Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK'S CLAIMS FOR MEDICAID SERVICES PROVIDED UNDER ITS TRAUMATIC BRAIN INJURY WAIVER PROGRAM DID NOT COMPLY WITH CERTAIN FEDERAL AND STATE REQUIREMENTS

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Office of Inspector General

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EXECUTIVE SUMMARY

New York State claimed approximately $54 million in Federal Medicaid reimbursement for traumatic brain injury waiver program services that were unallowable.

WHY WE DID THIS REVIEW

New York State's traumatic brain injury (TBI) waiver program allows the New York State Department of Health (Health Department) to claim Medicaid reimbursement for home and community-based services (HCBS) provided to individuals with TBIs who would otherwise require institutionalization in a nursing home. We reviewed two of the three highest paid providers of Medicaid TBI waiver program services in New York State. These reviews identified significant unallowable and potentially unallowable Federal reimbursements, so we audited other New York State TBI waiver program providers in this review.

Our objective was to determine whether the Health Department's claims for Medicaid reimbursement for TBI waiver program services complied with certain Federal and State requirements.

BACKGROUND

Federal regulations require a State agency to provide for an initial evaluation, with annual reevaluations, of the beneficiary's need for the level of care that would be provided in an institution unless the individual receives HCBS. The Health Department's waiver agreement with the Centers for Medicare & Medicaid Services (CMS) requires that assessors performing these evaluations complete certain training requirements. Furthermore, Federal regulations require that HCBS be furnished under a written plan of care approved by the State agency. In addition, Federal law requires providers to maintain complete and accurate records to support any services billed.

In New York State, the Health Department's Office of Long-Term Care administers the TBI waiver program through nine contracted regional resource development centers that serve specific counties throughout New York State. (We refer collectively to these organizations as "the centers.")

HOW WE CONDUCTED THIS REVIEW

For the 3-year period January 1, 2007, through December 31, 2009, we reviewed 68,211 beneficiary-months for which the Health Department claimed approximately $196.5 million ($98 million Federal share) for TBI waiver program services by certain providers within New York State. A beneficiary-month includes all TBI waiver program services for a beneficiary for 1 month.

WHAT WE FOUND

The Health Department claimed Federal Medicaid reimbursement for some TBI waiver program services that did not comply with certain Federal and State requirements. The Health Department properly claimed Medicaid reimbursement for all TBI waiver program services during 11 of the 138 beneficiary-months in our random sample. However, the Health Department claimed Medicaid reimbursement for TBI waiver program services that were not allowable or were potentially unallowable for the 127 remaining beneficiary-months.

The claims for unallowable and potentially unallowable TBI waiver program services were made because (1) the centers did not ensure and document that all beneficiaries approved for TBI waiver program services were assessed by certified individuals and determined eligible for those services, (2) the Health Department did not ensure that the assessors and screeners properly evaluated beneficiaries for placement in the TBI waiver program, and (3) providers did not ensure that they documented TBI waiver program services billed and claimed reimbursement only for allowable ones. We estimated that the Health Department improperly claimed at least $54,265,195 in Federal Medicaid reimbursement for unallowable TBI waiver program services and at least $662,510 for potentially unallowable TBI waiver program services.

WHAT WE RECOMMEND

We recommend that the Health Department:

- refund $54,265,195 to the Federal Government;
- work with CMS to resolve the claims, totaling $662,510, for which Medicaid reimbursement may have been unallowable; and
- ensure that it complies with certain Federal and State requirements by requiring:
    - the centers to ensure and document that all beneficiaries approved for TBI waiver program services have been assessed by certified individuals and are eligible for those services,
    - adequate training for assessors on the Federal and State requirements for the TBI waiver program, and
    - providers to ensure that they document TBI waiver program services billed and claim reimbursement only for allowable ones.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency generally disagreed with our first recommendation (financial disallowance), disagreed with our second recommendation (potential disallowance), and stated that it is implementing procedures to address our final recommendation. After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

TABLE OF CONTENTS

APPENDIXES

INTRODUCTION

WHY WE DID THIS REVIEW

New York State's traumatic brain injury (TBI) waiver program allows the New York State Department of Health (Health Department) to claim Medicaid reimbursement for home and community-based services (HCBS) provided to individuals with TBIs who would otherwise require institutionalization in a nursing home. We reviewed two of the three highest paid providers of Medicaid TBI waiver program services in New York State. These reviews identified significant unallowable and potentially unallowable Federal reimbursements, so we audited other New York State TBI waiver program providers in this review.

OBJECTIVE

Our objective was to determine whether the Health Department claimed Federal Medicaid reimbursement for TBI waiver program services in compliance with certain Federal and State requirements.

BACKGROUND

The Medicaid Program: How It Is Administered

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 the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements. The Health Department administers New York State's Medicaid program.

Home and Community-Based Services Waivers Under the Medicaid Program

Section 1915(c) of the Social Security Act (the Act) authorizes Medicaid 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.

HCBS may be provided only to beneficiaries who a State agency (the organization that administers a State's Medicaid program) determines 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 intellectual disabilities.[1] Also, HCBS must be furnished under a written plan of care subject to approval by each State's State agency. Further requirements include at least annual reevaluations of each beneficiary receiving HCBS.

[1] Changes in terminology are based on Rosa's Law (P.L. No. 111-256). For more information, see CMS Final Rule, 77 Fed. Reg. 29002, 29021, and 29028 (May 16, 2012).

For an individual to be eligible for HCBS, 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 under a section 1915(c) waiver for HCBS furnished without a written plan of care.

