DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

JUN 16 1994

Memorandum

Date

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Personal Care Services in Westchester County Under the New York State Medicaid Program (A-02-91-01055)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on June 20, 1994 of our final audit report. A copy is attached.

This report contains the results of our audit of the personal care services program in Westchester County covering the period January 1, 1988 through December 31, 1990. Personal care involves aides rendering services, in the home, to recipients who require varying degrees of assistance with activities of daily living such as hygiene, dressing and feeding. The provision of these type services is a rapidly growing and costly component ($1.4 billion for Calendar Year 1990) of the New York State (NYS) Medicaid program.

The objectives of our audit included an assessment of controls over (a) the billing for services to determine whether provider charges are reasonable and adequately supported and (b) the eligibility of recipients to receive personal care services. We also made a determination as to whether the State's claim for the Federal share of personal care service costs was proper and in compliance with applicable State and Federal regulations.

Our review disclosed significant weaknesses with respect to documentation and billing of services rendered and the authorization of personal care services. We found weaknesses in the design of internal control systems, as well as the routine bypassing of critical internal control procedures. Collectively, the control weaknesses increase the risks of the program to fraud, waste, and abuse. For example, we found services billed by providers but not rendered and physicians prescribing services without current knowledge of the recipient's medical condition. These weaknesses raise serious questions as to the adequacy and appropriateness of care rendered to recipients. We also found that the State had not effectively monitored the personal care program in Westchester County.

We reviewed documentation related to the billing of services for a statistical random sample of 120 recipients receiving services from 38 personal care providers. This involved a review of provider time sheets to determine if each date billed was supported by documentation of the time spent providing the service. We found that 85 of 120 recipient cases and 33 of the 38 providers in our review had some type of error related to the documentation or billing of services. This involved 7,102 services, or $862,573 (Federal share - $431,286) in costs which were unallowable. We recommended that NYS immediately notify the providers of the identified errors, obtain a refund of these payments, and credit the Federal Government. Both the State Department of Social Services and the State Medicaid Fraud Control Unit have been alerted to potential fraud and abuse by certain providers.

By projecting our sample results to the total universe, we estimate that between $3,172,483 and $11,174,534 may have been inappropriately charged to the Federal Government. We recommended that the State: (1) work with the Health Care Financing Administration (HCFA) to identify a cost-effective plan to identify the erroneous payments made to each provider, (2) institute appropriate recovery action, (3) issue more specific guidance on acceptable time sheet documentation, (4) issue additional guidance and enforce existing regulation concerning aides working 24-hour continuous care cases, and (5) increase monitoring to ensure providers are billing properly and maintaining adequate supporting documentation.

With respect to the authorization of personal care services, we identified 63,126 services (Federal share - $4,100,786) of the 97,162 reviewed where prior approvals had been issued to providers before a valid authorization package consisting of a physician's order, nursing assessment and social assessment was in place. Although the services were unauthorized, we recognize that in most cases, services were rendered to Medicaid recipients by providers and NYS had paid these providers. Further, in many cases, authorizations were eventually processed although they were untimely. Given this, we are not recommending disallowance of costs claimed for reimbursement. Rather, we recommended a number of procedural improvements to preclude recurrence of the control weaknesses found.

The HCFA regional officials concurred with the findings and recommendations contained in our report. In their comments, State officials were in basic agreement with most of the report's recommendations. However, the State did not agree with one recommendation concerning the need to issue more specific guidance on documentation of services rendered. The State also did not

adequately respond to our recommendation concerning 24-hour continuous care cases. In the OIG response to the State's comments, we have reemphasized the need to fully implement the recommendations in the report.

For further information, contact:

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Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PERSONAL CARE SERVICES IN WESTCHESTER COUNTY UNDER THE NEW YORK STATE MEDICAID PROGRAM

JUNE GIBBS BROWN
Inspector General

JUNE 1994
A-02-91-01055

SUMMARY

This report contains the results of our audit of the personal care services program in Westchester County covering the period January 1, 1988 to December 31, 1990. The provision of these type services is a rapidly growing and costly component ($1.4 billion for calendar year 1990) of the New York State (NYS) Medicaid program. Personal care involves aides rendering services, in the home, to recipients who require varying degrees of assistance with activities of daily living such as hygiene, dressing and feeding. The key players include the NYS Department of Social Services which sets overall policy and program controls, pays the claims and bills for the Federal share; the Westchester County Local Department of Social Services which has responsibility for authorizing services, arranging service delivery, and monitoring providers; and the providers which recruit and monitor aides and bill for services rendered. Our review encompassed work at all three levels.

The audit involved three broad but interrelated objectives:

- Assessment of controls over the billing for services to determine whether provider charges are reasonable and adequately supported.

- Assessment of controls over the eligibility of recipients to receive personal care services to determine whether services are being provided to those the program is intended to serve.

- Determination as to whether the State's claim for the Federal share of personal care services costs was proper and in compliance with applicable State and Federal regulations.

Our review disclosed significant weaknesses with respect to documentation and billing of services rendered and the authorization of personal care services. We found weaknesses in the design of internal control systems as well as the routine bypassing of critical internal control procedures. Collectively, the control weaknesses increase the risks of the program to fraud, waste and abuse. For example, we found services billed by providers but not rendered and physicians prescribing services without current knowledge of the recipient's medical condition. These weaknesses raise serious questions as to the adequacy and appropriateness of care rendered to recipients.

The two major findings are summarized below:

- o Documentation and Billing of Services Rendered

Significant weaknesses exist with respect to documentation and billing of services by personal care providers. We found inadequate guidance from and audit coverage by the State and poor documentation and serious billing errors by providers. These deficiencies increase the opportunity for fraud and abuse in the program.

Our statistical sample review of time sheet errors for 120 recipients disclosed, as unallowable, $431,286 of the $6,599,697 in Federal share reviewed. Using stratified random sampling techniques, we estimate that payments totalling between $3,172,483 and $11,174,534 were inappropriately charged to the Federal Government. We are recommending that the State immediately notify providers of the error amounts identified in our sample and obtain a refund of these payments. With respect to our statistically estimated range of error amounts, we are recommending that the State work with the Health Care Financing Administration in developing a cost effective plan to identify the erroneous payments made to each provider and institute appropriate recovery action. We have also made a number of procedural recommendations.

- o Authorization of Personal Care Services

With respect to the initial authorization and periodic reauthorization of personal care services, we found material noncompliance with applicable requirements and control systems. The authorization controls were routinely bypassed. Prior approvals were improperly granted for services that had not been properly authorized. Physician's orders were submitted which were incomplete and we obtained evidence that some physicians completed the orders without knowledge of the recipient's current medical status. We also found that the State had not effectively monitored the personal care program in Westchester County.

We identified 63,126 services, of the 97,162 reviewed, where prior approvals had been issued to providers before a valid authorization package consisting of a physician's order, nursing assessment and social assessment was in place. As a result, unauthorized services were rendered and billed. Our statistical sample review of authorizations for 120 recipients disclosed as an error amount, $4,100,786 of the $6,599,697 in Federal reimbursement reviewed. Using stratified random sampling techniques, we estimate that payments totalling between $54,864,884 and $65,485,473 were inappropriately charged to the Federal government. The midpoint of the precision range amounted to $60,175,179.

Although the services were unauthorized, we recognize that, in most cases, services were rendered to Medicaid recipients by providers and New York State had paid these providers. Further, in many cases, authorizations were eventually processed although they were untimely. Given this, we are not recommending disallowance of costs claimed for reimbursement. Rather, we are recommending a number of procedural improvements to preclude recurrence of the control weaknesses found. We are also recommending that New York State reassess whether any changes are needed in the level of control procedures given the high degree of noncompliance found in our audit. For example, the current regulations in Westchester County require reassessment of services every six months. We understand that New York City has received permission to reauthorize services once a year. Lengthening the reauthorization period in Westchester County for some or all cases should reduce the paperwork level while still maintaining the integrity of the program. Program officials might have other suggestions to improve the effectiveness of the control procedures based on experienced gained in running the program.

In a letter dated February 14, 1994, New York State provided its response to our draft audit report. In general, the State was in basic agreement with eight of the ten report recommendations and its comments discussed what actions would be taken, system improvements already made, and any concerns it had relating to them. Of the remaining two recommendations, the State did not agree with one and, in our opinion, was not responsive to the other. The State's complete response is contained in Appendix III of this report. Also, we have summarized the comments after each of the recommendations and have provided an OIG response.

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INTRODUCTION

Background

Medicaid, authorized by Title XIX of the Social Security Act, as amended, provides grants to States for furnishing medical assistance to eligible low-income persons. The States arrange with medical service providers such as physicians, pharmacies, hospitals, nursing homes, and other organizations to provide the needed medical assistance.

To be eligible for Federal financial participation under the Medicaid program, each State must submit an acceptable plan, herein referred to as the State Plan, to the Health Care Financing Administration (HCFA). The State Plan specifies the amount, duration, and scope of all medical and remedial care services offered to Medicaid recipients, and becomes the basis of operation for the Medicaid program in the State. The HCFA has the responsibility for monitoring the activities of the State agency in implementing the Medicaid program under the State Plan. The Medicaid program in New York State is administered by the Department of Social Services (DSS) which is the Single State Agency for Medicaid.

This audit focused on New York State's administration of the personal care services program in Westchester County. The State Plan includes personal care services rendered in a recipient's home as a covered service. The New York State Code of Rules and Regulations, Section 505.14 of Title 18, defines and describes the administration of the personal care program including: definition and scope of services, criteria and authorization for services, administrative and nursing supervision, case management, payment and reimbursement, and submissions by local social services districts of annual plans for personal care services to the State.

The State regulation defines personal care services as:

> "... some or total assistance with personal hygiene, dressing and feeding; nutritional and environmental support functions and health-related tasks. Such services shall be essential to the maintenance of the patient's health and safety within his/her own home, ordered by the attending physician, based on an assessment of the patient's needs, provided by a qualified person in accordance with a plan of care and supervised by a registered professional nurse."

Federal financial participation (FFP) in the cost of personal care services for eligible Medicaid beneficiaries was authorized in Public Law 92-603, enacted October 17, 1972. Current Federal regulations relating to personal care services are found in 42 Code of Federal Regulations (CFR) Part 440 under "Subpart A--

Definitions". Section 440.2(b) entitled "Definitions of services for FFP purposes." states in part:

> ". . . FFP is available in expenditures under the State plan for medical and remedial care or services as defined in this subpart." (Emphasis added.)

Personal care services are specifically defined for FFP purposes in Section 440.170(f) which states, in part:

> ". . . 'personal care services in a recipient's home' means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is--
>
> (1) Qualified to provide the services;
> (2) Supervised by a registered nurse; and
> (3) Not a member of the recipient's family."

Further, HCFA Action Transmittal 79-33, dated April 4, 1979, which transmitted Section 5-140-00 of the Medical Assistance Manual to the State, provided guidelines for State use in defining, categorizing and standardizing the provision of personal care services to a recipient in his/her home.

