Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

New York Personal Care Services (PCS)

Focused Program Integrity Review

Final Report

April 2018

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the New York Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that can be used to advance the program integrity of delivery of these services.

Ascertaining that billed services are provided safeguards against improper payments to providers, and protects the health and welfare of beneficiaries by ensuring that they receive essential non-medical services instrumental to improving the quality of their daily living activities. It is the responsibility of all parties involved in providing, authorizing, supervising, and furnishing PCS to protect and preserve Medicaid program integrity.

Background

Medicaid PCS is categorized as a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish activities of daily living (ADLs) or instrumental activities of daily living. It is a Medicaid benefit furnished to eligible beneficiaries according to a state's approved plan, waiver, or demonstration. These services are provided in the beneficiary's home setting or at other locations. Services offered under Medicaid PCS are optional, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Services must be approved by a physician or by some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease; services can only be rendered by qualified individuals, as designated by each state.

States administer their Medicaid programs within broad federal rules and according to a state plan approved by CMS. In addition to providing PCS under their state plans, states may also seek permission from CMS to provide PCS under waivers of traditional Medicaid requirements.

Pursuant to the regulations found at 42 CFR 440.167 and 42 CFR 441.303(f)(8), Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions of all ages. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or the PCA may provide cuing/prompting to the beneficiary in order to perform a task. Such assistance most often involves ADLs, such as eating and drinking, bathing, dressing, grooming, toileting, transferring, and mobility.

Also, the regulation at 42 CFR 441.450 provides the opportunity for participants (or their representatives) to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train, and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

The New York State Department of Health (SDOH) is the single State agency designated to administer the administration of the Medicaid program under title XIX of the Social Security Act. The state's federally approved Medicaid state plan provides the authorization for rendering PCS in New York. New York SDOH provides Medicaid State Plan PCS to eligible beneficiaries as a traditional fee-for-service (FFS) state plan benefit, and those enrolled in HCBS waiver programs. PCS is not a HCBS waiver benefit; therefore, HCBS beneficiaries access PCS through state plan authorities. In addition, Medicaid PCS is available to managed care plan enrollees through the 1115 demonstration waiver. The SDOH offers several Home and Community-Based Services (HCBS) under Section 1915(c) Medicaid waiver authorities: Long Term Home Health Care Program (LTHHCP), Traumatic Brain Injury (TBI), and Nursing Home Transition and Diversion (NHTD).

Additional HCBS Waivers are operated by agencies affiliated with the Department of Mental Hygiene (DMH). Care at Home Waivers operated by the Office for People with Developmental Disabilities (OPWDD), Bridges 2 Health Waivers operated by the Office of Child and Family Services (OCFS), and Serious Emotional Disturbances (SED) Waiver operated by the Office of Mental health (OMH) were not included in this review.

Methodology of the Review

In advance of the onsite visit, CMS requested that New York complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. In addition, questionnaires were sent to providers in order to help gain an understanding of their role in PCS program integrity. A four-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of August 21, 2017, the CMS review team visited the New York State Department of Health (SDOH). They conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, the CMS team reviewed primary data to validate the state's program integrity practices with regard to PCS.

Results of the Review

The CMS team identified areas of concern with the state's PCS program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Section 1: Personal Care Services

Overview of the State's PCS

New York provides Medicaid PCS to eligible beneficiaries according to the state's approved state plan, 1915(c) waiver and 1115 Medicaid demonstration authorities. The SDOH does offer a self-directed PCS services option. The Consumer Directed Personal Assistance Program (CDPAP) promotes personal choice and control over the delivery of services to Medicaid recipients enrolled in a MCO or fee-for-services through the Medicaid State Plan.

Summary Information of the State Plan Services and Waivers Reviewed

Table 1.