New York's Traumatic Brain Injury Waiver Program: How It Is Administered

The Health Department's Office of Long-Term Care administers the TBI waiver program through nine contracted regional resource development centers, which serve specific counties throughout New York State. (We refer collectively to these organizations as "the centers.") The TBI waiver program allows the Health Department to claim Medicaid reimbursement on a fee-for-service basis for HCBS provided to individuals with TBIs who would otherwise require institutionalization in a nursing home.[2]

During calendar years 2007 through 2009, the Health Department claimed Federal reimbursement totaling $136 million for TBI waiver program services provided by 231 providers under the TBI waiver program.

Traumatic Brain Injury Waiver Program Eligibility

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 when applying to the TBI waiver program, and be assessed to need a nursing home level of care. The Health Department uses two forms, the Hospital and Community Patient Review Instrument (H/C-PRI) and the SCREEN, to determine a beneficiary's eligibility for the TBI waiver program and identify resources available to the person. The H/C-PRI, which must 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 identify the care and support available to the beneficiary in the community setting.

The Health Department contracts with a Quality Improvement Organization[3] 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 verifying their ability to complete each form. These individuals may be employed by providers or by local social services districts.

On the basis of their responses to the H/C-PRI, beneficiaries are assigned to 1 of 16 Resource Utilization Group II (RUG-II) groupings. The 16 RUG-II groupings are used to determine

[2] Services offered under New York State's TBI waiver program (the "Home and Community Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury") 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.

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

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 Health Department's requirements for nursing home level of care.[4] Patients assigned to the four remaining groupings (Clinically Complex A, Severe Behavioral A, Reduced Physical Functioning A, and Reduced Physical Functioning B) were not considered qualified for nursing home level of care for most of our audit period.[5]

Traumatic Brain Injury Waiver Program Oversight

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, who is 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, and must maintain documentation of each plan of care and level of care assessment for at least 3 years. The regional resource development specialist approves eligibility decisions at the regional level, with technical oversight provided by the Health Department's management staff. In addition, the Health Department's management staff reviews a minimum of 5 percent of eligibility decision approvals per year.

HOW WE CONDUCTED THIS REVIEW

Our review covered the Health Department's claims for Medicaid reimbursement for HCBS provided under the TBI waiver program during calendar years 2007 through 2009 for selected providers.[6] During this period, the Health Department claimed $196,505,824 ($98,251,380 Federal share) for TBI waiver program services provided during 68,211 beneficiary-months.[7] From the sampling frame of 68,211 beneficiary-months, we reviewed a stratified random sample of 138 beneficiary-months.

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

[4] 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.

[5] In November 2009, New York State added these four groupings to its list of RUG-II groupings that qualify for nursing home level of care (N.Y. Dept. of Health, Recently Adopted Regulations, Pre-Admission Screen Resident Review (PASRR) Requirements (Nov. 4, 2009)).

[6] We excluded claims related to the two providers we previously reviewed (*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, issued May 25, 2011; and *Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Belvedere of Albany, LLC, From January 1, 2005, Through December 31, 2007*, A-02-09-01006, issued June 1, 2011). We also excluded claims related to those providers audited by the New York State Office of the Medicaid Inspector General during our audit period.

[7] A beneficiary-month includes all TBI waiver program services for a beneficiary for 1 month. A beneficiary-month could include multiple services.

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 objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The Health Department claimed Federal Medicaid reimbursement for some TBI waiver program services that did not comply with certain Federal and State requirements. The Health Department properly claimed Medicaid reimbursement for all TBI waiver program services during 11 of the 138 beneficiary-months in our random sample. However, the Health Department claimed Medicaid reimbursement for TBI waiver program services that were not allowable or were potentially unallowable for the 127 remaining beneficiary-months.

Specifically, TBI waiver program services totaling $362,254 (Federal share) in 122 beneficiary-months did not comply with Federal and State requirements, and TBI waiver program services totaling $10,292 (Federal share) in 9 beneficiary-months may not have complied with Federal and State requirements. Of these 9 beneficiary-months, 4 also contained TBI waiver program services that were unallowable. Of the 122 beneficiary-months with TBI waiver program services for which the Health Department improperly claimed Federal Medicaid reimbursement, 66 contained more than 1 deficiency. Appendix D contains a summary of deficiencies, if any, identified for each sampled beneficiary-month.

The Health Department claimed reimbursement for unallowable and potentially unallowable TBI waiver program services because:

- the centers did not ensure and document that all beneficiaries approved for TBI waiver program services were assessed by certified individuals and determined eligible,

- the Health Department did not ensure that the assessors and screeners properly evaluated beneficiaries for placement in the TBI waiver program, and

- providers did not ensure that they documented TBI waiver program services billed and that they claimed reimbursement for only allowable ones.

Using our sample results, we estimated that the Health Department improperly claimed at least $54,265,195 in Federal Medicaid reimbursement for TBI waiver program services that did not comply with Federal and State requirements during calendar years 2007 through 2009. In addition, we estimated that the Health Department claimed at least $662,510 in Federal Medicaid reimbursement for TBI waiver program services that may not have complied with Federal and State requirements.

For details on the Federal and State requirements related to TBI waiver program services, see Appendix E.

TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES PROVIDED TO BENEFICIARIES NOT QUALIFIED FOR NURSING HOME LEVEL OF CARE

The State agency must provide for an initial evaluation of the beneficiary's need for the level of care that would be provided in an institution unless the individual receives the HCBS (42 CFR § 441.302(c)). Each beneficiary receiving HCBS must also have at least annual reevaluations to determine whether the beneficiary continues to need the level of care provided and would, but for the provision of waiver services, be institutionalized (42 CFR § 441.302(c)). The Health Department's waiver agreement with CMS states that, to be eligible for the TBI waiver program, a beneficiary must be assessed to need nursing facility level of care. The Health Department's *TBI Waiver Program Manual*, which provides further clarification of definitions and scope of the TBI waiver program, 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 the SCREEN. The H/C-PRI and the SCREEN assign patients to 1 of 16 RUG-II categories. 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 (10 NYCRR § 400.12).[8]

For 92 beneficiary-months, the Health Department claimed reimbursement for TBI waiver program 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.[9] 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 during most of our audit period.

TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES NOT DOCUMENTED

States must have agreements with Medicaid providers under which providers agree to keep records that fully disclose the extent of the services provided to individuals receiving assistance under a State plan (section 1902(a)(27) of the Act). In addition, Federal cost principles require providers to maintain documentation of services provided.[10]

For 58 beneficiary-months, the Health Department claimed reimbursement for some TBI waiver program services that were not adequately documented. For these services, providers did not maintain notes to support the services billed or did not fully document the services billed.

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[8] Effective November 4, 2009, the Health Department revised its regulations to include four other RUG-II groupings to its list of groupings that qualify for skilled nursing facility level of care. (See footnote 5.)

[9] All of the beneficiaries associated with the 92 beneficiary-months were assessed before the November 4, 2009, regulation change.

[10] Specifically, costs must be adequately documented to be allowable under Federal awards (2 CFR § 225, App. A § C.1.j (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*)). In addition, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services rendered by certified providers (section 2497.1 of CMS's *State Medicaid Manual*).

TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES NOT PROVIDED IN ACCORDANCE WITH AN APPROVED PLAN OF CARE

HCBS must be furnished under a written plan of care subject to approval by the State agency (42 CFR § 441.301(b)(1)(i)). In addition, New York State's waiver agreement with CMS states that all waiver services will be furnished pursuant to a written plan of care and that Federal financial participation will not be claimed for waiver services that are not included in the individual written plan of care. A plan of care must specify the services to be provided, their frequency, and the type of provider (section 4442.6 of CMS's *State Medicaid Manual*).

For 25 beneficiary-months, the Health Department claimed reimbursement for some TBI waiver program services that were not in accordance with an approved plan of care. Specifically:

- **Excess Units Billed.** For 17 beneficiary-months, providers claimed reimbursement for TBI waiver program services in excess of the number of units allowed in the plan of care.

- **Services Not Included.** For 6 beneficiary-months, providers claimed reimbursement for TBI waiver program services not included in the plan of care.

- **Plan of Care Not Approved.** For 2 beneficiary-months, providers claimed reimbursement for TBI waiver program services when the beneficiary's plan of care was not approved by the Health Department.

ASSESSMENTS FOR TRAUMATIC BRAIN INJURY WAIVER PROGRAM ELIGIBILITY CONDUCTED BY UNCERTIFIED INDIVIDUALS

Waiver agreements must 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, including a description of the party or parties responsible for the evaluation and reevaluation and their qualifications (section 4442.5 of CMS's *State Medicaid Manual*). The Health Department's waiver agreement with CMS states that, to be eligible for the TBI waiver program, a beneficiary must be assessed to need the required level of care by individuals who have completed the Health Department's H/C-PRI and SCREEN training and certification program.[11]

For 17 beneficiary-months, the Health Department claimed reimbursement for some TBI waiver program services provided to beneficiaries whose assessments for program eligibility were conducted by uncertified individuals (i.e., individuals without an assessor number). The centers did not detect that these assessors had not completed the Health Department's training and certification program and, therefore, approved the related TBI waiver program services. Specifically:

[11] The Health Department assigns "assessor numbers," which are required to complete the H/C-PRI and the SCREEN, to registered nurses, social workers, and discharge planning professionals who successfully complete the training and certification program.

- For 7 beneficiary-months, the Health Department was unable to verify that the H/C-PRI assessor met New York State training and certification requirements.

- For 7 beneficiary-months, the Health Department was unable to verify that the SCREEN assessor met New York State training and certification requirements.

- For 3 beneficiary-months, the Health Department was unable to verify that both the H/C-PRI and SCREEN assessors met New York State training and certification requirements.

ASSESSMENTS FOR TRAUMATIC BRAIN INJURY WAIVER PROGRAM ELIGIBILITY NOT DOCUMENTED

HCBS may be provided only to beneficiaries who a State agency determines 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 intellectual disabilities (section 1915(c) of the Act and 42 CFR § 441.301(b)(1)(iii)). Federal regulations require the State agency to provide for an initial evaluation of the beneficiary's need for the level of care that would be provided in an institution unless the individual receives HCBS (42 CFR § 441.302(c)). The regulations further require at least annual reevaluations of each beneficiary receiving HCBS.

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

The Health Department's waiver agreement with CMS states that individuals with a TBI or other neurological conditions that result in conditions similar to a TBI are eligible for the waiver. Federal financial participation is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services rendered by certified providers (section 2497.1 of CMS's *State Medicaid Manual*).

For 14 beneficiary-months, the Health Department claimed reimbursement for some TBI waiver program services for which an eligibility assessment for the TBI waiver program was not documented. Despite the lack of documentation, centers approved the related TBI waiver program services. Specifically:

- **Annual Reevaluation Missing.** For 8 beneficiary-months, neither providers nor the associated center provided documentation of the annual reevaluation to determine whether TBI waiver program services were needed.