Finally, Federal Office of Management and Budget (OMB) Circular No. A-87 establishes principles and standards for determining allowable costs applicable to grants with State and local governments. Section C.1.b. of these principles states that in order to be allowable under a grant program, costs must be authorized or not prohibited under State or local laws or regulations. Section C.1.d. further indicates that the costs must be consistent with policies, regulations, and procedures that apply uniformly to both federally assisted and other activities of the unit of government of which the grantee is a part.

Personal care services costs represent a significant portion of New York State's total Medicaid expenditures and its program is one of the largest and most costly in the nation. In addition, the level of expenditures in New York has been increasing dramatically. In calendar year (CY) 1988, New York State's personal care expenditures totaled approximately $978 million; however, in CY 1990, expenditures rose to over $1.4 billion, an increase of more than 43 percent. Personal care service costs in Westchester County increased nearly 40 percent during this same period. For FY 1992, the Medicaid paid and FFP amounts in New York State for personal care services were approximately $1.66 billion and $832 million, respectively.

Organizationally, New York State's personal care services program was located within the DSS Division of Medical Assistance (DMA), which recently became the Division of Health and Long Term Care. Within the Division, the personal care program is operated by the Bureau of Long Term Care. In New York State, the Medicaid program is locally administered which, in effect, means there are 58 local personal care services programs in the State (57 counties plus New York City). Although DSS has overall responsibility for the program, the local districts are responsible for authorization of service, arrangement for service delivery and program monitoring within guidelines developed by the State. In Westchester County, the personal care program is administered by the Office of Medical Services within the Local Department of Social Services (LDSS).

This audit of Westchester County's personal care program was initiated based on the work performed in our survey of New York State's program. During this survey, we visited Westchester County, Rensselaer County and New York City. At each location, we reviewed a limited number of case files and related billing material for compliance with Federal and State regulations. Our review disclosed numerous problems with respect to the authorization and reauthorization of services, especially in Westchester County. In addition, Westchester County was originally included in our survey because of the problems noted by the Office of the State Comptroller (OSC) during its review of home health care in New York State. The OSC report stated that although DSS was responsible for monitoring each local district's personal care operations to ensure the program operates effectively and in compliance with State laws and regulations, these monitoring activities were not effective.

Scope of Review

A primary objective of our audit was to assess the adequacy of controls over the eligibility of recipients to receive personal care services. In addition, we made an assessment of controls over provider billings for services. Our last objective was to determine whether the State's claim for the Federal share of personal care services costs was proper and in compliance with applicable State and Federal regulations. Our audit covered the period January 1, 1988 to December 31, 1990.

We determined that the primary internal controls relative to the personal care services program are the following:

1) New York State's organizational structure and regulations

2) Westchester County's organizational structure and regulations

3) Providers' policies and procedures

4) the Medicaid Management Information System (MMIS) computer edit routines

Specifically, the authorization of services, the prior approval process, and the documentation of services were the primary internal controls in place to identify personal care services costs eligible for FFP. The New York State DSS has overall responsibility for the program; however, the Westchester County LDSS is responsible for authorizing the service, inputting the prior approvals, and arranging for service delivery. In addition, each provider is responsible for supporting the time spent in provision of each service billed.

Our evaluation of the internal control structure disclosed significant deficiencies at the State, County, and provider level. In planning our audit, we considered the weaknesses in internal controls noted during our survey, assessed control risk at the maximum level and decided to perform substantive testing to evaluate the propriety of the State's claims for Medicaid reimbursement.

In order to accomplish our audit objectives, we reviewed pertinent documentation and held discussions with cognizant New York State, HCFA, and Westchester County officials. We also utilized computer applications at the MMIS fiscal agent to identify a universe of recipients who received personal care services. These applications extracted from the Medicaid paid claims history files all claims (except those that were not claimed for FFP) with a category of service of 0264 (Vendor Personal Care Services) and a recipient county code of 55 (Westchester County). These applications identified 5,123 personal care recipients, representing 2,058,935 claims with a Medicaid paid amount of $200,836,230 ($100,418,006 Federal share). Of the 5,123 total recipients, we eliminated 1,784 from our review ($6,105,747 Medicaid paid and $3,052,860 FFP) due to their relatively low Medicaid paid amounts (under $10,000). Thus, our audit universe consisted of 3,339 recipients with personal care service costs of $194,730,483 (Federal Share $97,365,146), representing 1,950,860 claims.

To evaluate this universe we used stratified random sampling techniques. From each of four strata in the universe, we selected a random sample of 30 sampling units, for a total sample size of 120 sampling units. The book value of each sampling unit (a recipient) was the total Medicaid paid and FFP claimed for the services during the review period. In total, the Medicaid paid amount associated with the 120 recipients was $13,199,402 of which the Federal share was $6,599,697. This represented a total of 97,162 services.

For each of the sample recipients reviewed, we performed detailed audit work at both the LDSS and at the 38 personal care providers who were responsible for service delivery. At the LDSS, we reviewed each recipient's case file for evidence that services had been properly authorized. Specifically, we reviewed each record for timely completion of physician's orders, nursing assessments, and social assessments. At each provider, we reviewed documentation related to the billing of services. This involved a review of time sheets to determine if each date billed was supported by documentation of the time spent in provision of the service. Finally, we also reviewed recipient case files, maintained by both the LDSS and the providers, for pertinent notes and observations. Based on an evaluation of this information, we made a determination whether the cost of each service provided was eligible for FFP. In addition, at each provider, we reviewed the personnel folder of the "primary" aide who had serviced the recipient to determine whether the aide was properly trained.

As part of our review, we also obtained information from the Medicaid and Medicare paid history files. We analyzed this information to determine whether the physicians who were completing the physician's orders had billed Medicaid or Medicare for services to the recipient and the date the services were provided. Our objective was to determine if physicians were completing the orders based on current medical examinations of the recipients. We also performed other analyses of the information on authorization documents to assess completeness and consistency.

Our review was conducted in accordance with generally accepted Government auditing standards. It included such tests and other auditing procedures that we considered necessary in the circumstances. Consistent with our audit objectives, our review of internal controls encompassed an assessment of the policies and procedures that were in place to ensure the proper administration and claiming of personal care services. Therefore, we did not perform a facility-wide review of EDP general and application controls in place in the MMIS.

Audit field work was performed at DSS, the MMIS fiscal agent in Albany, New York, the LDSS in Westchester County, and at the 38 personal care providers involved in our sample during the period September 1991 to January 1993.

FINDINGS AND RECOMMENDATIONS

Our review disclosed significant weaknesses with respect to documentation and billing of services rendered and authorization of personal care services. Collectively, the weaknesses increase the risks of the program to fraud, waste and abuse. They also raise questions as to the adequacy and appropriateness of care rendered to recipients. As the result of documentation and billing problems noted, we are recommending that the State immediately notify providers of the error amounts identified in our sample ($431,286 Federal share) and obtain a refund of these payments. With respect to our statistically estimated range of error amounts, we are recommending that the State work with HCFA in developing a cost effective plan to identify the erroneous payments made to each provider and institute appropriate recovery action. Because of deficiencies in the authorization of personal care services, we are recommending a number of procedural improvements to preclude recurrence of the control weaknesses found.

In its comments, dated February 14, 1994, New York State expressed general agreement with the majority of our recommendations, indicating actions to be taken in response to problems noted in the report and system improvements already effected. The State's comments are summarized after each recommendation and are included in their entirety as Appendix III to this report.

DOCUMENTATION AND BILLING OF SERVICES

Our review disclosed significant weaknesses in the documentation maintained to support services billed as well as various billing errors which raise concerns about the adequacy of provider billing controls and procedures. Our statistical sample review of time sheet errors for 120 recipients disclosed, as unallowable, $431,286 of the $6,599,697 in FFP reviewed. Using stratified random sampling techniques, we estimate that payments totaling between $3,172,483 and $11,174,534 were inappropriately charged to the Federal Government. We believe that the State needs to issue more specific guidance on acceptable documentation. In addition, both the State and Westchester County need to increase their monitoring to ensure providers are maintaining adequate supporting documentation for services billed and are properly billing for services.

Providers are required to obtain prior approval before services are initiated or billed to the Medicaid program. According to State regulation 505.14(h)(1), no payment to the provider shall

be made for authorized service unless such claim is supported by the documentation of the time spent in provision of service for each individual patient. Although it is the responsibility of each provider to maintain the documentation of services rendered, State regulations do not specify the form such documentation must take.

At all 38 providers included in our review, the documentation of services rendered consisted of time sheets which varied in form, content, and neatness from provider to provider. We also found a wide variance in provider controls for ensuring that time sheets were complete and accurately reflected the hours worked by the aides. Several providers had extremely lax controls. We believe the lack of guidance to providers (and to Westchester County) concerning the specific manner and form for documenting services is a contributing factor to the deficiencies we found. In general, we believe the problems we observed with time documentation significantly increase the vulnerability of the program to fraud, waste and abuse.

In our opinion, the time sheets should have, at a minimum, indicated the name of the aide rendering the personal care service, the patient's name, the date of service, and the hours worked on the case each day. Further, we believe the time sheets should have been signed by the aide and by the patient or some representative of the patient to verify the aide worked the hours listed. Our review of the billing material at each provider indicated that all of these elements were not always present.

In summary, we found that 85 of 120 recipient cases and 33 of the 38 providers in our review had some type of error related to the documentation or billing of services. This involved 7,102 services, the costs of which were unallowable. The errors, which are summarized below, can be grouped into the following 8 categories:

Category	Error Cases[1]	Related Services	Medicaid Paid	Federal Share
Missing Time Sheets	45	4,242	$554,070	$277,035
Time Sheets Do Not Support Billing	51	472	29,366	14,683
Double-Billing	9	50	4,514	2,257
One Aide Worked Entire 24 Hours	21	662	71,928	35,964
No Services Rendered	16	29	2,002	1,001
Altered Time Sheet	4	5	554	277
No Records Found	8	1,375	174,844	87,422
Other	2	267	25,295	12,647
Total	156	7,102	$862,573	$431,286

The first two categories above denote cases where the providers could not provide us with documentation to support all or some of the time billed to the Medicaid program. Those two categories as well as the Double-Billing, No Records Found, and the Other categories are defined and discussed further in Appendix I. The remaining three billing error categories are discussed below because they are indicative of fraud, waste and abuse:

- o One Aide Worked Entire 24 Hours - This occurred on continuous 24-hour cases when only one aide worked the entire 24 hours. For such cases, State regulations require that at least two aides cover the 24-hour period; this is to assure the recipient receives the proper level of service, namely, uninterrupted service. The difference in the level of service provided is also reflected by the fact that for 24-hour continuous care

[1] The case counts under each of the above categories are not mutually exclusive since some cases exhibited more than one type of error. However, our disallowances amounts (Medicaid paid and Federal share) and error classifications were based on specific dates and hours of service within a case, thus the costs associated with a specific service period were only disallowed once.

cases, providers are authorized to bill using an hourly rate rather than a daily rate for "live-in" (one aide - 24 hours) cases; this results in a much higher rate of reimbursement for the 24-hour period. For the 21 cases in this error category, the providers improperly used one aide for the 24-hour period and incorrectly billed using the hourly rate when they should have been billing the "live-in" rate.

