DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

May 24, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Diann M. Saltman/ for
George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Venture Forthe, Inc., From January 1, 2005, Through December 31, 2007 (A-02-09-01005)

Attached, for your information, is an advance copy of our final report on Medicaid payments for services provided under New York's section 1915(c) traumatic brain injury waiver at Venture Forthe, Inc. We will issue this report to the New York State Department of Health within 5 business days.

If you have any questions or comments about this report, please do not hesitate to contact me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-09-01005.

Attachment

Office of Audit Services
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

May 25, 2011

Report Number: A-02-09-01005

Nirav R. Shah, M.D., M.P.H.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Venture Forthe, Inc., From January 1, 2005, Through December 31, 2007*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Brenda Tierney, Audit Manager, at (518) 437-9390, extension 222, or through email at Brenda.Tierney@oig.hhs.gov. Please refer to report number A-02-09-01005 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID PAYMENTS FOR SERVICES PROVIDED UNDER NEW YORK'S SECTION 1915(C) TRAUMATIC BRAIN INJURY WAIVER AT VENTURE FORTHE, INC., FROM JANUARY 1, 2005, THROUGH DECEMBER 31, 2007

Daniel R. Levinson
Inspector General

May 2011
A-02-09-01005

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

Section 1915(c) of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid.

The New York State Department of Health (the State agency) administers the State's Medicaid program and provides oversight for compliance with Federal requirements. The State's traumatic brain injury (TBI) waiver program allows the State agency to claim Medicaid reimbursement for HCBS provided to individuals with TBIs who would otherwise require institutionalization in a nursing home.

The State agency's Office of Long-Term Care administers the TBI waiver program through 10 contracted regional resource development centers (not-for-profit organizations) that serve specific counties throughout the State. Under the TBI waiver program, each beneficiary is required to have an individualized plan of care that, every 6 months, is reviewed by a regional resource development specialist. As part of the plan-of-care review, the regional resource development specialist must ensure that the beneficiary is assessed to need a nursing home level of care by a State agency-certified assessor. The regional resource development specialist must maintain documentation of each plan of care and assessment for at least 3 years.

During calendar years 2005 through 2007, the State agency claimed Federal reimbursement totaling $131 million for services provided by 212 providers under the TBI waiver program. During this period, Venture Forthe, Inc. (Venture), a TBI service provider, received Medicaid reimbursement for 3,125 beneficiary-months totaling $13.8 million ($6.9 million Federal share). A beneficiary-month includes all HCBS for a beneficiary for 1 month. Venture provided TBI waiver program services in areas covered by regional resource development centers in Binghamton, Buffalo, and Rochester, New York. (We refer collectively to these organizations as "the centers.")

OBJECTIVE

Our objective was to determine whether the State agency's claim for Medicaid reimbursement for TBI waiver program services provided by Venture complied with certain Federal and State requirements.

SUMMARY OF FINDINGS

The State agency claimed Federal Medicaid reimbursement for some TBI waiver program services provided by Venture that did not comply with certain Federal and State requirements. Of the 100 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for all TBI waiver program services during 7 beneficiary-months. The State agency claimed Medicaid reimbursement for services that were not allowable or were potentially unallowable for the 93 remaining beneficiary-months. Specifically, services totaling $133,698 (Federal share) in 82 beneficiary-months did not comply with Federal and State requirements, and services totaling $30,038 (Federal share) in 16 beneficiary-months may not have complied with Federal and State requirements. Of these 16 beneficiary-months, 5 also contained services that were unallowable. Of the 82 beneficiary-months with services for which the State agency improperly claimed Federal Medicaid reimbursement, 42 contained more than 1 deficiency.

Based on our sample results, we estimated that the State agency improperly claimed $3,156,501 in Federal Medicaid reimbursement for TBI waiver program services provided by Venture that did not comply with Federal and State requirements during calendar years 2005 through 2007. In addition, we estimated that the State agency claimed $352,968 in Federal Medicaid reimbursement for services provided by Venture that may not have complied with Federal and State requirements.

The claims for unallowable and potentially unallowable services were made because (1) the centers did not ensure and document that all beneficiaries approved for services were assessed by certified individuals and determined eligible for TBI waiver program services, (2) the State agency did not ensure that the assessors and screeners properly evaluated beneficiaries for placement in the TBI waiver program, and (3) Venture did not ensure that it documented services billed and claimed reimbursement only for allowable services.

RECOMMENDATIONS

We recommend that the State agency:

- refund $3,156,501 to the Federal Government;
- work with CMS to resolve the claims, totaling $352,968, for which Medicaid reimbursement may have been unallowable;
- require the centers to ensure and document that all beneficiaries approved for services have been assessed by certified individuals and are eligible for TBI waiver program services;
- provide adequate training to assessors on the Federal and State requirements for the TBI waiver program; and

- require Venture to ensure that it documents services billed and claims reimbursement only for allowable TBI waiver program services.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance), indicated that it would work with CMS to resolve our second recommendation, and stated that it already had procedures in place to cover our remaining recommendations. The State agency also disagreed with many elements of our findings and requested that we provide information that it needed to review some of the claims related to our first recommendation. Specifically, the State agency indicated that our interpretation of what constitutes nursing facility level of care determinations did not consider all relevant information. In addition, the State agency stated that we misinterpreted TBI waiver program requirements for services provided in accordance with an approved plan of care. The State agency's comments appear in their entirety as Appendix D.

After reviewing the State agency's comments on our draft report, we maintain that our findings and recommendations are valid. We provided the information that the State agency requested in order to review some of the claims related to our first recommendation.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements. The New York State Department of Health (the State agency) administers the State's Medicaid program and provides oversight for compliance with Federal requirements.