- **Approved Medical Documentation Missing.** For 6 beneficiary-months, neither providers nor the associated center provided approved medical documentation indicating that the beneficiary had a TBI.

ADDITIONAL TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES POTENTIALLY UNALLOWABLE, BUT DATA INSUFFICIENT TO DETERMINE ELIGIBILITY

HCBS may be provided only to beneficiaries 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 intellectual disabilities (section 1915(c) of the Act and 42 CFR § 441.301(b)(1)(iii)). An assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care (section 4442.6 of CMS's *State Medicaid Manual*).

For 9 beneficiary-months, the Health Department claimed reimbursement for TBI waiver program services to beneficiaries who may not have been eligible to receive those services under Federal and State requirements. Specifically, the RUG-II groupings for the beneficiaries were not documented on the H/C-PRIs provided by providers and the centers. As a result, the associated beneficiaries' need for nursing home level of care could not be determined.

CONCLUSION

Using our sample results, we estimated that the Health Department improperly claimed at least $54,265,195 in Federal Medicaid reimbursement for TBI waiver program services that did not comply with Federal and State requirements during calendar years 2007 through 2009. In addition, we estimated that the Health Department claimed at least $662,510 in Federal Medicaid reimbursement for TBI waiver program services that may not have complied with Federal and State requirements. Specifically, (1) the centers did not ensure and document that all beneficiaries approved for TBI waiver program services were assessed by certified individuals and determined eligible for those services, (2) the Health Department did not ensure that the assessors and screeners properly evaluated beneficiaries for placement in the TBI waiver program, and (3) providers did not ensure that they documented TBI waiver program services billed and claimed reimbursement only for allowable ones.

RECOMMENDATIONS

We recommend that the Health Department:

- refund $54,265,195 to the Federal Government;
- work with CMS to resolve the claims, totaling $662,510, for which Medicaid reimbursement may have been unallowable; and
- ensure that it complies with certain Federal and State requirements by requiring:
    - the centers to ensure and document that all beneficiaries approved for TBI waiver program services have been assessed by certified individuals and are eligible for those services,

- adequate training for assessors on the Federal and State requirements for the TBI waiver program, and

- providers to ensure that they document TBI waiver program services billed and claim reimbursement only for allowable ones.

HEALTH DEPARTMENT COMMENTS

The State agency generally disagreed with our first recommendation (financial disallowance), disagreed with our second recommendation (potential disallowance), and stated that it is implementing procedures to address our final recommendation.

Regarding our first recommendation, the Health Department stated that "not all of the alleged deficiencies identified [in the report] warrant a full refund and a number of deficiencies are in dispute." Specifically, the Health Department disagreed with our finding concerning beneficiaries not qualified for nursing home level of care and indicated that our interpretation of what constitutes nursing facility level of care determinations did not consider all relevant information. The Health Department indicated that the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) combined all residential health care facilities (i.e., health-related and skilled nursing facilities) participating in Medicaid into one level of care. The Health Department stated that eligibility is not based solely on an H/C-PRI form but is supplemented by other documents and reviews.[12] Regarding our second recommendation, which addressed potentially unallowable claims submitted for reimbursement, the Health Department stated that the absence of a RUG-II grouping on an H/C-PRI does not invalidate the need for nursing facility level of care.

See Appendix F for the full text of the State agency comments.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Health Department's comments on our draft report, we maintain that our findings and recommendations are valid.

We maintain that our interpretation of the RUG-II scoring system for determining eligibility for nursing home level of care is accurate. We agree that OBRA 1987 reclassified skilled nursing facilities, rehabilitation facilities, and health-related facilities as nursing facilities. Nevertheless, New York State 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 service. This is in contrast to 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

[12] The Health Department stated that the H/C-PRI and the SCREEN are components of a "multi-phase assessment process for determining eligibility for the TBI waiver program."

information, dietary supervision, and supervised hygienic services. Health-related facilities cannot provide nursing care under New York State law as can nursing homes.[13]

The Health Department's suggestion that eligibility can be determined without an H/C-PRI is inaccurate. 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 the SCREEN. The H/C-PRI and the 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 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.[14]

In addition, the regulations cited by the Health Department (10 NYCRR §§ 86-2.30(e) (1) and (3)) do not support the proposition that eligibility for the TBI waiver program may be based on documents that supplement the H/C-PRI and the SCREEN. Rather, these regulations provide that the Health Department may review certain information when auditing a residential health care facility's performance in completing H/C-PRIs.

[13] 10 NYCRR § 700. 2 also distinguishes between nursing homes, which provide nursing care to patients, from health-related facilities, which do not.

[14] Effective November 4, 2009, the Health Department revised its regulations to include four other RUG-II groupings to its list of groupings that qualify for skilled nursing facility level of care. (See footnote 5.)

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered the Health Department's claims for Medicaid reimbursement for HCBS provided under the TBI waiver program during calendar years 2007 through 2009. We limited our audit to certain Medicaid costs claimed for TBI waiver program services delivered by selected providers. Specifically, we excluded:

- all beneficiary-months for two providers that we previously reviewed—Venture Forthe, Inc., and Belvedere of Albany, LLC, and

- all beneficiary-months for providers reviewed by New York State's Office of Medicaid Inspector General during our audit period.

After taking into account these exclusions, we determined that our revised sampling frame consisted of 68,211 beneficiary-months totaling $196,505,824 ($98,251,380 Federal share) during calendar years 2007 through 2009. We reviewed a stratified random sample of 138 beneficiary-months.