- No Services Rendered - This occurred when there was evidence that services were not rendered to the client for a date billed or for part of a date billed. We noted this in 16 of the 120 cases reviewed. In 9 of the 16 cases there was a discrepancy between the billing and the case notes maintained by the provider or by the LDSS. In 3 cases the provider billed when the aide was off duty due to a paid holiday or sick day. In 2 cases the recipient was hospitalized. Also, in 1 case the aide listed no activity for two dates of service yet the provider billed. Finally, in 1 case the public health nurse noted during her supervisory review visit to the recipient's home that the aide had not been present, yet we found a time sheet prepared listing the aide as having worked during those same hours.

  The existence in our sample of providers billing for services not rendered is a very serious matter. The following are several examples which highlight our concerns:

  Case 15 - Case notes for one date of service stated:

  "Called to see if aide had made it in because of the snow. Patient says that no aide did not make it in but she has a friend with her, name Robert he didn't want to give last name. But everything is grate (sic) Patient has food & is warm."

  and for another service date:

  "I told her (aide's name) her aide can't work today. She said she would call some friends to stay with her. She doesn't want another aide."

We found that for each of the above dates, eight hours was billed by the provider. In addition, we found time sheets indicating that the aide had purportedly worked.

Case 38 - Case notes for one date of service stated:

"No service today. Hm.[2] had a medical appointment. I didn't send a sub. because last time Clt. didn't open the door to the Hm. sub. Clt. called this p.m. to inform that Hm. didn't show up. I explained to Clt. that she was told that Hm. had an app. for today.

M.L."

We found a time sheet supporting the eight hours billed to Medicaid for this date.

Case 74 - For two consecutive service dates, the provider billed 12 hours for this recipient, but did not have supporting time sheets. In response to our request for further information, the provider indicated that the client had been hospitalized on those two dates. We question how these hours could have been billed since there did not appear to have been a time sheet originally prepared.

Case 104 - This recipient was being serviced by her granddaughter, which was allowable since they did not live together. However, in the case files, we found an incident report which indicated the aide had been disciplined for submitting time sheets for services rendered on three consecutive service dates when, in fact, the aide had been hospitalized. The provider billed for 12 hours on each of these dates and, although there was an incident report on the matter dated the following month, there was no evidence that the provider adjusted its billing for these three dates.

- Altered Time Sheet - This occurred when a provider had submitted a time sheet, subsequent to our site visit, which showed evidence of alteration when compared with the copy made by us during the visit. We made copies of selected time sheets during our visits when we noted

[2]"Hm." is homemaker and "Clt." is client

that some service hours billed were missing supporting documentation. When we compared the two time sheets, we concluded that the second time sheet had been altered. We noted this problem in 4 of the 120 recipient cases and 2 providers accounted for these 4 cases.

Under separate cover, we intend to provide the State with information on the providers with poor controls and those with serious billing inaccuracies. We believe the State should consider conducting in-depth audits of these providers and whether referrals to the Medicaid Fraud Control Unit are warranted.

In addition to the above serious billing errors, we found a general "sloppiness" in the time sheets maintained at certain providers. Some time sheets had been processed and accepted by the provider where the month and/or day and/or year of service had been omitted from the time sheet. Some aides failed to indicate whether the shift worked was A.M. or P.M.. Still other time sheets did not indicate the total number of hours worked and many were not signed by the recipients, although the form provided a place for signature. In our opinion, the reason for a missing recipient signature should be documented on the time sheet.

Since the time sheet should have been the basic document to support the billing, we were dismayed at the lack of standardization in the industry. At virtually every provider visited, we requested answers and supporting documentation for a lengthy list of "open" items because the information needed to substantiate each date billed could not be found, even though each provider had prior notice of specifically what information we needed. Ultimately, personnel at most providers were able to locate the missing documentation.

The errors noted during our review indicate that providers need to significantly improve their controls over the preparation and maintenance of time sheets. Because of the lack of specific guidance from the State, we found wide variances in the quality of time sheets. We believe the time records constitute such an important control factor that the State should develop a uniform personal care time documentation record which would be mandatory for all providers rendering services in Westchester County and perhaps the rest of the State. In this regard, we understand that most providers in the New York City area utilize a standardized time record.

We believe specific guidance should be given to providers on how the time sheet should be prepared including the need for certification by the aide and by the patient (or representative) of hours worked and services received. The guidance should also stress that the time record is to be used as the basic source document for generating billings to the Medicaid program. During our audit, we observed that some providers appeared to have prepared their billings from documents other than time sheets (eg. scheduling sheets) which could explain why we noted discrepancies between the hours billed and the hours contained on the time sheets. In all cases, we believe the time sheet should be the basic source and support document for all billings.

In developing a uniform time sheet, we believe the State needs to coordinate with HCFA to resolve differences between current Federal and State criteria. The HCFA Medical Assistance Manual states that although there are no specific record-keeping requirements, the personal care aide should keep daily notes on the tasks performed, the condition of the patient, and the total number of hours worked. Such records should be made part of the patient's health chart and retained as documentation of the provision of services.

We found that the aides servicing our sample recipients generally did not prepare notes on the condition of the patient. Although we found evidence of activity sheets at 36 of the 38 providers visited, it is our opinion these sheets did not fully satisfy HCFA's intended requirements. For the most part, the activity sheets found merely included check marks next to the services provided on a given day; a notation of the patient's condition was not included. The current provider time sheets do not contain written notes on the tasks performed for the patient nor did the time sheets satisfy the requirement for notes on the condition of the patient. The only notes on the patient's condition were those made when a registered nurse from the LDSS or the provider made a periodic visit.

In addition to the documentation and billing errors outlined above, we also noted at one provider what we believe, at a minimum, is a quality of care issue regarding the number of hours worked by certain aides. During our attempt to "look behind" the time sheets at this provider, we requested copies of scheduling sheets and earnings statements for selected aides. During our review of these documents, we noted two major problems. First, we found that certain aides were working an exorbitant number of hours a week. For example, one aide, over a 13-week period, worked 1,707 hours, or an average of 131 hours per week or approximately 19 hours per day. Another aide worked 1,680 hours

(over a different 13-week period), which included two separate weeks where the aide worked 156 hours or an average of more than 22 hours per day.

The second problem involved a single aide working two 12-hour shifts on the same day for two different recipients. For example, we noted that one aide worked 144 hours during a particular week. During that week, the aide worked five consecutive 24-hour shifts for two different recipients (12 hours each day for each recipient). The aide did not work Saturday, but worked 24 hours for one recipient on Sunday, which is against regulations.

We could not find any regulations which specifically limit the number of hours an aide can work; however, as noted earlier in this report, State regulation 505.14(a)(3) states that continuous 24-hour personal care services shall mean the provision of uninterrupted care, ***by more than one person.*** We informed Westchester County officials of these findings and they, too, expressed great concern that an aide was working the number of hours indicated above or that an aide was servicing two 12-hour shifts for two different recipients on the same day.

In our opinion, the above examples of unusual work patterns also raise program risks in that they may be indicative of time sheet abuse by the aide or abusive billing practices by the provider in the claiming of personal care services. These conditions, as well as the other billing errors noted by our review, highlight the need for additional provider monitoring and audits by DSS. We had originally requested DSS to furnish us copies of all the personal care audits they had performed. We were provided with one report on an internal review and a draft report of one provider audit. Considering the size and growth of the personal care program, we believe much greater audit coverage at the provider level by DSS is needed.

In summary, the providers were unable to substantiate the services hours billed or documentation existed which indicated that billing errors had been made. As a result, New York State improperly claimed and received Federal reimbursement for personal care services that were undocumented or were improperly claimed.

Recommendations

We recommend that New York State:

1. With respect to the $862,573 (Federal share - $431,286) of sampled payments actually found to contain billing errors, immediately notify the providers of the errors, obtain a refund of these payments, and credit the Federal Government.

2. With respect to our statistically estimated range of error amounts, jointly develop with HCFA, a cost-effective plan to identify the erroneous payments made to each provider and, after such identification, institute appropriate recovery action.

3. Establish specific and detailed regulations with respect to the documentation of services at the provider level. This would include the development of a uniform time sheet for use by personal care providers. The regulations should incorporate the guidance contained in the HCFA Medical Assistance Manual concerning the aide making daily notes on the tasks performed, the patient's condition, and the hours worked. There should also be a requirement for time sheet signatures by both the aide and the recipient or a representative and documentation on the time sheet of the reason for lack of a recipient signature.

4. Issue guidance to providers on the importance of accurate and complete time sheets and the importance of record retention. Providers should be specifically advised that time sheets are to be used as the basic source documents to generate billings to the Medicaid program.

5. Develop and issue guidance or regulations covering the number of consecutive hours that aides can work on personal care cases and more strongly enforce existing regulations concerning 24-hour continuous care cases.

6. Conduct more frequent audits of individual providers with emphasis on service documentation and billing.

STATE AGENCY COMMENTS

The State indicated that, with regard to the collection of the $862,573 (Federal share $431,286) in sample payments actually found to contain billing errors, it would follow up on the report's findings and recoup, where possible, the potential overpayments. The State also made the point that 50 percent of the identified billing errors were attributed to one provider, Kelly Kare, Inc. (actually Kelly Kare Limited), which had been previously audited by the State and, as a result, referred to the State's Attorney General (which includes the Medicaid Fraud Control Unit) for further investigation. According to the State, the operators of Kelly Kare were subsequently found guilty of submitting fraudulent billings of more than $1.1 million during the period April 1987 to October 1990; the provider was terminated from the Medicaid program on October 27, 1993, and is no longer in business. With respect to developing a plan to identify, from the statistically estimated range of error payments, the erroneous payments made to each provider and to recover such payments, the State indicated the results of its efforts to recover the sampled overpayments will determine what additional steps, if any, need to be done in this area. Further, the State questioned the accuracy of the projection of the amount of potential overpayments to be recovered, since the provider with the largest amount of billing errors is no longer in the Medicaid program.

The State believes its current policy is adequate regarding the required use of time sheets; the personal care services regulations and contracts specify that time records must be maintained. To ensure providers are aware of the requirements, the State will include in a future edition of the Medicaid Provider Update an article that addresses the specific information that should be included on the timecard. Although the State did not believe it is necessary to create a Statewide uniform time sheet, it is investigating a means of automating timecards, such as the electronic submission of time information currently being tested as an Innovative Demonstration Project in Rockland County. With regard to the daily notes which should be maintained by the aides, the State commented that the timecard is not the appropriate document to be used for such notes, because this information is considered confidential medical information. According to the State, the aide activity sheets should be used for such purposes. Concerning the need to issue guidance to the providers on the importance of accurate and complete time sheets and record retention, the State will issue a Medicaid Provider Update article on the subject.

In response to our fifth recommendation, the State indicated that the number of hours aides can work is covered by State and Federal labor laws and is not a function of DSS. However, the State will emphasize in a Medicaid Provider Update article the need to be familiar with the labor laws and it will issue a Local Commissioners Memorandum to remind local districts to review the number of hours worked by personal care services aides.