Home and Community-Based Services Waivers

Section 1915(c) of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible beneficiaries in the community rather than in an institutional setting.

Section 1915(c) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(iii)) provide that HCBS waiver services may be provided only to recipients who have been determined would, in the absence of such services, require the Medicaid covered level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. Pursuant to 42 CFR § 441.301(b)(1)(i), HCBS must be furnished under a written plan of care subject to approval by each State's State agency. In addition, Federal regulations (42 CFR § 441.302(c)) require the State agency to provide for an initial evaluation of the recipient's need for the level of care that would be provided in an institution unless the individual receives the HCBS. The regulations further require at least annual reevaluations of each recipient receiving HCBS.

Pursuant to section 4442.6 of the CMS *State Medicaid Manual*, an assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care. In addition, the plan of care must specify the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available for HCBS waiver services furnished without a written plan of care.

New York's Traumatic Brain Injury Waiver Program

New York State's waiver program for those with traumatic brain injury (TBI), the Home and Community Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI waiver program), is administered by the State agency. The State agency's Office of Long-Term Care administers the TBI waiver program through 10 contracted regional resource development

centers, which serve specific counties throughout the State. The TBI waiver program allows the State agency to claim Medicaid reimbursement on a fee-for-service basis for HCBS provided to individuals with TBI who would otherwise require institutionalization in a nursing home.[1]

Program Eligibility

Pursuant to the State's waiver program agreement with CMS, to be eligible for the TBI waiver program, a beneficiary must be a Medicaid recipient, have a diagnosis of TBI, be between the ages of 18 and 64 on application to the waiver program, and be assessed to need a nursing home level of care. According to the State's waiver program agreement with CMS, the State agency uses two forms, the Hospital and Community Patient Review Instrument (H/C-PRI) and the Screen, to assess nursing home level of care. The H/C-PRI, which is to be completed by a registered nurse, is a clinical tool used to assess a beneficiary's condition. The Screen, which may be completed by a social worker, discharge planner, or other professional with experience in psychosocial assessments, is a referral tool used to assess the care and support available to the beneficiary in the community setting.

The State agency contracts with a Quality Improvement Organization[2] to train and certify individuals to complete the H/C-PRI and the Screen. On completion of the training program, individuals receive an assessor number and a screener number verifying their ability to complete each form. These individuals may be employed by TBI waiver program service providers or by local social services districts.

Based on their responses to the H/C-PRI, beneficiaries are assigned to 1 of 16 Resource Utilization Group II (RUG-II) groupings. Pursuant to Title 10, § 400.12, of the New York Compilation of Codes, Rules, & Regulations (NYCRR), the 16 RUG-II groupings are used to determine whether beneficiaries qualify for nursing home level of care. During our audit period, beneficiaries assigned to 12 of the 16 RUG-II groupings met the State's requirements for nursing home level of care.[3] Patients assigned to the four remaining groupings (Clinically

[1] Services offered under the State's TBI waiver program include service coordination, respite, environmental modifications, independent living skills, structured day programs, substance abuse programs, intensive behavioral programs, community integration counseling, home and community support services, assistive technology, and transportation.

[2] According to section 1862(g) of the Act, Quality Improvement Organizations were established for "the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services…."

[3] Specifically, beneficiaries assigned to the RUG-II groupings Special Care A, Special Care B, Heavy Rehabilitation A, Heavy Rehabilitation B, Clinically Complex B, Clinically Complex C, Clinically Complex D, Severe Behavioral B, Severe Behavioral C, Reduced Physical Functioning C, Reduced Physical Functioning D, and Reduced Physical Functioning E were considered qualified for nursing home level of care.

Complex A, Severe Behavioral A, Reduced Physical Functioning A, and Reduced Physical Functioning B) were not considered qualified for nursing home level of care.[4]

Program Requirements

Pursuant to the State's waiver program agreement with CMS, each TBI waiver program beneficiary is required to have an individualized plan of care that, every 6 months, is reviewed and approved by a regional resource development specialist (an employee of the resource development center). The regional resource development specialist is responsible for reviewing application packets, including eligibility decisions and plans of care. These specialists approve eligibility decisions at the regional level, with technical oversight provided by State agency management staff. In addition, State agency management staff review a minimum of 5 percent of decision approvals per year.

A TBI service coordinator, who may be an employee of the TBI waiver program service provider, prepares the individualized plan of care for the beneficiary. The service coordinator ensures that the beneficiary is assessed as required and that the regional resource development specialist reviews the assessment before approving the plan of care. The regional resource development specialist must maintain documentation of each plan of care and level of care assessment for at least 3 years.

During calendar years 2005 through 2007, the State agency claimed Federal reimbursement totaling $131 million for services provided by 212 providers under the TBI waiver program.

Venture Forthe, Inc.

Venture Forthe, Inc. (Venture), was the second largest provider of services under the State's TBI waiver program during calendar years 2005 through 2007. During this period, Venture received Medicaid reimbursement totaling $13.8 million ($6.9 million Federal share). Venture provided TBI waiver program services in areas covered by Southern Tier Independence Center; Headway of Western New York, Inc.; and United St. Mary's Campus, regional resource development centers in Binghamton, Buffalo, and Rochester, New York. (We refer collectively to these organizations as "the centers.")

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claim for Medicaid reimbursement for TBI waiver program services provided by Venture complied with certain Federal and State requirements.

[4] In November 2009, after our audit period, the State added these four groupings to its list of RUG-II groupings that qualify for nursing facility level of care (N.Y. Dept. of Health, Recently Adopted Regulations, PASRR Screen Requirements (Nov. 4, 2009)).