Program Name/ Year Implemented	State Plan or Waiver Type	Service or Program	Administered By
State Plan PCS Implemented 1973 State Plan Self- Direction (CDPAP) Implemented 1990 Community First Choice Option Implemented 2015	State plan authorities	Provider managed service delivery model	SDOH/MCOs SDOH/MCOs
HCBS Implemented 1981 Implemented 1995 Implemented 2007	Waiver Authorities Section 1915(c) Section 1915(c) Section 1915(c)	 LTHHCP TBI NHTD	 SDOH SDOH SDOH
Managed Care Implemented 2010	Section 1115	Medicaid Redesign (formerly Partnership Plan)	MCOs

The SDOH provides PCS through 1905(a) authority, a FFS state plan option. In addition, a state plan amendment was approved by CMS on July 1, 2015 for SDOH to implement the 1915(k) state plan authority. The 1915(k) authority, more commonly known as the Community First Choice (CFC) option, provides home and community based services and supports through the state plan. Community supports such as community habilitation, home care aide, consumer directed personal care, and personal assistance services are provided under the CFC. The state's PCS is delivered under a provider managed service delivery model. Services are provided in the recipient's home by a qualified individual who is not a member of the recipient's family. CFC is offered in FFS, Medicaid managed care, and long term care environments[1].

The section 1915(c) HCBS waiver program identified as the LTHHCP, provides coordinated plans of care and services for individuals who would otherwise be medically eligible for placement in a nursing facility. This 1915(c) waiver program serves seniors and individuals with

[1] https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-12-10_cfco_update.pdf

disabilities who are medically eligible for nursing facility level of care; desire to remain at home; have an assessed service need that can be met safely at home; and, have a service plan with Medicaid costs for services which fall within the expenditure cap for nursing facility level of care. The LTHHCP enables the state to provide participants with a number of supportive services that are not available under the state plan for Medicaid services.

The section 1915(c) HCBS waiver program identified as the NHTD program, provides community-based long-term care services as an alternative to institutional care for seniors and individuals with physical disabilities. Participants must be at least eighteen (18) years old and require a nursing facility level of care. The goal of the waiver program is to assure access to the least restrictive, most community integrated care appropriate.

The section 1915(c) HCBS waiver program identified as the TBI program, provides support and services to assist individuals with a traumatic brain injury toward successful inclusion into the community. Waiver participants can choose to move into the community from a nursing facility or participate in the program to prevent unnecessary institutionalization. The TBI waiver services are available to supplement informal supports, the broad array of local, state, and federally funded services, as well as Medicaid state plan services to assure the health and welfare of the individuals in the community.

The CDPAP allows chronically ill, or physically disabled individuals receiving home care services under the Medicaid program greater flexibility and freedom of choice. The scope of services that may be authorized under CDPAP include the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed PA under the instruction, supervision and direction of a consumer or the consumer's designated representative. These tasks are administered by the PA whose scope of practice include that of a personal care aide, home health aide, licensed practical nurse, or registered nurse (RN). The CDPAP operates under the state’s PCS benefit and is currently a Medicaid state plan service. On November 1, 2012, the CDPAP was incorporated into the state’s Managed Long Term Care (MLTC) program and Medicaid Managed Care (MMC) benefit package. The eligibility, assessment and prior authorization of services processes mirror that of the state plan PCS program.

The Medicaid Redesign (formerly Partnership Plan), Section 1115 demonstration, was added in 2010 and utilizes a managed care delivery system to create efficiencies in the Medicaid program. This HCBS expansion program provides cost-effective HCBS to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirror those of existing section 1915(c) waiver programs. The program strives to provide quality services for individuals in the community, ensure the well-being and safety of the participants, and increase opportunities for self-advocacy and self-reliance. In 2012, the state added an initiative to the demonstration waiver in order to improve service delivery and coordination of long term care services and supports for individuals through a managed care model to the demonstration. Under the MLTC program, eligible individuals in need of more than 120 days of community-based long-term care (CBLTC) are enrolled in MLTC plans to receive CBLTC services as well as other ancillary services as deemed eligible.

New York's total Medicaid expenditures in federal fiscal year (FFY) 2016 were $57,672,394,874. There were 6,129,524 unduplicated beneficiaries enrolled in New York's Medicaid program in FFY16. New York's total Medicaid expenditures for PCS in FFY16 were $3,433,625,600. The unduplicated number of beneficiaries who received PCS in FFY16 were 115,813. There were 668 PCS agency providers enrolled by SDOH in FFY16.

Table 2.

State Plan Authority/Program	**FFY2014**	**FFY2015**	**FFY2016**
PCS Program	$285,547,360	$235,652,400	$217,510,010
Consumer Directed Personal Assistance Program (CDPAP)	$218,861,940	$201,982,390	$199,186,590
Total State Plan Expenditures	$504,409,300	$437,634,790	$416,696,600
1115 Demonstration Waiver	**FFY2014**	**FFY2015**	**FFY2016**
	$3,754,801,980	$4,527,396,140	$3,016,929,000
Total PCS Expenditures	**$4,259,211,280**	**$4,965,030,930**	**$3,433,625,600**

*All expenditure data was provided to CMS by the state.