With respect to the recommendation to conduct more frequent audits of individual providers with emphasis on service billing and documentation, the State indicated the Westchester County Department of Social Services (Westchester County LDSS) has in the past few years increased the auditing of provider agencies' records. The LDSS has reported improvement in provider recordkeeping and has received Innovative Home Care grant money for increased auditing of providers, training and employment records.

OIG RESPONSE

We are pleased the State will follow up on our findings and recoup overpayments, where possible. With respect to Kelly Kare, we were aware that the owners had been convicted of Medicaid fraud; however, it should be noted that the case involved billings for nursing rather than personal care services. Also, a provider's termination from the Medicaid program would have no impact on the State's responsibility to recoup overpayments from that provider, but the fact that the provider is no longer in business could. The State will need to carefully evaluate the Federal regulations governing such situations found at 42 CFR 433.318.

Further, we would note that despite the percent of billing errors related to Kelly Kare, our estimated range of error amounts is accurate since it was based on statistically valid sampling techniques. As such, it could serve as the basis of other recoupment approaches. For example, if the overpayments from Kelly Kare are determined to be uncollectible, these could be extracted from the sample results and a revised estimate generated. In any event, our recommendation was that the State work with HCFA to ***jointly*** develop a cost effective plan to identify the erroneous payments made to each provider, and after such identification, institute appropriate recovery action. We continue to believe that any determination with respect to the estimated range of error amounts should be made in consultation with HCFA.

Contrary to the State's belief, it is our opinion its current policy and regulations related to the documentation of services at the provider level are not adequate. Given the audit findings in our report, we continue to believe the State must issue more specific regulations in this area. In our opinion, the form of the time record should be specified in the regulations, as well as the requirement for both recipient and aide signatures on the document. Although we believe guidance to the providers is also necessary (and made a recommendation to that effect), we do not believe a Medicaid Provider Update article alleviates the need for more detailed regulations. Also, even in a system using automated timecards, there would have to be some means of verifying the time spent in providing services. With regard to the daily notes to be maintained by the aide, we did not recommend that these notes be maintained on the time sheet. Rather, our recommendation was that the requirement for the preparation and maintenance of such notes be made part of the State's regulations. In point of fact, although we found that 36 of 38 providers used activity sheets of some type, in general, aides were not preparing daily notes on the condition of the recipient.

Regarding our recommendation to develop guidance or regulations covering the number of consecutive hours that aides can work on personal care cases, our main concern was the quality of care provided to the recipients. Thus, we believe this issue would fall under the purview of DSS, since it has issued regulations on other quality of care issues such as requiring at least two aides to service a recipient in a 24-hour period on 24-hour continuous care cases. While employers should comply with all labor laws, we strongly believe DSS needs to evaluate and regulate the number of hours an aide can work in order to ensure the safety of the patient. Also, we note the State did not respond to that portion of our recommendation indicating it should more strongly enforce existing regulations concerning 24-hour continuous care cases.

Finally, we are pleased to hear that the Westchester County Department of Social Services has in the past few years increased the auditing of providers' records. We would point out that our recommendation was directed at the State rather than Westchester County. However, if the State intends to rely on audits performed under Westchester County's aegis, as opposed to additional State audits, we believe the State should monitor the scope and frequency of audit coverage and perform tests to determine the adequacy of the audits. The State should also receive copies of all audit reports and corrective action plans submitted by the providers. Based on this data, the State could determine whether there is a need for additional State audits.

AUTHORIZATION OF PERSONAL CARE SERVICES

We found significant noncompliance with applicable requirements regarding the initial authorization and periodic reauthorization of personal care services. We also found that the State Agency had not effectively monitored the personal care program in Westchester County.

Although New York State had established procedures and controls to ensure the proper authorization of personal care services, the controls were routinely and consistently by-passed by personnel within the LDSS of Westchester County. In effect, services were rendered before they were authorized.

The State of New York and Westchester County had designed internal control procedures (systems) to ensure that recipients had a medical need (i.e. were eligible) for personal care services, they received the proper level of services and there were front-end billing controls on the providers. These systems included two principal and interrelated internal controls:

- The necessity for a complete authorization package consisting of input from three separate professional disciplines ***prior to services being rendered.***

- The subsequent issuance of prior approval numbers to providers which permitted them to initiate or continue services in accordance with established hours of care and to bill for services rendered.

Another aspect of the control process was the DSS monitoring of the LDSS in Westchester County.

State regulation 505.14(b) requires that the authorization for personal care services shall be based on a physician's order, a social assessment and a nursing assessment. The regulation indicates the authorization is to be completed prior to the initiation of services and provides that the authorization is effective for a maximum time period of six months. If services are to continue, they must be reauthorized every six months and the regulations indicate that the reauthorization process shall follow the same procedures as the initial authorization. Accordingly, an updated physician's order and nursing and social assessments must be obtained prior to the continuation of services for each and every 6-month period.

The State regulations further discuss each component of the authorization package as follows:

- the physician's order should be based on the patient's current medical status as determined by a medical examination within 30 days of the request for services. Services must be based on medical need and supported by the recommendation of a physician. All physician's orders must include the recipient's primary diagnosis and the associated International Classification of Diseases (9th Revision) diagnosis code. A copy of the order should be forwarded to the LDSS and to the person responsible for the nursing assessment.

- the nursing assessment should be performed by a registered nurse and should include a review and interpretation of the physician's order, an evaluation of the functions and tasks required by the patient, the development of a plan of care and recommendations for authorization of services. The nursing assessment should be completed within five days of the original request; however, if the client is in immediate need of services, the initial authorization may be based solely on the physician's order and social assessment. In these cases, the nursing assessment must be completed within 30 days and the recommendations must be incorporated into the plan of care.

- the social assessment should be completed by the professional staff of the LDSS, normally the caseworker, and should include a discussion with the patient to determine perception of his/her circumstances and preferences. The social assessment should include an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care. It should be completed on a timely basis and be current.

Federal regulations for personal care services are contained in 42 CFR 440.170 (f) which state, in part, that the services must be prescribed by a physician and be supervised by a registered nurse. In electing to provide coverage for personal care services, New York State issued regulations that address and supplement the Federal requirements. Federal regulations indicate that personal care services must be "prescribed by a physician." Thus, the requirement for a physician's order in authorizing personal care services is found at both the Federal and State level. According to State regulations the nursing assessment should result in a plan of care; Federal regulations also call for a plan of care or treatment.

Although the State requirement for the physician's order and nursing assessment grew out of the Federal requirements, the State requirement for the social assessment does not appear to be specifically drawn from the Federal regulations related to personal care. Rather, according to State officials, the requirement for the social assessment as part of the authorization for personal care services grew out of the Federal Title XX homemaker case requirements. They explained that the requirements for the provision of homemaker services under Title XX keyed on the caseworker, one of whose major responsibilities was the assessment of the recipient's social situation and needs.

In the following sections, we discuss problems noted with respect to the authorization package, physician's orders, LDSS prior approval, and DSS oversight.

Authorization Package

The authorization process is a fundamental system for ensuring quality of care. The initial authorization package is critical as it establishes the recipient's eligibility for personal care services as well as the immediate level of care needed. The reauthorization of services is also important to quality of care because it permits an evaluation of the services provided during the previous authorization period as well as a reassessment of the current needs of the patient. Since each component of the authorization process has its own distinct requirements, if one or more of the components is not completed, or not completed timely, the recipient may not receive the proper level or type of care. However, we found that authorization packages were not always complete and timely.

Our review of initial authorizations and reauthorizations disclosed errors for 118 of 120 recipient cases. In total, we identified as errors the costs of 63,126 of the 97,162 services provided to the 120 recipients, or 65 percent. Of the 63,126 services considered errors, 41,839 services were errors because of problems related to missing or untimely social assessments. The second largest error group pertained to late or missing physician's orders where the costs of 20,202 services were involved. We found the fewest problems in the area of nursing assessments where 1,085 services were errors because of missing or late nursing assessments.

The following schedules summarize our results. A detailed explanation of our computation is included as APPENDIX II.

Results of Calculations for Initial Authorizations

Category	Error Cases[3]	Related Services	Medicaid Paid	Federal Share
Physician's Orders	6	404	$ 55,970	$ 27,985
Nursing Assessments	1	74	8,880	4,440
Social Assessments	23	5,678	775,793	387,896
Total	30	6,156	$840,643	$420,321

The above schedule documents those instances (remaining after billing errors were counted) when services were rendered before a required component of the authorization package had been received. Thus, for the 29 recipients with initial authorizations, there remained a total of 30 error cases having missing or late physician's orders, nursing assessments or social assessments.

With respect to the reauthorization of services, State regulations require this process every six months and indicate that it shall follow the procedures outlined for the initial authorization. This means that prior to services continuing, an updated physician's order, nursing assessment, and social assessment must be obtained. In evaluating compliance with State requirements, we provided a 3-month grace period in the deadline for all three components of the reauthorization before computing an error amount.

[3]The error case counts for the three categories is not mutually exclusive, since a case could have more than one type of error. However, once the related service cost was considered an error under one category and the related Medicaid and Federal amounts computed, it was not included in our calculations again.

The following schedule summarizes the results of our calculations with respect to reauthorizations:

Results of Calculations for Reauthorizations

Category	Error Cases[4]	Related Services	Medicaid Paid	Federal Share
Physician's Orders	91	19,798	$2,520,750	$1,260,374
Nursing Assessments	23	1,011	117,520	58,760
Social Assessments	100	36,161	4,722,664	2,361,331
Total	214	56,970	$7,360,934	$3,680,465

In summary, the reauthorization of personal care services was not generally based on a complete authorization package. As a result, recipients continued to receive services that may not have been necessary or appropriate in the circumstances.

In our opinion, when services started prior to the receipt of the required input from each of the three professional disciplines, the services were ***unauthorized***. Our statistical sample review of authorizations for 120 recipients disclosed, as an error amount, $4,100,786 of the $6,599,697 in FFP reviewed. Using stratified random sampling techniques, we estimate that payments totaling between $54,864,884 and $65,485,473 were inappropriately charged to the Federal Government. The midpoint of the precision range amounted to $60,175,179. The ranges shown have a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 8.82.

Although the services were unauthorized, we recognize that, in most cases, services were rendered to Medicaid recipients by providers and the State has paid these providers. Further, in many cases, authorizations were eventually processed although they were untimely. Given this, we are not recommending disallowance of costs claimed for reimbursement. Rather, we are recommending a number of procedural improvements to preclude recurrence of the control weaknesses found.

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[4]See previous footnote.

Physician's Orders

Our review disclosed significant weaknesses in the completion of orders by physicians. We found several examples where physicians completed the orders despite the fact they had not seen the recipients in years. Further, information obtained from the Medicaid and Medicare paid history files raised additional concerns as to whether physicians were completing the orders based on knowledge of the recipient's current medical status. These findings represent a significant breakdown in a fundamental internal control process with potentially serious quality of care and utilization implications for the personal care program.