Scope

Our review covered the State agency's claims for Medicaid reimbursement for HCBS provided by Venture under the TBI waiver program during calendar years 2005 through 2007. During this period, the State agency claimed $13.8 million ($6.9 million Federal share) for services provided by Venture during 3,125 beneficiary-months.[5] We will be issuing a separate report (A-02-09-01006) on TBI waiver service claims submitted by Belvedere of Albany, LLC, for the period January 1, 2005, through December 31, 2007.

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for the services that Venture provided and claimed for reimbursement.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective, which did not require an understanding of all internal controls over the TBI waiver program. We reviewed Venture's and the centers' internal controls for documenting services billed and claiming reimbursement for TBI waiver program services. We did not assess the appropriateness of HCBS payment rates.

We performed our fieldwork at Venture's offices in Niagara Falls, New York, and at the centers in Binghamton, Buffalo, and Rochester, New York.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid HCBS waiver laws, regulations, and guidance;

- met with CMS financial and program management officials to gain an understanding of the HCBS waiver approval, administration, and assessment processes;

- met with State officials to discuss the State's administration and monitoring of the TBI waiver program;

- interviewed Venture and the centers' officials regarding their TBI waiver program policies and procedures;

- reconciled the TBI waiver program services that the State agency claimed for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the population of all payments for TBI services to providers statewide obtained from the State's Medicaid Management Information System for the period January 1, 2005, through December 31, 2007;

[5] A beneficiary-month includes all HCBS for a beneficiary for 1 month. A beneficiary-month may include multiple services.

- obtained from the State's Medicaid Management Information System a sampling frame of 3,125 beneficiary-months with TBI waiver program services for which Venture claimed reimbursement totaling $13.8 million ($6.9 million Federal share) during the period January 1, 2005, through December 31, 2007;

- selected a simple random sample of 100 beneficiary-months from the sampling frame of 3,125 beneficiary-months and, for each beneficiary-month:

    - determined whether the beneficiary was assessed by a certified individual to be eligible to participate in the TBI waiver program,

    - determined whether TBI waiver program services were provided in accordance with an approved plan of care,

    - determined whether the staff members who provided the services met qualification and training requirements,

    - determined whether documentation supported the TBI waiver program services billed, and

    - identified services that were not provided or documented in accordance with Federal and State requirements; and

- estimated the unallowable and potentially unallowable Federal Medicaid reimbursement paid in the total population of 3,125 beneficiary-months.

Appendix A contains the details of our sample design and methodology. Appendix B contains our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency claimed Federal Medicaid reimbursement for some TBI waiver program services provided by Venture that did not comply with certain Federal and State requirements. Of the 100 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for all TBI waiver program services during 7 beneficiary-months. The State agency claimed Medicaid reimbursement for services that were not allowable or were potentially unallowable for the 93 remaining beneficiary-months. Specifically, services totaling $133,698 (Federal share) in 82 beneficiary-months did not comply with Federal and State requirements, and services totaling $30,038 (Federal share) in 16 beneficiary-months may not have complied with Federal and State requirements. Of these 16 beneficiary-months, 5 also

contained services that were unallowable. Of the 82 beneficiary-months with services for which the State agency improperly claimed Federal Medicaid reimbursement, 42 contained more than 1 deficiency. Appendix C contains a summary of deficiencies, if any, identified for each sampled beneficiary-month.

Based on our sample results, we estimated that the State agency improperly claimed $3,156,501 in Federal Medicaid reimbursement for TBI waiver program services provided by Venture that did not comply with Federal and State requirements during calendar years 2005 through 2007. In addition, we estimated that the State agency claimed $352,968 in Federal Medicaid reimbursement for services provided by Venture that may not have complied with Federal and State requirements.

The claims for unallowable and potentially unallowable services were made because (1) the centers did not ensure and document that all beneficiaries approved for services were assessed by certified individuals and determined eligible for TBI waiver program services, (2) the State agency did not ensure that the assessors and screeners properly evaluated beneficiaries for placement in the TBI waiver program, and (3) Venture did not ensure that it documented services billed and claimed reimbursement only for allowable services.

UNALLOWABLE SERVICES IN THE HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

Services Provided to Beneficiaries Assessed Not To Qualify for Nursing Home Level of Care

Pursuant to 42 CFR § 441.302(c), the State agency must provide for an initial evaluation of the recipient's need for the level of care that would be provided in an institution unless the individual receives the HCBS. The regulation further requires periodic reevaluations, at least annually, of each recipient receiving HCBS to determine whether the recipient continues to need the level of care provided and would, but for the provision of waiver services, be institutionalized. Pursuant to the State's waiver agreement with CMS, to be eligible for the TBI waiver program, a beneficiary must be assessed to need nursing home level of care. Pursuant to 10 NYCRR § 400.12, to meet the requirements for nursing home level of care, beneficiaries must be assessed to be in 1 of 12 RUG-II groupings that qualify beneficiaries for skilled nursing facility level of care.

For 70 beneficiary-months, the State agency claimed reimbursement for services provided to beneficiaries who were assessed by certified individuals to be in one of the four RUG-II groupings that did not qualify for nursing home level of care. For example, one beneficiary was assessed at Reduced Physical Functioning A level of care, a RUG-II grouping that did not qualify for nursing home level of care.