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for the TBI waiver program services claimed for reimbursement. We did not assess the Health Department's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. We reviewed the providers' and the centers' internal controls for documenting TBI waiver program services billed and claimed for reimbursement. We did not assess the appropriateness of HCBS payment rates.

We performed our fieldwork at 96 providers' offices throughout New York State, and at the nine centers in Binghamton, Buffalo, Islip Terrace, New York City, Queensbury, Schenectady, Syracuse, Rochester, and White Plains, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

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

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

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

- reconciled the TBI waiver program services that the Health Department 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 waiver program services to providers statewide obtained from New York State's Medicaid Management Information System for calendar years 2007 through 2009;

- obtained from New York State's Medicaid Management Information System a sampling frame of 77,123 beneficiary-months with TBI waiver program services for which the Health Department claimed reimbursement totaling $271 million ($136 million Federal share) during calendar years 2007 through 2009;

- removed from our sampling frame all beneficiary-months for two providers that we previously reviewed (Venture Forthe, Inc., and Belvedere of Albany, LLC);

- removed from our sampling frame all beneficiary-months for providers reviewed by New York State's Office of Medicaid Inspector General during our audit period;

- determined that our revised sampling frame consisted of 68,211 beneficiary-months totaling $196,505,824 ($98,251, 380 Federal share) during calendar years 2007 through 2009;

- selected a stratified random sample of 138 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 documentation supported the TBI waiver program services billed,

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

    - identified TBI waiver program 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 68,211 beneficiary-months.

See Appendix B for the details of our statistical sampling methodology and Appendix C for 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 objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of beneficiary-months of service provided under New York's TBI waiver program for which the Health Department received Medicaid reimbursement during calendar years 2007 through 2009.

SAMPLING FRAME

The sampling frame was an Access file containing 68,211 beneficiary-months of service totaling $196,505,824 ($98,251,380 Federal share). We eliminated from the sampling frame all beneficiary-months for two of the three highest paid providers of TBI waiver program services in New York State—Venture Forthe, Inc., and Belvedere of Albany, LLC—which we reviewed previously, and TBI waiver program services for all providers reviewed by New York State's Office of Medicaid Inspector General during calendar years 2007 through 2009. The data for beneficiary-months of service under the New York State 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 2007 through 2009 for which the Health Department claimed Medicaid reimbursement for services provided under the TBI waiver program. A beneficiary-month is defined as all TBI waiver program services for one beneficiary for 1 month.

SAMPLE DESIGN

We used a stratified random sample to review Medicaid payments made to the Health Department on behalf of beneficiaries enrolled in the New York State TBI waiver program. To accomplish this, we separated the sampling frame into two strata, as follows:

- Stratum 1: beneficiary-months with total payments for TBI waiver program services totaling $10,000 or less—68,173 beneficiary-months totaling $195,548,941 ($97,772,939 Federal share).

- Stratum 2: beneficiary-months with total payments for TBI waiver program services greater than $10,000—38 beneficiary-months, totaling $956,883 ($478,441 Federal share).

SAMPLE SIZE

We selected a sample of 138 beneficiary-months of service:

- 100 beneficiary-months from stratum 1 and
- 38 beneficiary-months from stratum 2.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample items in the first stratum. After generating 100 random numbers for this stratum, we selected the corresponding frame items. We selected for review all 38 beneficiary-months in stratum 2.

ESTIMATION METHODOLOGY

We used OAS statistical software 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 TBI waiver program services in the beneficiary-months.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

UNALLOWABLE TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES

Sample Details and Results

Stratum	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)
1	68,173	$97,772,939	100	$125,058	89	$102,128
2	38	$478,441	38	$478,441	33	$260,126
Total	**68,211**	**$98,251,380**	**138**	**$603,499**	**122**	**$362,254**

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

Point estimate	$69,883,989
Lower limit	$54,265,195
Upper limit	$85,502,782

POTENTIALLY UNALLOWABLE TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES

Sample Details and Results

Stratum	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)
1	68,173	$97,772,939	100	$125,058	7	$3,714
2	38	$478,441	38	$478,441	2	$6,578
Total	**68,211**	**$98,251,380**	**138**	**$603,499**	**9**	**$10,292**

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

Point estimate	$2,538,541
Lower limit	$662,510
Upper limit	$4,414,571

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

Legend

Deficiency	Description
1	Traumatic Brain Injury Waiver Program Services Provided to Beneficiaries Not Qualified for Nursing Home Level of Care
2	Traumatic Brain Injury Waiver Program Services Not Documented
3	Traumatic Brain Injury Waiver Program Services Not Provided in Accordance With an Approved Plan of Care
4	Assessments for Traumatic Brain Injury Waiver Program Eligibility Conducted by Uncertified Individuals
5	Assessments for Traumatic Brain Injury Waiver Program Eligibility Not Documented

Office of Inspector General Review Determinations for the 138 Sampled Beneficiary-Months

Sample Beneficiary-Month[15]	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-1	X					1
S1-2	X					1
S1-3	X					1
S1-4	X					1
S1-5						0
S1-6	X					1
S1-7	X			X		2
S1-8	X					1
S1-9						0
S1-10	X	X	X			3
S1-11	X		X			2
S1-12	X	X				2
S1-13	X					1
S1-14	X					1
S1-15	X	X	X			3
S1-16	X					1
S1-17	X	X				2
S1-18						0
S1-19	X					1

[15] S1 and S2 indicate stratum 1 and stratum 2, respectively.