Our detailed review of selected physician's orders in our sample also disclosed instances of incomplete information on the physician's orders as well as orders which apparently did not support the need for personal care services. Despite these shortcomings, the physician's orders were accepted by the LDSS. Collectively, the observed problems raise questions about the adequacy and reliability of the physician's orders as well as the adequacy of the review performed by LDSS personnel of these critical authorization documents.

Our concerns about whether the physician's orders were being completed based on the patient's current medical condition were heightened when our analysis revealed six separate cases, within our sample, where the signing physician noted on a physician's order that he/she had not seen the recipient in some time; specifically, the time periods ranged from 18 months to 3 years. Nevertheless, in four of the six cases the doctor still signed the subject order. In addition, when we reviewed other orders prepared for these six recipients for the time period mentioned above, we found that in five of the cases, the same physician had completed and signed a previous order despite the fact that it appears no examination was performed.

In five of the six cases, we saw no evidence the caseworker or supervisor took any action to either contact the signing physician or another physician to document the need for continuation of services. Instead, the documents containing the physicians' notations were merely accepted as fulfilling the requirement for a physician's order. In addition, in two of the six cases Westchester County sent the subsequent order to the same physician. In our opinion, these physician's orders should have been rejected and no prior approvals of services should have been based on them. The fact that neither the caseworkers nor their supervisors challenged the validity of the orders indicates that an adequate review of these documents was not made.

Based on the review of six cases discussed above, we expanded our audit efforts to determine if we could obtain information from the MMIS which would enable us to ascertain whether the physician(s) completing the physician's order(s), for all 120 cases, had billed Medicaid for services to the client and whether the service dates were 30 days prior to the signed physician's order(s). In our opinion, a physician's order which was signed based on an examination more than 30 days prior to it would not reflect the recipient's *current* medical condition and, of course, any examination subsequent to the date of an order would not have been of any use to the physician in signing that order.

In accomplishing the above objectives, we first obtained each recipient's practitioner and clinic Medicaid claims histories from the MMIS. In reviewing these histories, we compared not only the physician's name but also the physician's address with that on each physician's order. We also determined if the signing physician was a Medicaid provider. If we did not find any visit to the physician by the recipient on the Medicaid claims history, we obtained additional recipient data and conducted another computer match to the Medicare Part B paid history files.

We had previously indicated there were 29 recipients whose services started during our audit period. In our review of both the Medicaid and Medicare information for initial authorizations, we could not make a determination in 4 of the 29 cases. We could find evidence of current visits by the recipient to the physician signing the order in only 7 of the 25 cases for which we could make determinations. Based on the results noted, it is our opinion that our audit tests raise very serious questions about the reliance which can be placed on initial physician's orders in terms of the State's requirement that the order be based on the recipient's current medical status as determined by a medical examination within 30 days of the request for service.

With respect to reauthorizing physician orders, our tests showed that 16 recipients had no services listed on the paid history files of the Medicaid or Medicare programs from the physician(s) who had signed their order(s). As these 16 recipients had Medicare and Medicaid coverage, we believe it is reasonable to expect to find evidence of services to the recipients by the signing physician(s). Even where visits were found on either the Medicare or Medicaid histories, 38 recipients had a service visit within 30 days prior to the signing of just some of their orders and for only 4 of the 38 recipients were all orders signed based

on a visit to the signing physician within 30 days prior to the completion of the form.

In order to be based on current medical knowledge, the examination by the physician should, in our opinion, be made within 30 days prior to the signing of the order. Without a current medical examination, the completion of the physician's order becomes merely a paper exercise which defeats the entire purpose of the authorization control process.

In addition to finding physician's orders which contained notes indicating the physician had not seen the recipient in some time, we also found eight cases where it appeared the physician was completing the order by merely repeating the information from previous orders. We also observed that some of the physician's orders in these eight cases were incomplete in that pertinent data was missing. For example:

> For case 80, we found physician's orders dated December 27, 1987, June 26, 1989, and July 24, 1990. None of the three orders contained a diagnosis, suggested medications, or treatments. Each stated "Renew all Previous orders" or "Continue all Previous orders". We checked the recipient's Medicaid and Medicare paid history files and found no evidence that services were rendered or billed by the signing physician.

Further, we performed additional detailed work on 18 selected cases. Our analytical review disclosed 13 cases where there were various deficiencies in the physician's orders. Specifically, the primary diagnosis, diagnosis code, or specific recommendation for personal care services was missing. We also noted 4 cases where the diagnoses listed on the physician's order were different from or did not include all those on the nursing assessments. For example, in case 93, a nursing assessment indicated the recipient had a stroke in August 1990 but the subsequent physician's order dated November 8, 1990 did not include this incident. Also, in reviewing nursing assessments, we noted 7 cases where the name of the doctor on the assessment was different from the doctor signing the physician's order. We believe these types of discrepancies should be noted and resolved by the staff of the LDSS to ensure that the signing physician is the physician currently caring for the recipient.

These omissions and deficiencies point out that caseworkers and their supervisors should have been more careful in reviewing and approving the fundamental authorization documents to ensure that quality of care questions were identified and resolved. In order

for the authorization to be valid, the documents should be complete and consistent.

We believe our audit work on physician's orders highlights conditions with serious quality of care ramifications as well as utilization and program cost concerns. Our work disclosed specific examples where physicians authorized services without current knowledge of the patient's condition or needs. In addition, our analysis of the information from the computer matches to the Medicaid and Medicare paid history files raises additional concerns as to whether physicians were signing orders based upon current medical knowledge of the patient. Under the State's system of internal controls, the doctor's input is extremely critical because he/she has the medical expertise and, through a patient examination, has the ability to assess whether personal care is appropriate and beneficial. The State needs to significantly strengthen controls to ensure that physician's orders are completed based upon knowledge obtained via a current medical examination.

Prior Approval by LDSS

Under the control system, prior approval numbers are only to be issued and entered into the State's computer system after the services had been authorized by all three professional disciplines. The caseworker is responsible for preparing a data entry form which contains a prestamped prior approval number.

The supervisor is charged with the responsibility for reviewing the complete authorization package and ensuring that the three required components have been obtained and are adequate. Only when this critical independent verification step had been completed is the supervisor authorized to sign the prior approval form.

The importance of the supervisor's review and approval is contained within Program Guide Transmittal Memorandum No. 507, which Westchester County issued with an effective date of May 1, 1981. The transmittal states that:

> "No 6-month authorizations are to be approved by supervisors without completed forms #1050 [physician's order], ... scored Nursing Assessment, and Social Assessment. If the physician does not provide a timely form #1050, the client or his/her family should be informed that personal care services cannot be provided without a physician's order."

The prior approval is the mechanism for another critical internal control over the personal care program. Personal care services are billed by providers through the State's MMIS. The MMIS is a computer-based claims processing system. The State has instituted a billing control which requires providers to obtain a prior approval number for each recipient before services are rendered and billed. The State provides prenumbered prior approval forms to the LDSS. In Westchester County, the prior approval forms are completed by the caseworker and must be signed by the caseworker's supervisor. Once approved, the form is then sent to the Prior Approval Unit, within the Office of Medical Services, which has the responsibility for entering the prior approval information into the MMIS. The MMIS will not accept any claim for the costs of services without a prior approval number.

Our analysis indicated that caseworkers were routinely preparing prior approval forms and submitting them for input into the MMIS without any assurance the required three components of the authorization package had been obtained and were adequate. In addition, we concluded that the caseworkers' supervisors were signing the prior approval forms without verifying the authorization package was complete. Further, in discussing the problem with one LDSS supervisor, we were made aware of another lapse in internal controls. We were advised that she limited her review of prior approval forms to those prepared by new and inexperienced caseworkers. Experienced caseworkers were allowed to write her name on the prior approval form even though she had not reviewed the completeness or adequacy of the authorizing documents. The reason given was that supervisors do not have sufficient time to review and sign all prior approval forms. Other LDSS officials also indicated that supervisors look at selected case files but do not check every case.

The above information directly contradicts the internal control requirements found in Westchester County's program guide which we highlighted previously. This situation represents a serious breakdown of controls because there is no longer a separation of duties or independent validation process.

This condition raises the potential for fraud at the caseworker level. Since the caseworker has the ability to enter a prior approval number into the MMIS without the existence of a complete authorization package, it is possible that a caseworker, in collusion with a provider, could approve services for a recipient who was not eligible for and, perhaps, was not even receiving personal care services.

DSS Oversight

Our findings with respect to the authorization and prior approval process also highlight the absence of effective oversight by DSS. The State agency is responsible for monitoring each local district's personal care operations to ensure the programs operate effectively and in compliance with State laws and regulations. The responsibility includes visiting local districts to provide technical assistance related to program operations and to examine recipient case documentation to ensure compliance with regulations.

The New York State OSC found that DSS monitoring activities were not effective. The OSC report indicated the visits by program personnel were not adequately planned, they did not occur frequently enough, and a sufficient number of cases were not tested. The report noted that although Westchester County had nearly 2,800 personal care recipients, the number of cases tested fell from 28 in 1985, to 16 in 1986, to 3 in 1988 despite the fact that similar documentation deficiencies were found in each of the years (the deficiencies noted included missing physician's orders). We requested copies of the 1989 and 1990 monitoring visit reports from DSS. Agency officials informed us that no monitoring visit was made in 1989. In 1990, program personnel limited their review to a sample of 44 24-hour continuous care cases, but individual case record documentation was not recorded during this effort. Further, DSS officials informed us that during 1991 and 1992, visits to the County involved the provision of technical assistance rather than the formal review of case records. However, in 1992, 10 case records were reviewed on an informal basis and it was noted there continued to be a problem with the timeliness of reauthorizing physician's orders. The lack of monitoring visits coupled with very limited testing indicates a control weakness by the State in terms of ensuring that the program is operating effectively and in compliance with regulations.

Conclusions and Recommendations

In summary, our audit clearly documented that internal controls with respect to the authorization package, completion of the physician's orders, and the issuance of prior approvals had been significantly and substantially by-passed. We also determined that the monitoring efforts by DSS needed improvement. The State and Westchester County need to take immediate action to ensure adherence to control procedures.

In implementing our recommendations, we believe that New York State should first reassess whether any changes are needed in the level of control procedures as the degree of noncompliance documented by our audit was so high. For example, the current regulations in Westchester County require reassessment of services every six months. It is our understanding that the State has extended the reauthorization period to once a year in New York City for most cases. Lengthening the reauthorization period in Westchester County for some or all cases should reduce the paperwork level while still maintaining the integrity of the program. Program officials might have other suggestions to improve the effectiveness of the control procedures.

In addition, we recommend that New York State:

1. Direct LDSS senior management to implement controls to ensure their staff review the physician's order and the indicated date of the last medical examination to confirm it occurred within the previous 30 days, thus verifying the recommendation for services is based on current knowledge of the patient's condition.

2. Direct senior management to take steps to ensure their staff are adequately reviewing the physician's orders to verify they are completed properly and are consistent with other information available in the LDSS files. Guidance should be issued as to specific actions required when data is missing or the orders are not properly completed.

