001 and March 2001, Medicaid paid $2,982, $2,166 and $2,100, respectively, for the recipient's prescription drugs.

Further, LTHHCP recipients were able to obtain medical services outside of the program without the knowledge and authorization of HCSP case managers, which increased the actual cost of the recipients' care. In all 18 cases reviewed, we found that recipients received services outside of the program that were not included in their approved LTHHCP budgets. For example, we identified a recipient who had nearly $81,150 in LTHHCP services during the audit period. However, this recipient also had about $52,960 in nursing home day care services for the audit period. These

nursing home day care services were not included in the recipient's LTHHCP budgets, and increased the actual cost of care to $134,110. The actual cost of care exceeded the regulatory cost limit for the audit period ($114,888) by $19,222.

To address the matter of timeliness, HCSP officials proposed a ten-day timeline for providers to submit LTHHCP reassessment documents to HCSP case managers, and suggested the Department support the HCSP on this issue. HCSP officials also urged the Department to develop the means to deny provider claims for unauthorized services. The Department should evaluate whether HCSP's efforts to impose timeliness standards on providers would enhance HCSP's oversight of LTHHCP expenditures.

The Mandate Relief Demonstration Project also changed HCSP's case approval from an exclusively paper-driven process to a computerized one, involving electronic transmissions of recipient records from providers to HCSP caseworkers. These electronic transmissions include the essential recipient information the HCSP caseworker would need to review and approve the case for LTHHCP entry or continuing placement. The transmissions were to be loaded into a LTHHCP database, maintained by HCSP.

During our case review at HCSP, we found a flaw in a computer application used to transmit LTHHCP recipient budget and service summary information electronically from the providers to the HCSP case managers. If a provider transmitted a budgeted cost consisting of five digits, the application truncated the first of the five digits. As a result, the HCSP case manager would have incorrect budget information as a basis for deciding whether to authorize the recipient's placement into the LTHHCP and the provision of services.

For example, in one case we reviewed, the LTHHCP provider indicated the budgeted cost of personal care service would be $13,349 per month. After processing this information from the provider, the application presented this cost to the HCSP case manager as only $3,349 per month. In another case, the provider budgeted the client's monthly home health aide costs at between $11,175 and $11,937 through our audit period (October 2000-September 2002). After processing the provider's information, the budgets at HCSP showed home health aide costs as $1,175 or $1,937 per month. Consequently, the case manager was not aware that the LTHHCP budget actually exceeded the expenditure cap and approved the client's continued LTHHCP placement and services.

In their response to our preliminary audit findings concerning the flaw in the computer application, HRA officials indicated they would take immediate corrective action. HRA officials told us that as of September 12, 2003, they identified 53 LTHHCP cases that were affected by the flaw. They also told us they plan to upgrade HCSP's computerized LTHHCP case management system and would like the Department to mediate between HCSP and the providers to ensure the system upgrade is done in an efficient and effective manner.

2. Variations in Local District Procedures

We found local districts take different approaches to ensure that services are provided within the cost limits. Nassau and Suffolk, in addition to approving LTHHCP budgets, require providers to submit expenditure information for comparison to cost limits. Westchester and HCSP in New York

City review and approve budgets, but do not obtain expenditure information from providers for comparison to cost limits. We also noted there is ambiguity in the requirements that local districts must follow in ensuring that LTHHCP costs do not exceed the limits.

State law and regulations stipulate that total expenditures for each LTHHCP recipient must not exceed established cost limits. Administrative Directives from the Department require local district case managers to compute budgets, based upon service requirements, for comparison to the cost limits. Administrative Directives also require local district case managers to monitor services to assure that services are provided within the cost limits. It is not clear whether this means local district case managers should compare only the budget to the cost limit or they should also compare the actual expenditures to the cost limit.

Department officials told us they believe local districts meet statutory requirements by computing LTHHCP budgets and comparing the budget amounts to the cost limits before they authorize LTHHCP placement and services. In their opinion, local districts are not required to compare expenditure amounts to the cost limits, after services are provided to recipients. However, Department officials told us they believe there are benefits to Nassau and Suffolk's approaches. They told us they would evaluate Nassau and Suffolk's practices further and recommend them to other local districts as best practices, if feasible for other local districts.