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-20						0
S1-21	X					1
S1-22	X	X				2
S1-23	X		X			2
S1-24		X				1
S1-25	X	X				2
S1-26					X	1
S1-27	X					1
S1-28	X					1
S1-29	X					1
S1-30						0
S1-31	X	X	X			3
S1-32	X			X		2
S1-33	X					1
S1-34	X	X				2
S1-35				X		1
S1-36	X					1
S1-37	X					1
S1-38	X					1
S1-39	X		X			2
S1-40	X	X	X			3
S1-41		X				1
S1-42		X				1
S1-43		X				1
S1-44	X					1
S1-45	X					1
S1-46	X	X				2
S1-47						0
S1-48	X	X				2
S1-49	X					1
S1-50	X					1
S1-51	X		X			2
S1-52	X	X				2

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-53	X					1
S1-54	X				X	2
S1-55		X			X	2
S1-56					X	1
S1-57	X	X	X			3
S1-58	X					1
S1-59	X		X			2
S1-60					X	1
S1-61	X					1
S1-62	X	X	X			3
S1-63	X			X		2
S1-64	X			X		2
S1-65	X	X				2
S1-66	X					1
S1-67	X	X				2
S1-68	X	X				2
S1-69	X					1
S1-70						0
S1-71	X					1
S1-72	X	X	X			3
S1-73						0
S1-74	X	X				2
S1-75	X					1
S1-76	X			X		2
S1-77	X	X				2
S1-78						0
S1-79	X					1
S1-80	X	X				2
S1-81	X					1
S1-82		X			X	2
S1-83	X			X		2
S1-84	X					1
S1-85						0

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S1-86	X					1
S1-87	X					1
S1-88		X				1
S1-89	X					1
S1-90		X				1
S1-91	X					1
S1-92		X	X			2
S1-93			X		X	2
S1-94	X	X			X	3
S1-95	X	X				2
S1-96	X	X	X		X	4
S1-97	X					1
S1-98	X				X	2
S1-99						0
S1-100	X					1
S2-1		X		X		2
S2-2		X				1
S2-3	X	X				2
S2-4	X	X	X			3
S2-5	X	X				2
S2-6		X			X	2
S2-7	X	X	X			3
S2-8		X	X			2
S2-9						0
S2-10						0
S2-11						0
S2-12	X	X				2
S2-13	X	X				2
S2-14	X			X		2
S2-15	X			X		2
S2-16		X				1
S2-17	X	X		X		3
S2-18						0

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
S2-19		X	X			2
S2-20			X			1
S2-21		X	X	X		3
S2-22	X					1
S2-23		X		X		2
S2-24	X	X				2
S2-25						0
S2-26				X		1
S2-27		X		X		2
S2-28	X	X				2
S2-29		X	X			2
S2-30		X				1
S2-31	X	X				2
S2-32	X	X	X	X		4
S2-33	X	X		X		3
S2-34		X			X	2
S2-35					X	1
S2-36					X	1
S2-37	X	X	X			3
S2-38	X		X			2
Category Totals	**92**	**58**	**25**	**17**	**14**	**206**
122 Beneficiary-Months in Error						

APPENDIX E: FEDERAL AND STATE REQUIREMENTS FOR TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES

FEDERAL AND STATE REQUIREMENTS FOR ELIGIBILITY FOR TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES

Section 1915(c) of the Act authorizes Medicaid 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 may be provided only to beneficiaries 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 intellectual disabilities. Federal regulations (42 CFR § 441.301(b)(1)(i)) require that HCBS 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 a State agency to provide for an initial evaluation of the beneficiary's need for the level of care that would be provided in an institution unless the individual receives HCBS. The regulations further require at least annual reevaluations of each beneficiary receiving HCBS.

Section 4442.6 of CMS's *State Medicaid Manual* requires that an assessment of the individual to determine the services needed to prevent institutionalization 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 under a section 1915(c) waiver for HCBS furnished without a written plan of care.

New York State's waiver agreement with CMS states that to be eligible for the TBI waiver program, a beneficiary must be assessed to need nursing facility level of care. The Health Department's *TBI Waiver Program Manual*, which provides further clarification of definitions and scope of the TBI waiver program, 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 the SCREEN. The H/C-PRI and the SCREEN assign patients to 1 of 16 RUG-II categories. New York State regulations say that 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 (10 NYCRR § 400.12).

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. Effective November 4, 2009, the Health Department revised its regulations to include the four other RUG-II groupings to its list of groupings that qualify for nursing home level of care (N.Y. Dept. of Health, Recently Adopted Regulations, PASRR Screen Requirements (Nov. 4, 2009)).

FEDERAL REQUIREMENTS FOR DOCUMENTATION NEEDED TO SUPPORT TRAUMATIC BRAIN INJURY WAIVER PROGRAM SERVICES BILLED

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. The Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), requires that costs be adequately documented to be allowable under Federal awards.

Federal financial participation is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services rendered by certified providers (section 2497.1 of CMS's *State Medicaid Manual*). 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.

FEDERAL AND STATE REQUIREMENTS FOR SERVICES BEING PROVIDED IN ACCORDANCE WITH AN APPROVED PLAN OF CARE

HCBS, by Federal regulation, must be furnished under a written plan of care subject to approval by the State agency (42 CFR § 441.301(b)(1)(i)). In addition, New York State's waiver agreement with CMS states that all waiver services will be furnished pursuant to a written plan of care and that Federal financial participation will not be claimed for waiver services that are not included in the individual written plan of care.