3. Direct Westchester County LDSS senior management to emphasize the importance of adherence to pertinent regulations and internal control systems to ensure that:

    a. Complete authorization packages are obtained by caseworkers before prior approvals become effective.

    b. Supervisors fulfill their responsibilities to review the authorization package, assure it is complete, and sign the prior approval form. Supervisors should not allow the caseworkers to sign the supervisors' name to the prior approval form.

4. Increase the frequency and scope of its monitoring, oversight and testing of the Westchester County LDSS to ensure that program staff comply with the personal care regulations and internal control systems.

STATE AGENCY COMMENTS

In response to our recommendation that the State direct LDSS senior management to implement controls which would verify the physician's signing of the order for services is based on current medical knowledge, the State indicated it had reminded Westchester County of the importance of timely and adequate physician's orders. According to the State, the County has reorganized its personal care services administration and its recent monitoring efforts have shown the timeliness of case record documentation is greatly improved.

The State agreed with the recommendation that it direct LDSS senior management to take steps to ensure their staff are adequately reviewing physician's orders to verify they are completed properly and are consistent with other information available in the LDSS files. The State indicated it would advise Westchester County to take the necessary steps to implement the recommendation. It also will send a Local Commissioners Memorandum to all social services districts to reinforce the recommendation.

Concerning our recommendation dealing with the importance of adherence to pertinent regulations and internal control systems, the State responded that the Westchester County LDSS has improved the administration of the authorization process since the audit review period. For instance, the caseworker and nurse now make a joint visit, when possible, and the timeliness of documentation has improved. In addition, the State indicated the County has reorganized its personal care services administration, instituted a computer tracking system, and requires supervisory review on 20 percent of its personal care cases. Further, the State will request that Westchester County increase its supervisory review of the authorization document package prior to writing the prior approval.

Finally, the State responded to our recommendation to increase the frequency and scope of its monitoring of the Westchester County LDSS by indicating that both it and the County have increased monitoring activities and plan to further enhance these efforts in 1994.

OIG RESPONSE

We are pleased to note that NYS was in basic agreement with the four recommendations we made in the authorization of personal care services section of the report. The response indicates that Westchester County has reorganized the administration of the

personal care services program and this has apparently resulted in an improvement in the timeliness of case record documentation. The State has also stressed to the County the importance of timely and complete physician's orders and will advise the County to take steps to ensure that a proper review of physician's orders is made. The State also plans to issue a local commissioners memorandum to all social service districts to reinforce this recommendation.

With respect to our third recommendation, we note that Westchester County, in its comments to the State, did not include or make reference to documentation of its new policies and procedures, such as procedure manuals or policy issuances. All that was provided was a brief reorganization plan and a description contained in a 1993 NACo (National Association of Counties) Achievement Award Program Summary. We believe it is important, from an internal control standpoint, that the policies and procedures related to Westchester County's authorization process be reduced to writing. In this connection, when we met with Westchester County officials in June 1992, they discussed their improved procedures with us. At that time, we requested they send us copies of the written documentation supporting the new process. Although we received a copy of procedures related to the implementation of the joint case assessment, we did not receive anything new with respect to procedures which assure that services are not initially authorized without physician's orders. All that was sent in that regard was the May 1, 1981 Program Guide Transmittal No. 507 (which we already had) discussed above.

Also, with regard to complete authorization packages, the State's recent monitoring effort did indicate an improvement in the timeliness of social assessments. It also revealed that 20 percent of the case files reviewed did not contain a current physician's order and that most, but not all, of the case files contained documentation that a physician's order had been requested. Although the percent of cases not containing timely physician's orders is lower than that noted in our review, the error rate is still significant, in our opinion. (It should be noted that the State's monitoring report did not specifically indicate if any of the cases without a current physician's order were for recipients whose services were just being initiated.) Further, in its comments, Westchester County states it does reauthorize services without physician's orders, based on information contained in the nursing and social assessments. We are concerned that Westchester County has decided to reauthorize services in cases where not all the provisions of the State regulations have been met. The State needs to review this

situation with County officials and work with them in developing appropriate controls.

On the subject of prior approvals and supervisory review of cases, the State indicated that improvements have been made in obtaining necessary input because caseworkers and nurses are making joint visits and a computer tracking system has been instituted. Apparently as a result, supervisors are now only required to review 20 percent of the cases. The State further indicated that it will request Westchester County to increase its supervisory review of the authorization document package prior to writing the prior approval. In our opinion, an 80 percent reduction (from 100 to 20 percent) in required supervisory reviews appears unreasonable. We believe the State should review information on error rates, corrective action taken and based on this data work with Westchester County in setting realistic levels of supervisory review. A gradual reduction in the level of supervisory review may be warranted as error rates decrease. As we previously stated, supervisory reviews are critical to ensure that required authorizations have been obtained and to preclude clerks from issuing prior approval numbers before services were properly authorized via a complete authorization package.

Additionally, relative to our recommendation that New York increase the frequency and scope of its monitoring of Westchester County, the State provided a copy of the report on the latest monitoring visit as part of its comments. We did note that 30 cases had been reviewed, which represents an increase over the number reviewed in recent past years. However, we also noted the 30 cases reviewed represented only a little more than one percent of the 2,347 total cases in the County and there was no indication in the report as to how the cases were selected for review, i.e., statistically, judgementally, etc. Also, the report's recommendation for monitoring frequency was for yearly visits. Given the findings noted during our review and the fact that Westchester County has been and is in the process of implementing new procedures and a computer tracking system, we believe yearly monitoring visits by State officials may not be frequent enough.

Overall, we encourage the State to increase its interaction with and monitoring of Westchester County until all of our report recommendations have been fully implemented.

OTHER MATTERS

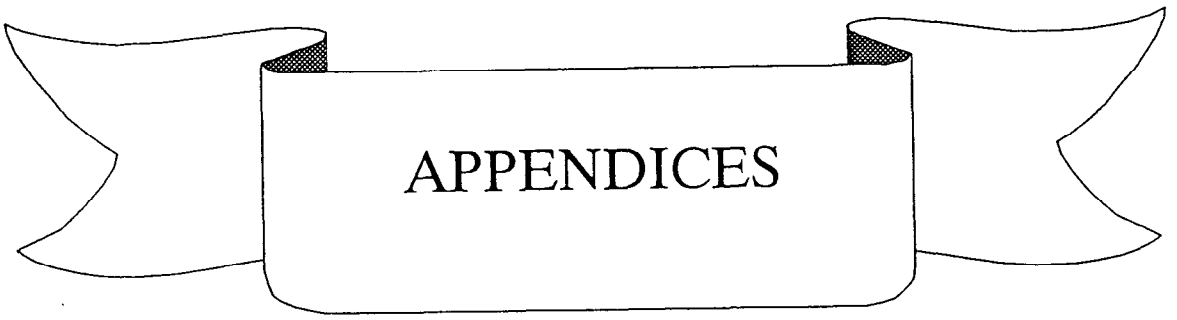
As part of our audit of personal care services in Westchester County, we reviewed the personnel file of the "primary" aide for each recipient to determine if the aide had completed all required training while servicing the recipient. Generally, the primary aide was the aide who provided the majority of the services to the recipient during the review period. This part of the review was completed for informational purposes only and did not result in the disallowance of any service costs.

According to Section 505.14(e) of Title 18 of the New York State Code of Rules and Regulations, each person performing personal care services shall be required as condition of initial or continued participation to participate successfully in a training program approved by the State DSS. An approved training program shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision. Basic training shall total 40 hours in length and be directed by a registered professional nurse or social worker. In-service training shall be provided, at a minimum, for three hours semi-annually to develop specialized skills or knowledge not included in basic training or expand skills included in basic training. On-the-job training shall be provided, as needed, to instruct the aide in a specific skill or technique, or to assist the person in resolving problems in individual case situations.

As noted, we reviewed the primary aide's file at each provider who had serviced the recipient. Since many of the recipients in our sample were serviced, at times, by more than one provider, we actually reviewed a total of 220 aide files related to the 120 recipients.

We found that for 15 of the 220 aides, the provider could not locate the aide file. For one case we did not find the basic 40 hour training certificate. Finally, we noted that 75 of the aides' files were missing evidence of at least one semi-annual in-service training document. As with the billing difficulties, we notified the providers in writing when a document was not found; thus, we gave the provider every opportunity to locate these documents. However, with respect to the 75 cases, it should also be noted that in certain instances the providers claimed that the aide had not worked the entire year and had left the agency (provider) before semi-annual training was given.

Based on our limited review, we believe this is another area which requires increased monitoring by the State. When periodic audits of providers are conducted, we believe the audit scope should include coverage of the adequacy of the training provided to aides.


APPENDICES

DOCUMENTATION AND BILLING ERROR CATEGORIES

Missing Time Sheets

This occurred when the provider could not furnish us with a time sheet to support any of the hours billed for one service date. Ample time was afforded all providers to locate missing time sheets. Without documented time sheets, there was no assurance that services were provided to the recipient. We noted this error in 45 of the 120 recipient cases in the sample.

The provider with the largest errors was recently convicted of Medicaid fraud in a related home health care program. In addition, the provider was suspended from the personal care program in 1991. A detailed close-out audit of this provider should be performed by the State.

Time Sheets Do Not Support Billing

This occurred when a time sheet was provided to support some, but not all, of the hours billed for one service date. Accordingly, the providers were unable to substantiate a portion of the time billed to the Medicaid program. Fifty-one of 120 cases had evidence of this condition.

Double-Billing

This occurred when two providers billed for more than 24 hours of service on one date for one client. Essentially, this indicates that there was more than one aide servicing a client at one time. According to State officials, such a situation should not normally occur, except in very limited and authorized situations. The nine cases in which we noted this error had no such authorization in the files. We noted that for two of these nine cases, two different providers billed the "live-in" rate for the same date. For the other seven cases, two providers billed some combination of hours that exceeded 24 for one date for one client.

One Aide Worked Entire 24 Hours

This occurred on continuous 24-hour cases when only one aide worked the entire 24 hours. For such cases, State regulations require that at least two aides cover the 24-hour period; this is to assure the recipient receives the proper level of service, namely, uninterrupted service. The difference in the level of service provided is also

reflected by the fact that for 24-hour continuous care cases, providers are authorized to bill using an hourly rate rather than a daily rate for "live-in" (one aide - 24 hours) cases; this results in a much higher rate of reimbursement for the 24-hour period. For the 21 cases in this error category, the providers improperly used one aide for the 24 hour period and incorrectly billed using the hourly rate when they should have been billing the "live-in" rate.

No Services Rendered

This occurred when there was evidence that services were not rendered to the client for a date billed or for part of a date billed. We noted this in 16 of the 120 cases reviewed. In 9 of the 16 cases there was a discrepancy between the billing and the case notes maintained by the provider or by the LDSS. In 3 cases the provider billed when the aide was off duty due to a paid holiday or sick day. In 2 cases the recipient was hospitalized. Also, in 1 case the aide listed no activity for two dates of service yet the provider billed. Finally, in 1 case the public health nurse noted during her supervisory review visit to the recipient's home that the aide had not been present, yet we found a time sheet prepared listing the aide as having worked during those same hours.