In order to reduce costs, SDOH has focused on transitioning beneficiaries from the traditional FFS state plan service delivery into managed care delivery through the demonstration waiver. The demonstration waiver provides coordinated access to case management, appropriate services, and ongoing monitoring of the participant's health status. As a result, expenditures for traditional FFS PCS Program have decreased due to a decline in beneficiaries who receive traditional FFS benefits under the state plan. However, 1915(c) waiver beneficiaries access PCS through other state plan options such as the CFC; and managed care in the 1115 demonstration waiver. The PCS expenditures for the 1915(c) waiver beneficiaries are recorded within the state plan authorities, and 1115 demonstration waiver authority in the above table.

Table 3.

	FFY 2014	**FFY 2015**	**FFY 2016**
Total PCS Expenditures	$4,259,211,280	$4,965,030,930	$3,433,625,600
% Agency-Directed PCS Expenditures	93%	94%	90%
% Self-Directed PCS Expenditures	7%	6%	10%

Beneficiaries within the New York Medicaid program mainly utilize the agency directed delivery method in order to access PCS services. The PCS expenditure analysis table indicates there is a trending increase in beneficiaries accessing the self-directed program. In sum, the total PCS expenditures have decreased from FFY 2014 to FFY 2016.

Table 4-A.

State Plan Authority Service/Program	FFY 2014	FFY 2015	FFY 2016
PCS Program	14,980	12,190	10,460
Consumer Directed Personal Assistance Program (CDPAP)	8,320	7,350	6,830
Total State Plan Beneficiaries	**23,300**	**19,540**	**17,290**
1115 Demonstration Waiver	**FFY 2014**	**FFY 2015**	**FFY 2016**
	98,805	101,070	98,523
Total	**122,105**	**120,610**	**115,813**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

A large majority of beneficiaries within the state Medicaid program access PCS through MCOs within the demonstration waiver authority. MCOs continue to shoulder the larger responsibility of providing home care services in the New York Medicaid program. As a result, MCOs should consider enhancing their program integrity oversight efforts to accommodate the influx of beneficiaries into managed care over time. Providing effective oversight, and adequately identifying PCS fraud and abuse will continue to be a challenge as more beneficiaries access PCS services through MCOs.

State Oversight of PCS Expenditures

The New York State Department of Health (SDOH) is the single State agency designated to administer the administration of the Medicaid program under title XIX of the Social Security Act. The state's federally approved Medicaid state plan provides the authorization for rendering PCS in New York. Codified in the state plan is SDOHs responsibility to supervise the administration of the Medicaid program by Local Departments of Social Services (LDSS).

The state of New York is divided into a total of fifty-eight local social services districts. The five boroughs of New York City comprise one district. In the five boroughs of New York City, PCS are approved and administered by the New York City Human Resources Administration (HRA). For the remainder of the state, PCS are approved and administered at the county level through the LDSS. Outside of New York City, each district corresponds to one of the fifty-seven counties that make up the remainder of the state. Both, HRA and LDSS administer the full range of publicly funded social services and cash assistance programs. Although the local districts are responsible for authorizing, arranging and monitoring PCS, the state Medicaid agency has overall responsibility for the Medicaid PCS program.

New York's Medicaid home care service programs utilize a workforce of home health aides (HHAs) and personal care aides (PCAs) that provide direct care services. The SDOH established training standards that includes 40 hours of standardized training for PCAs and.75 hours of standardized training for HHAs. In-service training is required to be provided, at a minimum, for three hours semi-annually for each person providing home care services to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training. Although both titles involve personal care, the HHAs receives specialized training and can attend to more complex tasks such as dressing changes, or measuring vital signs. The PCAs are utilized for tasks such as bathing, shopping, home making and running errands. All beneficiaries have access to HHAs and PCAs depending on their medical plan of care (POC) and level of medical need.