Services Not Provided in Accordance With an Approved Plan of Care

Pursuant to 42 CFR § 441.301(b)(1)(i), HCBS must be furnished under a written plan of care subject to approval by the State agency. Pursuant to section 4442.6 of the CMS *State Medicaid*

Manual, a plan of care must specify the services to be provided, their frequency, and the type of provider. Pursuant to the State's waiver agreement with CMS, all waiver services will be furnished pursuant to a written plan of care, and Federal financial participation will not be claimed for waiver services that are not included in the individual written plan of care.
For 27 beneficiary-months, the State agency claimed reimbursement for some services that were not in accordance with an approved plan of care. Specifically, Venture provided services in excess of the number of units allowed in the plan of care or provided services that were not in the plan of care. For example, although the plan of care for one beneficiary allowed for 46 hours of service for 1 week, Venture billed for 56 hours of service that week.

Services Not Documented

Section 1902(a)(27) of the Act, 42 U.S.C. § 1396a(a)(27), mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under a State plan. Pursuant to Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), costs must be adequately documented to be allowable under Federal awards. Pursuant to section 2497.1 of the CMS *State Medicaid Manual*, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, the provider has adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

For 16 beneficiary-months, the State agency claimed reimbursement for some services that were not adequately documented. For these services, Venture did not maintain service notes to support the services billed or did not fully document the services billed. For example, during one beneficiary-month, Venture billed for services for which there was no documentation of the services performed.

Services Not Provided

Section 1902(a)(27) of the Act, 42 U.S.C. § 1396a(a)(27), mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under a State plan. Pursuant to section 2497.1 of the CMS *State Medicaid Manual*, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers.

For four beneficiary-months, the State agency claimed Federal reimbursement for some services that were not provided. Venture's records indicated that the services were canceled by the beneficiary before the service date or were not provided because the beneficiary refused the service.

Assessments for Traumatic Brain Injury Waiver Program Conducted by Uncertified Individuals

Pursuant to section 4442.5 of the CMS *State Medicaid Manual*, waiver agreements shall include an assurance by the State agency that it will provide for an evaluation and periodic reevaluations of the need for the level of care provided in an institution but for the availability of HCBS services, including a description of the party or parties responsible for the evaluation and reevaluation and their qualifications. Pursuant to the State's waiver agreement with CMS, to be eligible for the TBI waiver program, a beneficiary must be assessed to need nursing home level of care by individuals who have completed the State agency's H/C-PRI training and certification program.[6]

For three beneficiary-months, the State agency claimed reimbursement for some services provided to beneficiaries whose assessments for TBI waiver program eligibility were conducted by uncertified individuals. The centers did not detect the invalid assessments and, therefore, approved TBI waiver program services for the beneficiaries.

Duplicate Claims for Services

Section 1902(a)(27) of the Act, 42 U.S.C. § 1396a(a)(27), mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under a State plan. Pursuant to OMB Circular A-87, Att. A, § C.1.j (2 CFR § 225, Appendix A(c)(1)(j)), costs must be adequately documented to be allowable under Federal awards. Pursuant to section 2497.1 of the CMS *State Medicaid Manual*, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, the provider has adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

For three beneficiary-months, the State agency claimed reimbursement for some duplicate services. For each of these claims, Venture billed and was paid twice for a single service.[7]

Assessment for Traumatic Brain Injury Waiver Program Not Documented

Section 1915(c) of the Act and 42 CFR § 441.301(b)(1)(iii) provide that HCBS waiver services may be provided only to recipients who have been determined would, in the absence of such services, require the Medicaid covered level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. Pursuant to 42 CFR § 441.302(c), the State agency must provide for an initial evaluation of the recipient's need for the level of care that would be provided in an institution unless the individual receives the HCBS. The regulations further require at least annual reevaluations of each recipient receiving HCBS.

[6] The State agency assigns "assessor numbers," which are required to complete the H/C-PRI, to registered nurses who successfully complete the training and certification program.

[7] For each claim, Venture's service notes supported only one service provided to one beneficiary on the same date.

Pursuant to section 4442.6 of the CMS *State Medicaid Manual*, an assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care. Pursuant to the State's waiver agreement with CMS, the TBI service coordinator must ensure that the beneficiary is assessed at least annually, and the regional resource development specialist must review the assessment as a requirement for approving the plan of care.

For one beneficiary-month, the State agency claimed reimbursement for some services for which neither Venture nor the associated center could provide documentation of the annual reevaluation to determine whether TBI waiver program services were needed. Despite the missing annual reevaluation, the center approved TBI waiver program services for the beneficiary.

POTENTIALLY UNALLOWABLE SERVICES IN THE HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

Section 1915(c) of the Act and 42 CFR § 441.301(b)(1)(iii) provide that HCBS waiver services may be provided only to recipients who have been determined would, in the absence of such services, require the Medicaid covered level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. Pursuant to 42 CFR § 441.302(c), the State agency must provide for an initial evaluation of the recipient's need for the level of care that would be provided in an institution unless the individual receives the HCBS. The regulations further require at least annual reevaluations of each recipient receiving HCBS. Pursuant to section 4442.6 of the CMS *State Medicaid Manual*, an assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care. Pursuant to the State's waiver agreement with CMS, the TBI service coordinator must ensure that the beneficiary is assessed at least annually, and the regional resource development specialist must review the assessment as a requirement for approving the plan of care.

For 16 beneficiary-months, the State agency claimed reimbursement for some services that may not have complied with Federal and State requirements. Specifically, the RUG-II groupings for the beneficiaries were not documented on the H/C-PRIs provided by Venture and the centers. As a result, the associated beneficiaries' need for nursing home level of care could not be determined.