Altered Time Sheet

This occurred when a provider had submitted a time sheet, subsequent to our site visit, which showed evidence of alteration when compared with the copy made by us during the visit. We made copies of selected time sheets during our visits when we noted that some service hours billed were missing supporting documentation. When we compared the two time sheets, we concluded that the second time sheet had been altered. We noted this problem in 4 of the 120 recipient cases and 2 providers accounted for these 4 cases.

No Records Found

This occurred when a provider indicated that it did not have or had lost a group of records, specifically time sheets. According to New York State Department of Social Services regulations, Section 540.7(a)(8), records necessary to fully disclose the extent of care, services and supplies provided to individuals under the State Medicaid program will be kept for a period of not less than six years from the date of payment. This condition was found in 8 cases and involved 3

of the 38 providers in our sample. For 2 of the providers, the problem occurred as the result of a transfer of provider ownership.

Other

This category includes two recipient case errors that were not classifiable under one of the previously discussed categories. In one case, we found personal care services were provided to a recipient by her daughter; reimbursement for services provided by a relative living in the same home is specifically prohibited by both State and Federal regulations. The other case involved a provider billing two different personal care rate codes for one recipient on the same day for the same period of service. The provider in this case agreed that one of the billings was in error.

CALCULATION OF AUTHORIZATION ERRORS

To compute the costs related to the authorization problems noted, we considered errors related to initial authorizations first and then errors related to reauthorizations next. If our review disclosed that services were rendered without a complete authorization package in place, we considered the services to be unauthorized and calculated the costs, net of billing error amounts, related to them. Since we could only include the cost of a service date once in our calculations, we established the following order of precedence:

- services rendered prior to an initial physician's order
- services rendered prior to an initial nursing assessment
- services rendered prior to an initial social assessment
- services rendered prior to reauthorizing physician's orders
- services rendered prior to reauthorizing nursing assessments
- services rendered prior to reauthorizing social assessments

In computing the costs of authorization errors based on untimely initial authorizations, we granted the maximum 30-day grace period allowed by State regulations for nursing assessments in emergency situations. We did not allow any grace period for the initial physician's order or social assessment because State regulations clearly indicated that these documents had to be in place before services were rendered.

For the 29 cases where services began in our audit period, the authorization error amounts were calculated from the first service date billed to the date the order and assessments were signed. As noted above, we prioritized the determination of errors by considering missing or late physician's orders first, then nursing assessments and finally social assessments. For example, for case number 8, services began on March 13, 1989. However, a physician's order was not signed until August 4, 1989. Thus, the costs of all services from March 13 to August 3, 1989 were considered errors for the lack of a physician's order. The initial nursing assessment was also late but it was within the 30-day emergency grace period so no additional error amount was computed. With respect to the initial social assessment, it was dated September 5, 1990. Therefore, we could have included in the error amount the costs of all services starting with March 13, 1989. However, since we had previously included the costs for the period March 13 to August 3, 1989 under the physician's

order category we computed, as an additional error amount, only the costs for the period August 4, 1989 to September 4, 1990.

In evaluating compliance with State requirements, we provided a 3-month grace period in the deadline for all three components of the reauthorization before computing an error amount. For example, if an order or assessment was dated January 1, we would start counting service dates as errors only if the next order or assessment was dated subsequent to September 30, not June 30. It should be noted that the grace period was applied individually to all three components of the reauthorization package. Thus, if the physician's order and nursing assessment were prepared within the 9-month time frame but the social assessment was 2 months late (or 11 months from the previous assessment), the costs of all services within that 2-month period were treated as errors based upon the late social assessment. Also, error amounts were calculated, as appropriate, for the costs of services related to missing case files or portions of case files. For example, the four case files provided by an alternate source did not contain social assessments. Thus, the costs of any services not considered errors for problems related to the physician's orders and nursing assessments were included in the error amounts related to the lack of social assessments.

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MICHAEL J. DOWLING
Commissioner

NELSON M. WEINSTOCK
Deputy Commissioner,
Management Support and
Quality Improvement

February 14, 1994

Mr. John Tournour
Regional Inspector General
for Audit Services
Office of Inspector General
Office of Audit Services
Region II, 26 Federal Plaza
Federal Building
New York, NY 10278

Re: HHS/OIG Draft Report: Review of Personal Care Services in Westchester County Under the NYS MA Program A-02-91-01055 (93-035)

Dear Mr. Tournour:

The following is our response to the recommendations in your report on Personal Care Services in Westchester County covering the period January 1, 1988 to December 31, 1990. We also shared the report with the Westchester County Department of Social Services and are enclosing their comments.

Recommendation: With respect to the $862,573 (Federal Share - $431,286) of sample payments actually found to contain billing errors, immediately notify the providers of the errors, obtain a refund of these payments and credit the Federal Government.

Response: We will follow up on the report's findings and recoup, where possible, the potential overpayments. It is important to point out that 50 per cent of the identified billing errors were attributed to Kelly Kare Inc. That provider was previously audited by the Department and as a result of our review we referred Kelly Kare Inc. to the State's Attorney General (AG) for further investigation. Subsequently, the operators of Kelly Kare Inc. were found guilty of submitting fraudulent billings of more than $1.1 million during the period April 1987 and October 1990. Kelly Care was terminated from the Medicaid Program on October 27, 1993, and is no longer in business.

Recommendation: With respect to the statistically estimated range of error amounts, jointly develop with HCFA, a cost effective plan to identify the erroneous payments made to each provider and, after such identification, institute appropriate recovery action.

Response: The results of our efforts to recover the sampled overpayments will determine what additional steps, if any, need to be done in this area. Since the provider with the largest billing errors is no longer in the Medicaid Program, we would question the accuracy of the projection of the amount of potential overpayments to be recovered.

Recommendation: Establish specific and detailed regulations with respect to the documentation of services at the provider level. This would include the development of a uniform time sheet for use by personal care providers. The regulations should incorporate the guidance contained in the HCFA Medical Assistance Manual concerning the aide making daily notes on the tasks performed, the patient's condition, and the hours worked. There should also be a requirement for time sheet signatures by both the aide and the recipient or a representative and documentation on the time sheet of the reason for lack of a recipient signature.

Response: We believe our current policy is adequate regarding the required use of time sheets. The Personal Care Services regulations and contracts specify that time records must be maintained. To ensure providers are aware of the requirements, we will include in a future edition of the Medicaid Provider Update an article that addresses the specific information that should be included on the time card. Although we do not believe it is necessary to create a Statewide uniform time sheet, we are investigating a means of automating time cards, such as the electronic submission of time information currently being tested as an Innovative Demonstration Project in Rockland County.

With regard to the daily notes which should be maintained by aides, the time card is not the appropriate document to be used for such notes, because this information is considered confidential medical information. The aide activity sheets should be used for such purposes.

Recommendation: Issue guidance to providers on the importance of accurate and complete time sheets and the importance of record retention. Providers should be specifically advised that time sheets are to be used as the basic source documents to generate billings to the Medicaid Program.

Response: A Medicaid Provider Update article will be developed to emphasize the importance of accurate and complete time records.

Recommendation: Develop and issue guidance or regulations covering the number of consecutive hours that aides can work on personal care cases and more strongly enforce existing regulations concerning 24-hour continuous care cases.

Response: The number of hours that aides can work is covered by State and Federal Labor Laws and is not a function of this Department. However, we will emphasize in a Medicaid Provider Update article the need to be familiar with the Labor Laws and we will issue a Local Commissioners Memorandum to remind local districts to review the number of hours worked by personal care services aides.

Recommendation: Conduct more frequent audits of individual providers with emphasis on service documentation and billing.

Response: Westchester County Department of Social Services has in the past few years increased the auditing of provider agencies' records. The Agency has reported improvement in Provider recordkeeping and has received Innovative Home Care grant money for increased auditing of providers, training and employment records.

Recommendation: Direct LDSS senior management to implement controls to ensure their staff review the physician's order and the indicated date of the last medical examination to confirm it occurred within the previous 30 days, thus verifying the recommendation for services is based on current knowledge of the patient's condition.

Response: We have reminded Westchester County of the importance of timely and adequate physician's orders. The County has reorganized their personal care services administration and our recent monitoring efforts (see attached report) have shown that the timeliness of case record documentation is greatly improved.

Recommendation: Direct senior management to take steps to ensure their staff are adequately reviewing the physician's orders to verify they are completed properly and are consistent with other information available in the LDSS files. Guidance should be issued as to specific actions required when data is missing or the orders are not properly completed.

Response: We agree, and will advise Westchester County to take the necessary steps to implement the recommendation. A Local Commissioners Memorandum will also be sent to all social services districts to reinforce this recommendation.

Recommendation: Direct Westchester County LDSS senior management to emphasize the importance of adherence to pertinent regulations and internal control systems to ensure that:

a. Complete authorization packages are obtained by caseworkers before prior approvals become effective.

b. Supervisors fulfill their responsibilities to review the authorization package, assure it is complete, and sign the prior approval form. Supervisors should not allow the caseworkers to sign the supervisors' name to the prior approval form.

Response: Westchester County DSS has improved the administration of the authorization process since the audit review period. For instance, the caseworker and nurse now make a joint visit, when possible, and the timeliness of documentation has improved. In addition, the County reorganized its personal care services administration, instituted a computer tracking system, and requires supervisory review on 20% of its personal care cases.

We will request that Westchester County increase its supervisory review of the authorization document package prior to writing the prior approval.

Recommendation: Increase the frequency and scope of its monitoring, oversight and testing of the Westchester County LDSS to ensure that program staff comply with the personal care regulations and internal control systems.

Response: As indicated previously, both the Department and Westchester County have increased the monitoring activities and plan to further enhance these efforts in 1994.

Thank you for sharing your report with us.

Sincerely,

Nelson M. Weinstock
Deputy Commissioner
Division of Management Support
& Quality Improvement

Attachments

Westchester County

ANDREW P. O'ROURKE
County Executive

MARY E. GLASS
Commissioner
Department of Social Services

January 24, 1994

Ms. Marcia Anderson
Medical Assistance Specialist II
Bureau of Long Term Care
Division of Health and Long Term Care
40 North Pearl Street
Albany, N.Y. 12243

Dear Ms. Anderson:

I am writing in response to your request for comments to the Health and Human Services/Office of Inspector General Report on Personal Care Services in Westchester County. As you know, this report covers the years 1988 through 1990 and does not reflect our current administration of the Personal Care Program.

The Department of Health and Human Services draft report of the Personal Care program recommends that New York State conduct more frequent audits of individual providers with emphasis on service documentation and billing.

It fails to make any mention of the annual audits performed by Westchester County. The scope of these audits is attached and covers the following:

billing	surplus income hours worked less than Prior Approval time sheet consistent with billing
training	job orientation two references ineligible for work annual health evaluation annual performance evaluation in-service training
patient information	care plan activity notes supervisory visits home checks

Ms. Anderson January 24, 1994

Our auditor is completing his reports of 1992 but preliminary findings on two hundred cases reveal the following deficiencies:

Surplus Overbilled	Hours less than Prior Approval	Timesheet	Job Orientation	Two References	Annual Health Assessment
$47,850	2 cases	1	1	7	2

Annual Evaluation	In-Service	Care Plan	Weekly Activity	Supervisory Visit	Spot Checks
1	9	1	26	19	7

The surplus finding was a result of one agency's inability to program their billing system to not claim for surplus payment. Their repayment of $41,967 has already occurred and the billing system problem has been corrected. <u>There are no major findings regarding billing problems, other than surplus, for any of the initial nine (9) agencies.</u>

Westchester County's Auditing Program of our Personal Care Providers has proven very effective in ensuring contract compliance and is achieving the desired billing compliance.