The Office of Medicaid Inspector General (OMIG) has program integrity oversight over PCS expenditures. The OMIG is an independent entity created within SDOH to promote and protect the integrity of the Medicaid program in New York. The OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations. The OMIG has the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, illegal or inappropriate acts, or unacceptable practices. The OMIG has an audit work plan that includes oversight of PCS providers, and self-directed services in the audit plan. The level of risk assigned by SDOH at the time of enrollment is not considered in the development of the OMIG audit work plan.

The OMIG collaborates with additional SDOH divisions that share the responsibility for PCS oversight and administration. The Office of Primary Care and Health Systems Management, Division of Home and Community Based Services is responsible for the oversight of the PCS provider; and the Office of Health Insurance Programs (OHIP), Division of Long Term Care is responsible for oversight of the service delivery aspect of PCS. The SDOH does not have written memorandum of understandings (MOUs), or interagency agreements that detail oversight responsibilities of the aforementioned units.

The SDOH does not actively take the lead on organizing meetings with LDSS and HRA to regularly communicate about program oversight of PCS, and the cohesive administration of PCS in New York. The fifty-eight local entities throughout the state, dozens of contracted MCOs, and fiscal intermediaries in the state that administer PCS on behalf of SDOH could benefit from more frequent SDOH initiated meetings and communication on PCS administration. The current perceived lack of regular communication initiated by SDOH potentially creates vulnerabilities to the overall integrity of the administration of PCS in accordance with both, federal and state program integrity regulations. While onsite, the PCS agencies indicated that communication from the state and MCOs regarding desired outcomes and state policies could be improved. Some of the PCS agencies acknowledged that the state policies for plan of care re-certification were not fully adhered to, which indicates some PCS services are not being rendered in accordance with SDOH guidelines, yet being reimbursed as if they were. Further, PCS agencies acknowledged that they regularly terminate home care aides for potential fraud without notifying SDOH. Therefore, credible allegations of fraud are not being reported to the state, as required. A lack of consistent communication from SDOH may contribute to a lack of clarity about the importance of potential fraud reporting; or the importance of rendering PCS service in accordance in SDOH guidelines.

Table 5.

Agency-Directed and Self-Directed Combined	FFY 2014	FFY 2015	FFY 2016
Identified Overpayments*	$0	$10,218,557	$8,534,525
Recovered Overpayments*	$0	$108,530	$11,083,734
Terminated Providers**	268	20	53
Suspected Fraud Referrals	125	91	135
# of Fraud Referrals Made to MFCU	51	28	36

*Overpayments identified and recovered in FFY2015, and FFY2016 include fraud, waste, and abuse.
******264 providers were terminated in FFY2014 due to being inactive for two years.

During FFY14, OMIG indicated that the audit protocols for PCAs were under review and revision. As a result, audits were not finalized and there were no findings or recoveries for FFY14. Once the audit protocols were finalized, identified overpayments and recovered overpayments significantly increased. As a result, approximately $11 million in overpayments were recovered in FFY16. An identified overpayment is recorded as identified when a final action occurs, such as when a final audit report is issued. The overpayment recovery process may extend across multiple years. This results in large variances in the annual overpayment recovery figures, as those depicted in FFY15 and FFY16 in the table above. However, all overpayment amounts recorded and recovered can be traced back to an individual case for tracking purposes.

Section 2: PCS Provider Enrollment

Overview of PCS Provider Enrollment

States pay PCS providers for furnishing services to eligible beneficiaries on either a FFS basis or through risk-based managed care arrangements. However, when state Medicaid agencies pay fraudulent providers for services either not furnished or rendered to beneficiaries unnecessarily, Medicaid funds are diverted from their intended purpose and beneficiaries who need PCS may not receive them.

Identifying and recovering overpayments may be resource intensive and take considerable time. Preventing ineligible entities and individuals from initially enrolling as providers allows the program to avoid the necessity to identify and recover overpayments. Provider screening enables states to identify such parties before they are able to enroll and begin billing.

The Division of Health Plan and Contracting Oversight (DHPCO) is responsible for enrolling PCS agencies into the Medicaid program. The DHCPO is a division within OHIP at SDOH. The PCS agencies that service Medicaid beneficiaries solely through managed care are not required to be credentialed by SDOH. Only PCS agencies that render services under the FFS or SDOH state plan arrangement are required to be credentialed by SDOH. The PCS agencies must first establish a contract with LDSS in the county/counties they will be servicing before enrolling in the New York Medicaid program. Next, the PCS agency must complete a provider application and submit it to SDOH for credentialing. The application process includes the necessary database exclusion checks in accordance with CFR 42 455.436, and disclosure of ownership checks in accordance with 42 455.104. The PCS agency contracts with LDSS, and the PCS agency employs individual PCAs.