CAUSES OF UNALLOWABLE AND POTENTIALLY UNALLOWABLE CLAIMS

The centers did not ensure and document that all beneficiaries approved for services were assessed by certified individuals to be eligible for TBI waiver program services. Specifically, the centers did not maintain the State agency's H/C-PRI and related Screen for each beneficiary to document the beneficiary's need for the level of care that would be provided in an institution. The centers also did not verify that each beneficiary's need for nursing home level of care was assessed by an individual who had completed the State agency's H/C-PRI training and certification program.

In addition, the State agency did not ensure that the assessors and screeners properly evaluated beneficiaries for placement in the TBI waiver program. Specifically, beneficiaries who did not require nursing home level of care and beneficiaries whose need for nursing home level of care

had not been determined were recommended by assessors to participate in the TBI waiver program. The centers also approved the ineligible and incomplete assessments as part of their plan-of-care review.

Lastly, Venture did not ensure that it documented services billed and claimed reimbursement only for allowable services. Specifically, for some services, Venture did not maintain required service notes, including the name of the person providing the service; the nature, extent, or units of service; and the place of service.

RECOMMENDATIONS

We recommend that the State agency:

- refund $3,156,501 to the Federal Government;
- work with CMS to resolve the claims, totaling $352,968, for which Medicaid reimbursement may have been unallowable;
- require the centers to ensure and document that all beneficiaries approved for services have been assessed by certified individuals and are eligible for TBI waiver program services;
- provide adequate training to assessors on the Federal and State requirements for the TBI waiver program; and
- require Venture to ensure that it documents services billed and claims reimbursement only for allowable TBI waiver program services.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance), indicated that it would work with CMS to resolve our second recommendation, and stated that it already had procedures in place to cover our remaining recommendations. The State agency also disagreed with many elements of our findings and requested that we provide information that it needed to review some of the claims related to our first recommendation. Specifically, the State agency indicated that our interpretation of what constitutes nursing facility level of care determinations did not consider all relevant information. In addition, the State agency stated that we misinterpreted TBI waiver program requirements for services provided in accordance with an approved plan of care.

The State agency stated that it was unaware of any Federal or State legislation, regulation, or policy that disqualifies beneficiaries in four RUG-II groups (Clinically Complex A, Severe Behavioral A, Reduced Physical Functioning A, and Reduced Physical Functioning B) from being eligible for nursing facility level of care. The State agency indicated that the Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87) reclassified all residential health care facilities (i.e., health-related and skilled nursing facilities) participating in the Medicaid program as

"nursing facilities" governed by a single set of standards and regulations. The State agency also stated that no RUG-II score would eliminate a beneficiary from nursing home placement. According to the State agency, these scores are used only to determine rates and to establish a rate mix to balance nursing facility populations.

In addition, the State agency indicated that the standards to guarantee the health and welfare of waiver participants are designed to be flexible and responsive to the beneficiaries' needs; therefore, providers are obligated to respond to beneficiaries' changing needs for care in the community, including flexibility in the provision of authorized service hours.

The State agency's comments appear in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments on our draft report, we maintain that our findings and recommendations are valid. We provide a detailed response to the State agency's comments on our findings and first recommendation below. With respect to the last three recommendations, our findings indicate that the procedures described by the State agency are not adequate to ensure that it claimed reimbursement only for TBI waiver services that comply with certain Federal and State requirements. We provided the information that the State agency requested in order to review some of the claims related to our first recommendation.

We agree that OBRA '87 reclassified skilled nursing facilities, rehabilitation facilities, and health-related facilities as nursing facilities. Nevertheless, New York law retained distinctions between skilled nursing facilities (nursing homes) and health-related facilities. Section 2801 of the New York Public Health Law defines a "nursing home" as a facility providing nursing care in addition to lodging, board, and/or health-related services. This is in stark distinction from a "facility providing health-related service" (also known as a "health-related facility"), which section 2801 of the New York Public Health Law defines as a facility that provides lodging, board, and physical care, including the recording of health information, dietary supervision, and supervised hygienic services. Health-related facilities do not provide nursing care as do nursing homes under New York law.[8]

The State agency's waiver program agreement with CMS states that the waiver program is for individuals who, but for the provision of HCBS, would require "nursing facility" level of care. The State's TBI Waiver *Program Manual*, which provides further clarification of definitions and scope of the HCBS/TBI waiver services, states that, to be eligible for the TBI waiver program, a beneficiary must be assessed to need a "nursing home" level of care as determined by the H/C-PRI and Screen. The H/C-PRI and Screen assign patients to 1 of 16 RUG-II categories. Pursuant to 10 NYCRR § 400.12, patients in four RUG-II categories meet the requirements for health-related facility level of care. Patients in the other 12 RUG-II categories meet the requirements for skilled nursing facility level of care. Because health-related facilities are not

[8] Title 10 § 700.2 of the NYCRR also distinguishes nursing homes, which provide nursing care to patients, from health-related facilities, which do not.

the same as nursing homes under New York law, patients in the four RUG-II categories who require only health-related facility level of care do not need nursing home level of care.[9]

We agree that the standards allow for flexibility in response to beneficiaries' changing needs. In fact, the approved CMS waiver agreement grants the State agency flexibility in terms of how it delivers services to TBI recipients. However, the waiver agreement states that the types of services, duration, and any addendums to such shall be noted in the plans of care. In reviewing the plans of care, we took into consideration any addendums or notices of decision included in the beneficiary case file. We did not consider any additional services provided to the beneficiary unallowable if the services were included in an addendum or notice of decision.

[9] After we met with representatives of the State to discuss our findings, the State amended 10 NYCRR § 400.12, effective November 4, 2009, so that patients in the Clinically Complex A, Severe Behavioral A, Reduced Physical Functioning A, and Reduced Physical Functioning B RUG-II categories meet the requirements for skilled nursing facility level of care.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of beneficiary-months of service for which Venture Forthe, Inc. (Venture), received Medicaid reimbursement under New York's traumatic brain injury (TBI) waiver program during calendar years 2005 through 2007.