Recommendations

1. *Determine whether local social services districts have established adequate procedures for ensuring that each LTHHCP recipient receives services in compliance with the regulatory cost limits.*

2. *Consider and respond to HCSP's request to:*
   - *Implement and enforce a document submission timeliness requirement for LTHHCP providers in New York City, and*
   - *Devise mechanisms that would prevent Medicaid payments for unauthorized LTHHCP services or for other services provided to recipients outside of the LTHHCP.*

3. *Work with the HCSP and LTHHCP providers in New York City to ensure the planned upgrade of HCSP's computerized LTHHCP case management system is completed efficiently and effectively, and is tested thoroughly before being implemented.*

4. *Evaluate Nassau and Suffolk DSS' methods of obtaining and reviewing LTHHCP expenditure amounts and determine whether these methods are feasible for other local districts.*

We provided draft copies of this report to Department officials for their review and comment. Their comments have been considered in preparing this report. Department officials agreed with the report's recommendations and indicated actions taken or planned to implement them. A complete copy of the Department's response is included as Appendix A.

Within 90 after the 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 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.

Major contributors to the report include Ken Shulman, William Clynes, Ed Durocher, Lawrence Julien, Leo Shaw, Tina Santiago and Marticia Madory.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Yours truly,

Steven E. Sossei
Audit Director

cc: Robert Barnes

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

January 14, 2004

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 (2002-S-43) entitled "Long Term Home Health Care Program."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Howe
Ms. Kuhmerker
Ms. Pettinato
Mr. Reed
Mr. Seward
Mr. Van Slyke

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2002-S-43 Entitled
"Long Term Home Health Care Program"

The following are the Department of Health's (DOH) comments on the Office of the State Comptroller's (OSC) draft audit report (2002-S-43) entitled "Long Term Home Health Care Program."

Recommendation #1:

Determine whether local social services districts have established adequate procedures for ensuring that each LTHHCP recipient receives services in compliance with the regulatory cost limits.

Response #1:

The Department is actively working with a contractor to develop and distribute a manual for the Long Term Home Health Care Program (LTHHCP). The first draft of the manual has been reviewed and returned to the contractor. The Department expects to have a final version of the manual reproduced and distributed to all the local district social services (LDSS) and LTHHCP providers during the fourth quarter of 2004.

Additionally, the Department will distribute a letter in the second quarter of 2004 to LDSS and LTHHCP providers advising them of the audit findings relative to the budgets, as well as assessment/re-assessment documentation.

The Department will continue to disseminate information regarding the LTHHCP through the various organizations that represent the local districts, as well as the providers.

Recommendation #2:

Consider and respond to HCSP's request to:

- Implement and enforce a document submission timeliness requirement for LTHHCP providers in New York City, and
- Devise mechanisms that would prevent Medicaid payments for unauthorized LTHHCP services or for other services provided to recipients outside of the LTHHCP.

Response #2:

The Department will continue to work with the NYC Human Resources Administration's Home Care Services Program (HCSP) to improve the responsiveness of the LTHHCP providers in New York City. The Department and HCSP will meet with providers to disseminate the audit's findings and re-emphasize responsibilities. It is anticipated that the meeting will take place by the second quarter of 2004.

The Department will also investigate, with HCSP, options for addressing inappropriate payments. Discussions will include audit, systems and reporting staff as necessary. The Department has already initiated discussions with HCSP regarding their current systems and necessary modifications. These discussions will continue with an expectation that system changes will be implemented by the third quarter of 2004.

Recommendation #3:

Work with HCSP and LTHHCP providers in New York City to ensure the planned upgrade of HCSP's computerized LTHHCP case management system is completed efficiently and effectively, and is tested thoroughly before being implemented.

Response #3:

As stated above, the Department is currently working with HCSP in response to the audit's findings. The Department will monitor HCSP's progress on their system changes on a quarterly basis.

Recommendation #4:

Evaluate Nassau and Suffolk DSS' methods of obtaining and reviewing LTHHCP expenditure amounts and determine whether these methods are feasible for other local districts.

Response #4:

The Department will review further Nassau and Suffolk's practices and, where appropriate, will disseminate information to the LDSS that describes the methods used by Nassau and Suffolk Counties. If appropriate, local districts will be encouraged to review these methods for possible implementation. This information will be disseminated to the local districts in the letter referred to in response 1, during the second quarter of 2004.