Home care workers (HHAs and PCAs) are required to obtain and maintain a professional certificate issued by the state of New York. The SDOH is responsible for establishing and overseeing training standards for such certificates. Home care workers and attendants are not issued state identifiers or a national provider identifier, but they are required to register with the state's home care registry in order to be render home care services. On September 25, 2009, SDOH initiated a home care worker registry of all persons who have successfully completed a home health aide and/or personal care training program. The state's home care registry provides limited information about home care workers who have successfully completed a state approved training program, employment history, and information on any criminal convictions. Within ten business days after the home care worker has been employed by a home care services entity, the home care services entity is required to input the aide's information into the registry in the form and manner required by SDOH. Consequently, when the home care worker's employment with the entity is terminated, the home care entity is required to update the registry with the date on which the worker's employment with the entity was terminated.

State Oversight

As required by 42 CFR 455.450, the state has implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers. In addition, the state has implemented the federal database checks on any person with an ownership interest or who is an agent or managing employee of the provider as required. The state does check all parties against the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System on the System for Award Management (SAM) monthly after enrollment, and reenrollment as required at 42 CFR 455.436(c)(2).

The DHPCO is responsible for PCS provider screening and enrollment in New York that provide services under the state plan. The MCOs are responsible for providing PCS to the plan enrollees through network provider contracts and are responsible for managing those contracts and the PCS providers appropriately. PCS providers are not required to be enrolled with SDOH if they are only rendering services to beneficiaries enrolled in MCOs. The DHPCO is responsible for performing all the required federal database checks for state plan PCS providers, as well as collecting and storing all required disclosure information for enrolled providers during the enrollment process. The DHCPCO conducts monthly provider surveillance to check enrolled providers for maintenance of clear background checks. The onsite review team confirmed that DHPCO is performing all required federal database checks for the PCS providers as well as collecting and storing all required disclosure information.

When DHPCO receives notification, identifies or is made aware of a provider that has been terminated by Medicaid or convicted of a health care related criminal offense, DHPCO will terminate the provider from participation in the Medicaid program. A copy of the sanction is sent to the distribution list informing their employers, if applicable, other state departments, licensing boards, managed care health plans, HHS-OIG, and other relevant interested parties of the sanction.

Entities and/or individuals that are excluded from the NYS Medicaid program are included on the OMIG exclusion list, which is available on the OMIG website and is updated daily The PCS provider agencies are prohibited from employing individuals who have been convicted of a health care related crime. The SDOH requires Medicaid enrolled providers reimbursed by the Medicaid program to meet all background checks and enrollment screening requirements consistent with the Affordable Care Act requirements.

Section 3: Self-Directed / Participant-Directed Care Services

Summary of Information Reviewed

As previously mentioned, the self-directed PCS program operates under the state plan and as a self-directed service in the MCO benefit. The CDPAP beneficiary is responsible for hiring, training, supervising, and if necessary, firing their home care worker. There are no required licenses, background checks[2], or standardized training required of the CDPAP home care worker. The CDPAP beneficiaries are required to finance the cost of a background check, at their own expense, if they desire their home care worker to have a background check. The LDSS and/or MCO contracted fiscal intermediary (FI) is required to check CDPAP home care workers against the excluded provider list and the LEIE on a monthly basis. The FI responsibilities regarding the CDPAP can be found in state statute at subdivision (4-a) and (4-b) of §365-f and state regulation at subdivision (i) of 18 NYCRR §505.28.

The CDPAP home care workers must be legally allowed to work in the United States, complete annual physicals and have up to date vaccinations required by SDOH guidelines to be eligible for hire. The SDOH regulations prohibit spouses, designated representatives (individuals coordinating care on behalf of the CDPAP beneficiary when they are not self-directing) and parents (when the CDPAP beneficiary is under 21) from providing paid care under the CDPAP. Effective April 1, 2016, and in accordance with Chapter 511 of the laws of 2015, changes went into effect that modified who could work as a CDPAP personal assistant for an eligible beneficiary. The change permitted parents of adult children to be hired and work as CDPAP personal assistants. Parents of children who are younger than 21 cannot be hired as that minor child's CDPAP assistant. Consistent with current regulations, spouses and designated representatives continue to be prohibited from being hired as CDPAP assistants.