A plan of care must specify the services to be provided, their frequency, and the type of provider (section 4442.6 of CMS's *State Medicaid Manual*).

FEDERAL AND STATE REQUIREMENTS FOR TRAINING OF INDIVIDUALS TO ASSESS TRAUMATIC BRAIN INJURY WAIVER PROGRAM BENEFICIARIES

Section 4442.5 of CMS's *State Medicaid Manual* requires waiver agreements to 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, including a description of the party or parties responsible for the evaluation and reevaluation and their qualifications.

New York State's waiver agreement with CMS states that to be eligible for the TBI waiver program, a beneficiary must be assessed to need the required level of care by individuals who have completed the Health Department's H/C-PRI and SCREEN training and certification program. The Health Department assigns "assessor numbers," which are required to complete the H/C-PRI and the SCREEN, to registered nurses, social workers, and discharge planning professionals who successfully complete the training and certification program.

APPENDIX F: HEALTH DEPARTMENT COMMENTS

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

December 17, 2012

Mr. 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-02-10-01043

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-10-01043 on "New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements."

Thank you for the opportunity to comment.

Sincerely,

Michael J. Nazarko
Deputy Commissioner
for Administration

enclosure
cc: Jason Helgerson
James C. Cox
Diane Christensen
Mark Kissinger
Stephen Abbott
Stephen La Casse
Irene Myron
John Brooks
Ronald Farrell
Michelle Contreras

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New York State Department of Health Comments on the Department of Health and Human Services Office of Inspector General Draft Audit Report A-02-10-01043 on New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements

The following are the New York State Department of Health's (Department) comments in response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-10-01043 on "New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements."

Recommendation #1:

The New York State Health Department should refund $54,265,195 to the Federal Government.

Response #1:

It is the Department's position that not all of the alleged deficiencies identified within this audit warrant a full refund and a number of deficiencies are in dispute. Most significantly, OIG incorrectly interpreted the Resource Utilization Group II (RUG-II) scores indicating eligibility for nursing facility level of care. Additionally, and as per 10 NYCRR §§86-2.30(e) (1) and (3), eligibility for the TBI waiver program is not based solely on the Hospital and Community Patient Review Instrument (H/C PRI or PRI) but is supplemented by a number of other documents and reviews that serve to further support the requisite level of care determination. This regulation describes the Department's monitoring and review process which includes "the PRI and any underlying books, records, and/or documentation which formed the basis for the completion of such form."

As a result of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the two different levels of nursing facility care, "skilled nursing facility" and "health related facility", were eliminated as of October 1990 in New York State. While the Department did not update its regulations to include specific RUG-II groupings, nursing homes continued to provide care for persons in the four RUG-II categories which OIG excluded in its literal interpretation of the then extant Title 10 NYCRR Section 400.12, and the Department did issue a number of official communications to inform nursing homes, local districts and other service providers of the change:

- New York State Memorandum 90-43, dated September 27, 1990, informs Residential Health Care Facility operators of the elimination of the distinction between the skilled nursing facility (SNF) and the intermediate care facility (ICF) which is now known as a "health related facility" (HRF) into a single level of care.

- New York State Memorandum 90-47, dated October 17, 1990, lists the consolidation of requirements for nursing homes and health related facilities into a single level of certification known as "nursing homes."

- Local Commissioner Memorandum Transmittal # 90-LCM-177 provides official notice that all residential health care facilities were reclassified to one level of care: nursing facilities.

While New York's regulations did not specifically address the Nursing Facility Level of Care determinations for its TBI waiver program, the Department adhered to the overarching Federal legislation resulting from OBRA '87 which combined SKF and HRF into one level of care. Importantly, a person's needs do not change due to the regulatory inclusion or exclusion of a score category. The PRI and SCREEN are components of a multi-phase assessment process for determining eligibility for the TBI waiver program. The full assessment process is designed to further inform the often difficult task of determining an applicant's degree of cognitive functioning and potential for success in the community with waiver services. A full assessment of an individual includes, but is not limited to: life history, daily routine, strengths, interests, functional abilities, physical or mental conditions, the potential for improvement, communication abilities, nutritional status, medications and other related conditions impacting the individual's life. Participants receiving waiver services may exhibit mild to severe cognitive impairments while showing few physical limitations. The PRI is not designed to fully capture the severity of these cognitive issues in the absence of physical limitations.

As explained in the 2006 TBI Program Manual, eligibility is determined based on review of the application packet which includes: Application for Participation; choice; Medicaid eligibility; relevant information to support a diagnosis of a TBI and to confirm the age of onset of the TBI; a complete proposed Service Plan; identification of a residence; and a completed PRI /SCREEN and Plan of Protective Oversight. Further, the Manual states regarding the Service Plan, "This Plan must describe why the individual is at risk for nursing home placement without the services of the waiver and indicate how the available supports requested and the waiver services identified in the Plan will assure the health and welfare of the potential participant."

OIG incorrectly interpreted TBI waiver program policies regarding eligibility being based solely on the RUG-II grouping, and the Department is currently undertaking a review of the files associated with the 138 beneficiary-months included in the audit sample to identify the indicators supporting the need for nursing home level of care. Upon completion, the Department will furnish this data to OIG for consideration in finalizing the audit report.

It is additionally relevant to note that the Department's new Uniform Assessment System (UAS) for community based care will replace the PRI, and is expected to greatly enhance the ability to determine an individual's level of care needs and hence, waiver eligibility; all other qualifying conditions being met. The Department is anticipating implementation of the UAS for waiver programs in the near future.