SAMPLING FRAME

The sampling frame was an Access file containing 3,125 beneficiary-months of service totaling $13,807,346 ($6,903,648 Federal share). The data for beneficiary-months of service under the New York TBI waiver program were extracted from the New York State Medicaid Management Information System.

SAMPLE UNIT

The sample unit was a beneficiary-month during calendar years 2005 through 2007 for which Venture claimed Medicaid reimbursement for services under the TBI waiver program. A beneficiary-month is defined as all home and community-based services for one beneficiary for 1 month.

SAMPLE DESIGN

We used a simple random sample to review Medicaid payments made to Venture on behalf of beneficiaries enrolled in the New York TBI waiver program.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months of service.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services statistical software, RAT-STATS 2007. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the beneficiary-months of service in our sampling frame. After generating 100 random numbers, we selected the corresponding frame items for our sample. We then created a list of 100 sampled items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the overpayment associated with the unallowable and potentially unallowable services in the beneficiary-months.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

UNALLOWABLE SERVICES IN THE HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months With Unallowable Services	Value of Unallowable Services (Federal Share)
3,125	$6,903,648	100	$187,579	82	$133,698

Estimated Value of Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$4,178,069
Lower limit	3,156,501
Upper limit	5,199,637

POTENTIALLY UNALLOWABLE SERVICES IN THE HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months With Potentially Unallowable Services	Value of Potentially Unallowable Services (Federal Share)
3,125	$6,903,648	100	$187,579	16	$30,038

Estimate Value of Potentially Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$938,692
Lower limit	352,968
Upper limit	1,524,416

APPENDIX C: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED BENEFICIARY-MONTH

Deficiencies

1	Services provided to beneficiaries assessed not to qualify for nursing home level of care
2	Services not provided in accordance with an approved plan of care
3	Services not documented
4	Services not provided
5	Assessments for TBI waiver program conducted by uncertified individuals
6	Duplicate claims for services
7	Assessment for TBI waiver program not documented

Office of Inspector General Review Determinations for Sampled Beneficiary-Months

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
1	X							1
2	X							1
3	X							1
4	X							1
5	X							1
6		X						1
7	X							1
8	X	X						2
9	X	X						2
10	X							1
11		X						1
12								0
13	X							1
14	X							1
15	X							1
16							X	1
17		X						1
18	X		X					2
19	X	X						2
20		X						1
21	X					X		2
22	X							1
23								0
24								0
25	X							1
26	X							1

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
27	X							1
28								0
29	X							1
30	X							1
31	X		X					2
32	X							1
33	X							1
34	X	X	X					3
35								0
36	X							1
37	X							1
38								0
39	X			X				2
40								0
41		X	X	X				3
42	X							1
43	X							1
44	X							1
45	X							1
46	X							1
47			X					1
48	X	X						2
49	X			X				2
50								0
51	X							1
52	X							1
53	X	X	X					3
54	X							1
55	X							1
56	X							1
57	X		X					2
58	X							1
59	X		X					2
60	X							1
61	X							1
62	X	X						2
63	X	X				X		3
64	X	X						2
65	X		X					2

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
66		X	X					2
67	X	X						2
68	X							1
69								0
70								0
71								0
72								0
73	X							1
74								0
75	X	X						2
76	X							1
77	X							1
78	X							1
79	X							1
80	X	X						2
81	X	X						2
82	X		X					2
83	X	X						2
84	X							1
85	X	X	X			X		4
86			X					1
87	X	X		X				3
88								0
89								0
90	X							1
91		X						1
92	X	X	X		X			4
93	X	X			X			3
94								0
95		X						1
96								0
97	X	X	X					3
98			X		X			2
99								0
100	X							1
Category Totals	70	27	16	4	3	3	1	124

82 Beneficiary-Months in Error

APPENDIX D: STATE AGENCY COMMENTS

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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

October 13, 2010

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No. A-02-09-01005

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-09-01005 on "Review of Medicaid Payments for Services Provided Under New York's Section 1915 (c) Traumatic Brain Injury Waiver at Venture Forthe, Inc. From January 1, 2005, Through December 31, 2007."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: Robert W. Reed
Donna Frescatore
James Sheehan
Mark L. Kissinger
Diane Christensen
Dennis Wendell
Stephen Abbott
Stephen F. LaCasse
Irene Myron
Ronald Farrell
Mary Elwell
Lynn Oliver

New York State Department of Health's Comments on the Department of Health and Human Services Office of Inspector General's Draft Audit Report A-02-09-01005 on "Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Venture Forthe, Inc., From January 1, 2005, Through December 31, 2007"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-09-01005 on "Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Venture Forthe, Inc., From January 1, 2005, Through December 31, 2007."

Recommendation #1:

The State agency should refund $3,156,501 to the Federal government.

Response #1:

The Department does not agree that it should refund $3,156,501 to the Federal government, as its review of the audit findings' documentation and associated case records determined that OIG did not accurately interpret what constitutes nursing facility level of care determinations.

OIG's audit sample consisted of 100 randomly selected beneficiary-months from amongst the 3,125 beneficiary-months in the audit period during which Traumatic Brain Injury (TBI) waiver program services were reimbursed. OIG's review found that the Department claimed unallowable services in 82 of the 100 beneficiary-months in the audit sample (which the Department strongly disputes). OIG extrapolated the $133,698 reimbursed during these 82 beneficiary-months over the entire claims universe to conclude that the Department claimed $3,156,501 in unallowable reimbursement. OIG identified seven reasons for the non-compliance in the 82 beneficiary-months, which are listed below along with the Department's response to each.