In addition, it should be noted that approximately fifty percent of the billing errors were by one vendor, Kelly Kare. In 1990, Kelly Kare was terminated as a provider by Westchester County. Its owner was prosecuted for Medicaid fraud and is currently serving a three to nine year prison term.

With respect to this audit and its findings regarding our assessment and authorization process, they in no way reflect our current operation. Westchester County had determined in 1987 that the operation of our Personal Care Program was inadequate to meet the requirements of the program and to effectively manage Medicaid Home Care services. The major changes were twofold:

1. The program was centralized during 1987-88.
2. The program was restructured, as of 1991, so that it is administered jointly with the Department of Health.

These changes have resulted in a very efficient and effective Personal Care Program which has received national recognition as a model. I have attached copies of our reorganization plan and the task assessment process (which received a 1993 National Association of Counties Acievement Award.) *

* OIG Note - Referenced Attachments have not been included in APPENDIX III

An indicator of our successful management of these programs is that Personal Care expenditures were $75.6 million in 1991 and are estimated, based on 11 months expenditure, to be $48.9 million in 1993. We also were administratively reviewed by NYSDSS through the Fair Hearing process seventy-seven (77) times in 1993. Not once, was the Department found to not have followed correct procedure with regard to physician's orders, nursing assessment, social assessment or medical director review. At this time, absolutely no services are authorized without medical orders. Upon receipt of medical orders, a joint assessment by a DSS caseworker and a DOH nurse is completed. Therefore a complete authorization packet exists prior to services beginning. The one exception to this is for hospitalized patients. In order to assist in expediting appropriate discharges, we authorize initial services based on medical orders and a nursing assessment. This is then followed by a joint assessment by caseworker and nurse in the community in approximately four (4) weeks. This practice has proven very effective in ensuring that recipients receive the necessary service.

It should be noted that since two individuals from separate departments are involved in the assessment, we have created a system of checks in the authorization. The caseworker writes the Prior Approval based on the nursing recommendation and the nurse sees the patient within ninety days to supervise the care plan. Any approval of unauthorized hours would be apparent to the nurse during supervisory visits.

In addition, approximately twenty (20) percent of all authorizations are reviewed by supervisory staff on a random basis. If this review indicates closer supervision is necessary of any employee, then a review process will be initiated for that employee.

In order to better track and monitor the completion of all necessary documentation for our Personal Care Program, we are in the process of developing a Home Care Information System. This system will provide a great assist to caseworkers and supervisors in ensuring regulatory compliance. This will occur since the system will produce monthly reports of nursing, social, and medical orders which are coming due. The systemic tracking of all due dates will free workers from manual controls and also identify any problems which individual workers may have. The Home Care System is scheduled to be on line in March, 1994.

Regarding physician's orders, it should be noted that neither the County nor the Personal Care recipient should be held accountable for physician's untimeliness or unwillingness to complete updated orders. As previously noted, there are no situations where services are initially authorized without physician's orders. Initial physician's orders are returned if they are incomplete or not based on current examinations.

DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MICHAEL J. DOWLING
Commissioner

SUE KELLY
Deputy Commissioner
Division of
Health and Long Term Care

Ms. Mary E. Glass
Commissioner
Westchester County Department of Social Services
County Office Building #2
112 East Post Road
White Plains, New York 10601-5272

DEC 14 1993

Dear Commissioner Glass:

Thank you for the cooperation and courtesy extended to me when I recently visited your agency on November 22-23, 1993 to review the personal care services program in your district.

During the visit, I reviewed the program with your staff and read case records. The visit was also scheduled to provide a forum for discussion of local concerns and issues and an opportunity for the exchange of program information.

The findings of the visit are summarized in the enclosed In-Home Services Monitoring Visit Report. This report is intended to provide an overview of my observations, a statistical summary of the case record review and an identification of any deficiencies. Where applicable, I provided recommendations to assist your agency with program development and options for correcting compliance issues.

I want to especially thank Steve Riordan, Program Coordinator, for hosting Medicaid and home care officials from New Jersey for a presentation of the shared aide program in Westchester County. The meeting was most helpful.

Please feel free to contact me at: (518) 473-5602 should you have any questions or comments regarding this report.

Sincerely,

Marcia Anderson

Marcia Anderson
Medical Assistance Specialist II
Bureau of Long Term Care
Division of Health and Long Term Care

Enclosure
cc: Steve Riordan, WCDSS, PCS Program Coordinator

However, services are reauthorized without physician's orders. This occurs when orders, although requested, have not been received and the nursing and social assessment indicate that ongoing services are appropriate and necessary. In many of our cases, we are dealing with chronic geriatric conditions which are not subject to frequent change. The Department does try to pressure and demand orders but our efforts are sometimes unsuccessful or result in untimely orders. We are frequently told by physicians or their office staff that:

- o Medicaid does not pay enough
- o they are sick and tired of all the forms
- o the client is old and will need the services for the rest of his or her life

In instances where there is no question of the ongoing need, we will authorize and document our efforts to obtain the physician's orders. It is our contention that these services are appropriate and to reauthorize is the only responsible way to run the program.

It should also be noted that we have many surplus clients who directly pay their physician and provide documentation of this payment to meet their surplus. In all of these cases there would be no record of any Medicaid or Medicare billing.

Any questions regarding our response should be directed to Stephen C. Riordan at (914) 285-6046.

Very truly yours,

Phyllis Shearer
Deputy Commissioner

PS/SR/s

New York State Department of Social Services
Division of Health and Long Term Care
Bureau of Long Term Care
40 North Pearl Street
Albany, New York 12243-0001

Report Issuance Date:

DEC 14 1993

PERSONAL CARE SERVICES PROGRAM MONITORING VISIT REPORT

Agency Visited: Westchester County

Date Visited: November 22-23, 1993

Staff Person Making Visit: Marcia Anderson

Phone Number: (518) 473-5602

Purpose of Visit:

Scheduled Visit __X__

Specific Request _____

Other _____

Local Staff Involved:

DSS: Steve Riordan, Wendy DeMartis, Susan Wein, Ellen Callafano,
Other: Phyllis Shearer

A. Summary of Observation

Westchester County currently has 2,347 personal care services clients. Of these only 31 are 24 hour continuous care cases. There are 951 LIHHCP cases. Each case worker has a case load of 134 cases. The fiscal assessments have been completed on most cases. The completion of Attachment 10 and 11, for Exception Criteria No. 4 contained in the fiscal assessment administrative directive have proved the most problematic for your district.

Attached to this report is a summary of home care utilization for 1989, 1990, 1991 and 1992 from On-line SURS Information Retrieval Systems. Your district's expenditure for Personal Care Services has decreased from 1991 to 1992 by approximately $11 million. This decrease is attributed by Westchester County staff to be primarily due to the task based care plan. The average cost of a PCS case in 1992 was $16,834.

Topics discussed were: fiscal assessment, PERS, Shared Aide, Advanced Directives, Delegation of Case Management, Cost Savings Targets, Medicare Max, PCS and PSA, and out of county cases.

B. Case Record Documentation

Current Number of District Cases	2,347
Number of Case Records Reviewed	30
Number of Cases with Current Physician's Orders	24
Number of Cases with Current Nursing Assessments	30
Number of Cases with Current Social Assessments	29
Number of Cases with Current DMS-1 Score	30
Number of Cases with Current Written Notification of Service	23
Number of Cases with Current Record of Nursing Supervision	30

C. Narrative Summary Including Comments and Recommendations for Corrective Action

Physician's Orders

Six of the 30 cases reviewed did not contain a current physician's order form. However, most of the outstanding records did contain documentation that the orders had been requested. The records were:

AW22667W, CJ11187V, AP78843E, CH10552W, BB57369Q and one record did not have the CIN recorded.

Although this area of program administration is improving, efforts should continue to receive complete physician's orders in a timely fashion.

Written Notification of Services

Twenty-three of the 30 cases reviewed contained current written notification of services letters. Those cases deficient were:

AP78843E, BC94558X, AF12699N, BM94489J, CH10552W, AF19149F, and BU60547J

Caseworkers should be reminded of the need to send current notices. Supervisory review may be necessary to assure quality of the records in this area.

The above narrative, including our comments and recommendations, has been made to assist your agency in the management of the Personal Care Program in accordance with Department policies and regulations. Please complete and return to the Department within 30 days of this report's issuance date, the attached Corrective Action Plan. Please contact the staff person who visited your agency at the phone number listed on this report if you have any questions or need technical assistance.

THIS PAGE IS FOR DEPARTMENT USE ONLY AND IS NOT FORWARDED TO THE LOCAL DISTRICT.

D. **Summary of Local Concerns and Questions**

Westchester County is concerned about maintaining the reduction trend in the the average care cost of PCS services. They report that average weekly hours have gone from 213 in 1991 to 193 in 1992 to 147 weekly hours in 1993. They are concerned that the cost targets for shared aide and PERS may not be met but that they have decreased their overall expenditure with the task based care plan hour standards. I have attached a copy of that care plan form.

The county complained that shared aide rates were requested in 3/93 and 6/93 but rates were not approved until 10/93.

Westchester County had a great deal of trouble getting their county SNF to agree to review the attachment No. 10 from the fiscal assessment. The Deputy Commissioner may have to meet with the SNF administrator about their role in the review. Steve Riordan fears automatic agreement of the SNF with the attending physician.

Westchester County is also concerned with their out of county cases and the difficulties encountered in having HRA, HCSP puts up priors on NYC financially responsible cases living in Westchester County. I am working with Diane Cramer's office on this issue.

E. **State DSS Findings, Impressions and Follow-up Activities**

My impression is that Westchester County is a progressive county and is always willing to follow our regs. and policies whenever possible. They are innovative with the task based care plan and have been helpful to me on the issue of Protective Services for Adults and PCS. They also were most helpful in setting up the Shared Aide meeting with New Jersey and did a very good job of presenting an operational shared aide model using Norell.

Also, Westchester County DSS is in the process of creating an in-house data base of case authorizations with assessment document tracking and an in-house analysis piece.

G. **Recommendation of Monitoring Frequency:**

-X— District in Compliance. Yearly visits suggested.

TO BE COMPLETED AFTER RECEIPT OF CORRECTIVE ACTION PLAN.

—X- District had minor deficiency(ies). Plan of Correction submitted and accepted. Yearly visits suggested.

—— District had multiple deficiencies. Plan of Correction submitted and accepted. Twice yearly visits suggested to assure compliance.

—— District had multiple deficiencies. Plan of Correction submitted and returned for additional corrective action. Follow-up visit suggested within six months.