Recommendation #2:

The New York State Health Department should work with CMS to resolve the claims, totaling $662,510, for which Medicaid reimbursement may have been unallowable.

Response #2:

Absence of the RUG-II score on the PRI does not invalidate the assessment of the individual for nursing facility level of care, and OIG has not demonstrated any requirement for the score to be recorded on the form.

Additionally, it is relevant to note that the anticipated implementation of the new determination of nursing facility level of care in the community utilizing UAS will obviate the need for PRI and RUG-II scores for waiver applicants and participants.

Recommendation #3:

The New York State Health Department should ensure that it complies with certain Federal and State requirements by requiring:

- the centers to ensure and document that all beneficiaries approved for TBI waiver program services have been assessed by certified individuals and are eligible for those services;
- adequate training to assessors on the Federal and State requirements for the TBI waiver program; and
- providers to ensure that they document TBI waiver program services billed and claim reimbursement only for allowable ones.

Response #3:

OIG Recommendation: The New York State Health Department should ensure that it complies with certain Federal and State requirements by requiring the centers to ensure and document that all beneficiaries approved for TBI waiver program services have been assessed by certified individuals and are eligible for those services.

The Regional Resource Development Centers' Specialist is an employee of the Department's contracted Center with expertise in traumatic brain injuries. The qualifications for this position require that the individual "demonstrate expertise in brain injury and extensive familiarity with HCBS waivers." However, the assessors are registered professional nurses that have been trained and are certified in determining patient level of care. Centers are required to ensure and document that all beneficiaries are approved for services by certified individuals by verifying the presence of the assessor's signature and assessment certification number. Centers do not secure the assessor on behalf of the person seeking eligibility but are responsible, however, to review the results and the recommendations of each assessment when submitted to the center by the Service Coordinator.

The qualifying PRI certification of the assessor is assured by credentials issued by a contracted training entity, Island Peer Review Organization (IPRO), serving as an agent of the Department. The assessment service agency is responsible for verifying its employed assessors meet required PRI certification standards needed to complete the review instrument. The centers cannot evaluate the accuracy of the assessment. Only Registered Professional Nurses who are certified assessors trained by the Department's contracted entity can complete the PRI. It is the

responsibility of the assessor to maintain his/her certification, and to include their assessor identification number on the PRI.

Review of the information required by the waiver application permits centers to be able to conclude whether the applicant/participant would require care in a residential health care facility unless waiver services were provided. If, after reviewing all of the information in the PRI and supporting documentation, the center concludes the person does not require waiver services to be maintained in the community, the individual would not meet the level of care needed for enrollment in the waiver program. This information, in conjunction with the Initial Service Plan/Revised Service Plan and Application Packet, details the risk of nursing home placement without the services of the waiver program.

The Department has implemented improved practices regarding level-of-care assurances which now include routine annual reviews of participant files to provide the opportunity for corrective actions and follow-up as needed. In addition, center contracts now include a requirement that mandates the employment of a PRI-trained (soon to be UAS) registered nurse evaluator to assist in the evaluation/re-evaluation process. This OIG recommendation is also being addressed as part of the curricula associated with the roll-out of UAS. Training will obviate the old process and ensure greater accountability and control over assessors. Center staff will be trained on implementation of the tool and will complete assessments, with only approved/certified assessors able to access the tool to complete evaluations.

OIG Recommendation: The New York State Health Department should ensure that it complies with certain Federal and State requirements by requiring adequate training to assessors on the Federal and State requirements for the TBI waiver program.

TBI waiver program eligibility, and hence federal financial participation, is not wholly based on the presence of a fully completed PRI and indicated subset of RUG-II scores. The program, as authorized by the federal Centers for Medicare and Medicaid Services, permits other documents and mechanisms beyond those completed by the assessors to support the identified level of care need.

Title 10 NYCRR Section 400.11 addresses the Assessment of Long Term Care Patients and provides that "Hospital/Community PRI or the PRI as appropriate shall be completed by a registered professional nurse who has successfully completed a training program in patient case mix assessment approved by the department to train individuals in the completion of the patient review form (PRI)." The contracted training entity ensures the validity of their training and that assessors are competent in the assessment criteria and its application. During the time period of the audit, Center staff reviewing PRIs were not required to be certified as PRI assessors, so they could not possibly have been responsible for confirming the validity of the documents reviewed. Their role in reviewing the PRI and other documents was to ascertain information on the applicant's clinical history and adaptive living skills.

Prospectively, this OIG recommendation is also being addressed as part of the curricula associated with the roll-out of UAS, which necessitates new training for assessors. Assessors will be trained to a high level of competency, and accurate recordkeeping maintained to confirm training dates and curricula.

OIG Recommendation: The New York State Health Department should ensure that it complies with certain Federal and State requirements by requiring providers to ensure that they document TBI waiver program services billed and claim reimbursement only for allowable ones.

The TBI Provider Billing Guidelines are being updated to include new information regarding billing and record keeping practices. The updated Manual is expected to be posted on the Department's eMedNY website before the end of 2012. In addition, services and service plan development will be better defined, Center staff will continue to train providers at provider meetings conducted on a routine basis (a minimum of eight meetings per year), and the topics covered at the quarterly meetings with the regional resource development centers have been expanded to include: fraud and abuse prevention; concise and accurate documentation; fair hearings; quality improvement; and enhancement of programs. Further, representatives from the Office of the Medicaid Inspector General (OMIG) have also given presentations on corporate compliance and self-disclosure practices for providers.