State Oversight of Self-Directed Services

The Division of Medicaid Investigations, within OMIG, investigates complaints of all potential Medicaid fraud, waste, and abuse including allegations related to PCS. Administrative oversight of self-directed PCS is the responsibility of the FI. The purpose of this oversight is to assure that CDPAP services are provided according to the authorization of LDSS and the MCO, and within SDOH provider guidelines. All fiscal intermediaries must have a contract, or SDOH approved

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[2] Beneficiaries that are enrolled in the Program for the All-Inclusive of the Elderly (PACE) must conduct a CHBC on any proposed personal assistance caregiver. This is required by PACE regulations at 42 CFR 460.68

administrative agreement with the LDSS and MCO, respectively; be enrolled as a Medicaid provider through the provider enrollment process overseen by DHPCO, and have rates established or approved by the DOH or MCO respectively, in order to support CDPAP beneficiaries. Home care workers are responsible for adhering to plans of care and policy guidelines, which are monitored by LDSS/MCO and the FI.

Within the last three FFYs, no explanation of medical benefits were issued regarding services rendered by self-directed PCS providers. There was no self-directed PCS investigations or audits initiated in the last three FFYs. As a result, during the time period CMS reviewed, self-directed services were not being verified, and there was a lack of oversight of this service.

Section 4: Personal Care Service Providers

Overview of the State's PCS Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These non-medical services also assist beneficiaries with ADLs. Approximately 668 providers contracted directly with LDSS and/or HRA in FFY16. The majority of the state's PCS are now rendered through MCOs. As a result, a much larger population of PCS provider agencies are contracted with the numerous MCOs in the state.

The CMS review team randomly selected and interviewed four provider agencies and one MCO (under the MLTC program) that render PCS. Those agencies were: White Glove Community Care, Bronxwood Home for the Aged, Inc., Selfhelp Community Services, and Floral Home Care. The MCO interviewed was Integra Managed Long Term Care (Integra).

Provider Oversight of PCS

White Glove Community Care

White Glove Community Care (White Glove) has a history of providing home care services since 1997, but has provided PCS services since 2006 to recipients in Brooklyn, NY. The agency was established to address the needs of individuals at home, who were either disabled, chronically/terminally ill, in need of nursing care or assistance with the essential ADLs. White Glove has served 2,662 Medicaid beneficiaries and had approximately 3,866 PCA staff and 27 supervisory personnel during FFY16. White Glove provides Medicaid PCS services to eligible beneficiaries under the TBI Waiver and Section 1115 demonstration waiver.

White Glove has a formal compliance officer, corporate compliance plan and compliance committee. The corporate compliance committee meets on an ad hoc basis. The committee has oversight responsibility for the compliance program and reports to the performance improvement committee on an ad hoc basis. White Glove routinely performs internal audits of client and personnel files.

Prospective White Glove PCAs and HHAs must have completed a PCA training and certification program prior to completing an employment application. In addition, they must register with the New York State homecare registry. All PCAs and HHAs are credentialed in accordance with the regulatory mandate contained in Title 10, Part 766.11. White Glove submits all new PCA's to the New York State-Criminal History Record Check (CHRC). Training is provided to employees upon hire and annually thereafter. White Glove verifies all employees and contracts, including providers, against the LEIE, SAM, E-verify, CHRC and the OMIG exclusion database before hiring. All employees are checked monthly thereafter through their EVV software system-HHA eXchange, which is a home care software system platform.

All services are directed by the POC, which is authorized for 180 days, and approved by the patient's primary care physician. White Glove provides a written POC to the patient and family caregiver during the initial onsite assessment visit with the RN. The POC specifies tasks and duties of the PCA. Field supervisors conduct additional follow-up visits to ensure that duties and tasks performed by PCAs are specific and exclusive for the beneficiary. White Glove is contractually required to supervise all PCAs providing services initially, ongoing every 90 days, and as often as needed in between the 90 day interval. White Glove ensures it's hiring, contracting, operations, service provision and billing practices are compliant with regulatory mandates and requirements for minimum standards for a Licensed Home Care Services Agency.