1. ***Services Provided to Beneficiaries Assessed Not to Qualify for Nursing Facility Level of Care.***

   OIG found that for 70 of the beneficiary-months in the audit sample, the Department claimed reimbursement for services provided to beneficiaries who were assessed by certified individuals to be in one of the four RUG-II groupings that did not qualify for nursing facility level of care. OIG supports this finding with its statement, "Pursuant to Title 10 § 400.12 of the New York Compilation of Codes, Rules, & Regulations (NYCCRR), to meet the requirements for nursing facility level of care, beneficiaries must be assessed to be in 1 of 12 RUG-II groupings that qualify beneficiaries for ***skilled*** [emphasis added] nursing facility

level of care." The four RUG-II groupings which OIG interprets as not qualifying for nursing facility level of care are addressed in Subpart 3 of Title 10 § 400.12: "Patients in the following resource utilization groups [the four RUG-II groups which OIG contends did not qualify for nursing facility level of care] meet the requirements for ***health-rated facility*** [emphasis added] level of care."

The Department is unaware of any federal or State legislation, regulation or policy that disqualifies beneficiaries in these four RUG-II groups from ***nursing facility level of care***.

OIG's interpretation of what constitutes nursing facility level of care determinations did not consider all relevant information, including a federal OBRA '87 change implemented subsequent to promulgation of the New York State Regulation cited by OIG. As a result, the Department contends that beneficiaries assigned to each of the four RUG-II groupings which OIG interpreted as not qualifying for the TBI waiver program did, in fact, meet waiver eligibility requirements.

New York State Local Commissioners Memorandum Transmittal # 90-LCM-177 dated October 30, 1990, informed all local social services districts, "Effective October 1, 1990, the federal Health Care Financing Agency will reclassify all residential health care facilities (i.e., health related and skilled nursing facilities) participating in the Medicaid program as simply 'nursing facilities' (NFs), governed by a single set of standards and regulations..." This was confirmed in a memorandum dated January 31, 1991, advising that New York State has implemented a single level of certification for nursing homes in New York and a single set of requirements applicable to all such facilities. Further, Department Memorandums 90-43 and 90-47 dated September 27, 1990 and October 17, 1990, respectively, informed residential health care facility (i.e., nursing home) operators of the elimination of the distinction between a skilled nursing facility and a health related facility. With this October 1990 change, the RUG-II groupings relative to nursing facility level of care incorporated those for skilled nursing facilities and health-related facilities. Support for this is found at 42 CFR 483.5(a) which defines "facility" to mean a "skilled nursing facility or a nursing facility."

Additionally, it is important for OIG to recognize that there is no RUG-II score that would eliminate a beneficiary from nursing home placement. Scores are utilized only for determining rates and to establish a rate mix so that a facility has a balanced population with varying service/care needs; they have no impact on whether services are eligible for payment under the TBI waiver program. This is confirmed in the training documentation utilized by the State's Quality Improvement Organization contractor, Island Peer Review Organization (IPRO), which states that the 16 utilization groups are all defined differently and are utilized as indicators of patient needs.

Finally, OIG notes that New York State has considerable flexibility in designing and operating its Medicaid program, although it must comply with Federal requirements. The Department agrees, and while its Regulations do not specifically address nursing facility level of care determinations for the TBI waiver program, the Department strongly maintains that it has adhered to the overarching Federal legislation resulting from OBRA '87 which combined skilled nursing facility and health related facility into a single level of care.

2. ***Services Not Provided in Accordance With an Approved Plan of Care***

OIG found that for 27 of the beneficiary-months in the audit sample, services provided were in excess of the number of units allowed in the plan of care or were not included in the plan of care. OIG supports this finding with an example where the plan of care allowed for 46 units of independent living skills services, while the provider billed for 56 units.

Department review of the cases associated with this finding determined that OIG misinterpreted the TBI waiver program requirements. Consistent with the TBI waiver application approved by CMS, standards to guarantee the health and welfare of waiver participants are designed to be flexible and responsive to beneficiaries' needs. Concomitantly, providers are obligated to respond to beneficiaries' changing needs for care in the community. This includes flexibility in the provision of authorized service hours.

The TBI Waiver Program Manual utilized prior to 2006 along with various associated documentation provide for the modification of the billable units of service. The Manual states, "The HCBS/TBI waiver provides a source of funding for flexible services, and will be administered in a spirit of cooperation and partnership. The providers of waiver services are a vital part of this effort..." This reflects a period when services were identified in the narrative of the service plan and in a "projected schedule." In addition, the Notice of Decision identified services as being "authorized" or "reauthorized" for specific time periods without requiring specification of the number of units of services approved. Further, the Addendum to an Existing Service Plan also provided for modification of the billable units of service (and cost), as evidenced by it requesting the following information: "Please describe all significant functional and/or psycho-social changes that have occurred that are the basis for the addendum."

Currently, the Department approves utilization of services based on total annual units for the purpose of cost estimates, according to the proposed schedule and grid within the service plan. Monthly, biweekly, and weekly estimates accommodate flexibility in service delivery. Service accommodations are made in order to be responsive to the beneficiary's changing needs or other issues such as limited attention span, reduced stamina and fatigue or to accommodate unexpected illness. Providers are expected to document the reasons for each schedule accommodation in their notes. Under this approach, units of services may be approved that are not immediately utilized and/or units may be utilized sooner than planned, within the confines of the total annual units approved. However, the total approved annual units are not allowed to increase without a formal amendment to the service plan.

3. ***Services Not Documented***

OIG found that for 16 of the beneficiary-months in the audit sample, the provider did not maintain service notes to support the services billed or did not fully document the services billed. The Department requests OIG to identify the Transaction Control Number ("TCN" also known as Claim Reference Number) for each claim associated with this finding, which the Department requires to complete its review.

It is relevant to note that the Department's monthly Medicaid Update provider publication for January 2005 reinforced the necessity for providers to support their claims with a record of the services provided. Providers were advised that documentation maintained should minimally include: beneficiary name, date-of-service, start and end time for each session, description of the activities performed and the service plan goals worked on and progress towards attaining those goals.

4. ***Services Not Provided***

OIG found that for 4 of the beneficiary-months in the audit sample, reimbursement was claimed for services that were not provided because they were cancelled by the beneficiary before the service date or because the beneficiary refused the service. The Department requests OIG to identify the TCNs for the claims associated with this finding, which the Department requires to complete its review.

5. ***Assessments for TBI Waiver Program Conducted by Uncertified Individuals***

OIG found that for 3 of the beneficiary-months in the audit sample, reimbursement was claimed for services provided to beneficiaries whose assessments for TBI waiver program eligibility were conducted by uncertified individuals.

Centers are required to document, for each beneficiary approved for services, that a certified individual performed the assessment by verifying that the assessor has signed the proper documents and has furnished their assessment certification number. Certification credentials are issued by the State's Quality Improvement Organization contractor, currently IPRO. The assessment service agency is responsible for verifying that its employed assessors adhere to the required certification standards. Only licensed Registered Nurses may be certified to perform assessments which, as medical professionals, must perform the assessments in accordance with accepted standards of practice. Centers are not, and should not be, expected to verify the validity of the assessment or the credentials of the assessor, but are expected to confirm the presence of the assessor's signature and the assessment certification number.

The assessors which OIG found to be uncertified may have been credentialed by a previous Quality Improvement Organization contractor and therefore do not appear on the file of certified individuals maintained by IPRO, although the Department could possibly verify certification through State Education Department records or other means. OIG to requested to furnish identifying information on the specific assessors associated with this finding, and the Department will follow-up on the certification status of each.

6. ***Duplicate Claims for Services***

OIG found that for 3 of the beneficiary-months in the audit sample, reimbursement was claimed for some duplicate services. The Department requests OIG to identify the TCNs for all claims associated with this finding, which the Department requires to complete its review.

7. ***Assessment for Traumatic Brain Injury Waiver Program Not Documented***

OIG found that for one beneficiary-month in the audit sample, reimbursement was claimed for services for which documentation of an annual reevaluation was missing. The Department is following-up with the provider and will furnish OIG the missing documentation should it be located.

It is relevant to note that in 2009, Centers were trained on the importance of ensuring that services do not continue without a timely and valid nursing facility level of care redetermination. Furthermore, the Department recently implemented a new database for tracking compliance with annual reevaluations. Case record information is electronically collected by the Centers and the Department, with the data providing a statewide perspective of beneficiary demographics including, but not limited to, identified services, level of care and correlating service authorizations.

Recommendation #2:

The State agency should work with CMS to resolve the claims, totaling $352,968, for which Medicaid reimbursement may have been unallowable.

Response #2:

OIG found that for 16 of the beneficiary-months in the audit sample, the beneficiaries' RUG-II groupings were not documented on the Hospital and Community Patient Review Instrument and, as a result, the associated beneficiaries' need for nursing facility level of care could not be determined. OIG extrapolated the $30,038 reimbursed during these 16 beneficiary-months over the entire claims universe to conclude that the Department claimed $352,968 in potentially unallowable reimbursement. However, the Department is not aware of any standard, including those applied by OIG in this audit as identified in the report, that specifically requires the presence of the RUG-II grouping on the Hospital and Community Patient Review Instrument. While it is the Department's position that the absence of this information on the form does not invalidate the assessment, it will work with CMS to resolve the recommendation.

Recommendation #3:

The State agency should require the Centers to ensure and document that all beneficiaries approved for services have been assessed by certified individuals and are eligible for TBI waiver program services.

Response #3:

The Department does require the Centers to ensure and document that all beneficiaries approved for services were assessed by certified individuals by verifying the presence of the assessor's signature and assessment certification number. This is further discussed in section 5 of Response #1 above.

Recommendation #4:

The State agency should provide adequate training to assessors on the Federal and State requirements for the TBI waiver program.

Response #4:

The Department contends that it already provides for the adequate training of assessors through its Quality Improvement Organization contractor. The current contractor, IPRO, has been providing this service since 2004, predating the audit period.

In evaluating this OIG recommendation, the Department recognized that rather than assessor training, the underlying issue may actually relate to the content of the assessment instrument utilized to determine level of care, and hence, TBI waiver program participation. At the time that the assessment instrument was adopted as the tool by which to establish nursing home level of care, home and community-based services were in the early stages of development. The Department will work with IPRO to evaluate whether updates are needed to the assessment instrument and training materials to ensure they reflect the evolution of community-based long term care services and alternatives to institutional care.

Recommendation #5:

The State agency should require the provider to ensure it documents services billed and claims reimbursement only for allowable TBI waiver program services.

Response #5:

The Department does require all providers to document services billed and to claim reimbursement only for allowable TBI waiver program services, as documented in the Billing Manual and the Department's Medicaid Update provider publication. The Department will nonetheless reinforce the importance of this with the provider audited as well as all other TBI waiver program providers. The Department will additionally enhance its oversight and monitoring of the audited provider and direct that it implement internal control improvements to address the issues identified in this audit.