White Glove utilizes HHA eXchange for EVV service. The HHA eXchange is advertised as a unique customer-driven software platform designed for home care payers and providers looking for cost effective ways to provide better service to patients and maintain a high degree of compliance. The HHA eXchange is utilized for in-home scheduling, tracking and billing of PCS. All field staff must use HHA eXchange's Interactive Voice Response (IVR) unit to log tasks and work hours completed in accordance to the POC, as well as to track when the PCA begins work or "clocks-in" on a daily basis. The HHA eXchange's IVR is a tool put in place to help prevent inaccurate and/or fraudulent time charges. The system requires the field staff to use the patient's home phone. If the patient does not have a home phone, or does not allow the field staff to use their phone, then paper timesheets documenting the PCAs work hours and the tasks performed must be completed and signed by the patient on a daily basis.

Bronxwood Home for the Aged, Inc.

Bronxwood Home for the Aged Inc., (Bronxwood) is a non-profit Adult Care and Assisted Living Residence serving the Bronx and greater Metropolitan area for over 35 years. Bronxwood Homecare office for home health services has been operating since June 2005. Bronxwood has served 872 Medicaid beneficiaries and had approximately 703 PCA staff and 30 supervisory personnel during FFY16. Bronxwood provides Medicaid PCS services to eligible beneficiaries under the Section 1115 demonstration waiver authority.

Bronxwood does have a corporate compliance officer (CCO) and compliance committee. The CCO reports to the for the Bronxwood Administrator/Chief Executive Officer and Governing Body, while maintaining responsibility for overseeing the education of personnel regarding compliance. The CCO reports on the compliance plan to the compliance committee quarterly and to the Board of Governors annually. The fraud, waste, and abuse policy is required to be reviewed during the annual employee in-service classes. Bronxwood does perform internal audits of client and personnel files. Bronxwood has a continuous quality improvement program, which involves a process of systematic monitoring and evaluation of the quality of services provided. In addition, Bronxwood conducts checks on about ten percent of recipient records every quarter. The PCA and HHA are supervised once a year in the home of the recipient. The RN conducts visits every 30 days with the recipient and is also supervised every 90 days in the home of the recipient. During the annual visit, a nurse will observe and assess the PCA and the patients' needs. The visit reports are compared to the PCA's timesheet and schedule. Timesheets are monitored on a weekly basis by the branch coordinator or assistant branch coordinator.

Bronxwood PCA and HHA hiring requirements are similar to those described for White Glove above. However, prior to extending an employment offer and upon the applicant's prior consent that inquiries may be made, at least two applicant references must be checked and verification of the individual's credentials must be completed. All applicants offered employment and any individuals contracting with Bronxwood are checked against the LEIE, SAM, E-verify, CHRC and the OMIG exclusion database. Verifications are conducted upon hiring, but prior to assigning any work and then again monthly thereafter against the LEIE and SAM, as well as the OMIG exclusion database. All new employees go through an agency orientation and in-service, which includes a competency check prior to the start of servicing patients.

Bronxwood also utilizes EVV for in-home scheduling, tracking and billing of PCS. The Bronxwood EVV procedure resembles the White Glove process described above, to include the use of the HHA eXchange software platform.

Selfhelp Community Services

Selfhelp Community Services (Selfhelp) was founded in 1936. Selfhelp is one of the largest not-for-profit human service agencies in the New York metropolitan area, with 27 sites offering programs throughout Manhattan, Brooklyn, Queens, the Bronx, Nassau County and Westchester. Selfhelp office for home health services has been in operation for over 47 years. Selfhelp served approximately 1275 Medicaid beneficiaries, while employing approximately 1374 PCA staff and 21 supervisory personnel during FFY16. Selfhelp provides Medicaid PCS services to eligible beneficiaries under the Section 1115 demonstration waiver authority.

Selfhelp does have a formal compliance officer and compliance committee. The compliance officer reports directly to the Senior Vice President and is responsible for overseeing the administration and implementation of Selfhelp's compliance program. The compliance officer is also responsible for coordinating with the Human Resources Department to confirm that the LEIE has been checked with respect to all personnel, contractor, subcontractors, and consultants that are employed or contracted with Selfhelp. Selfhelp does perform internal audits of client and personnel files.

Prospective aides must provide their original PCA certificate, CHRC background check, and allow their identifying information to be entered into the New York State home care registry Selfhelp requires prospective aides to complete an application and undergo an interview. In addition, Selfhelp's employment, training, service verification and program integrity procedures resemble the aforementioned procedures described for White Glove and Bronxwood.

Floral Home Care

Floral Home Care, LLC (FHC) provides PCS in all five boroughs within New York City (The Bronx, Kings County, New York, Queens and Richmond County) as well as the Westchester County. The FHC office for home health services has been operating since March 2011 and has served 232 Medicaid beneficiaries and had approximately 218 PCA staff and six supervisory personnel during FFY16. The FHC provides Medicaid PCS services to eligible beneficiaries enrolled under the Section 1115 demonstration waiver authority.

The FHC has a compliance officer and compliance committee structure that resembles the aforementioned PCS providers. However, the FHC compliance committee meets on at least a quarterly basis to review the compliance program and activities. The fraud, waste, and abuse and compliance policy is reviewed annually during employee in-service classes. While onsite, the FHC administrator disclosed to CMS that FHC was unable to locate any employee fraud, waste, and abuse training verification records prior to May 2016. The FHC does perform internal audits of client and personnel files, but the FHC administrator advised CMS that they were unable to locate any documentation of initiated, or completed audits prior to May 2016. Federal regulations require FHC to retain audits and investigations for ten years.

Upon applying to FHC for employment, the aide must complete an application, undergo an interview with the HR compliance coordinator, and pass a competency exam. The prospective PCA must also provide FHC with their original PCA certificate, CHRC background check, and allow their identifying information to be entered into the home care registry. All aides are checked for exclusions in the same manner as previously described by the aforementioned PCS providers. The FHC also has a toll free anonymous phone hotline that is monitored at least weekly, for any messages regarding fraud, waste, and abuse.

All PCA assignments are overseen by the scheduling coordinator. The field nurse visits the patient on the first day of service to obtain consent, explain patient rights and responsibilities, explain advance directives, and introduce the aide to the POC. The nurse will visit the patient as needed, but at least once every 180 days. All PCAs are supervised by a RN or an LPN every 180 days. An annual evaluation is performed by an RN and is a more comprehensive assessment of the aide's skills and competency. All supervisory visits and annual evaluations are performed in the patient's home.

The FHC has utilized HHA eXchange for EVV services since 2011. The HHA eXchange allows FHC to enter authorizations from the MCOs, schedule visits in accordance with the authorization, confirm visits either through EVV or via time sheets, and then bill for reimbursement. The FHC payroll coordinator reviews all timesheets for accuracy and compliance prior to entry into the HHA eXchange. All visits, whether confirmed telephonically, via the smartphone application, or via a time sheet, must match the authorization to obtain reimbursement. The HHA eXchange is also used for aide compliance as with respect to physicals, purified protein derivative, as well as annual evaluations.

Integra Managed Long Term Care (Integra)

Integra Managed Long Term Care (Integra) is a New York State managed long term care plan designed for adults living with long-term disabilities. Integra MLTC has been providing services to Medicaid eligible residents in the five counties of New York City: Manhattan, Queens, Bronx, Brooklyn, or Staten Island; as well as in Nassau, Suffolk and Westchester counties since 2013. Integra has a compliance program in place that complies with federal or state regulations. Integra has written policies and procedures that outline protocols for reporting, detecting and preventing fraud, waste, and abuse practices.

Integra monitors PCS through several avenues: (1) required care management 30 day contact calls, (2) referrals of suspected fraud, waste, and abuse, (3) exclusion and sanction checks of federal databases (4) initial assessments and reassessments and (5) reviews and sample audits of authorizations. Integra did not report any audit findings in the last three FFYs, and did not have any referrals of suspected PCS fraud, despite having expenditures totaling 221.5 million dollars in the last three FFYs.

Integra attributed the low amount of investigations recoveries to a lack of a formal program integrity data mining process. In addition, Integra had no procedures in place for using algorithms to analyze claims for aberrant billing trends. As a result, there is a lack of program integrity oversight of PCS by the MCO.

The CMS review team identified that Integra does not have a formal program integrity data mining process. In 2016, the plan identified the need for such a process and began taking steps to build one through hiring senior management to design and build a data warehouse to oversee claims analytics. Integra did not have any policies or procedures in place for data mining and using algorithms to analyze claims and identify any claim outliers. This could be a reason why the state received no PCS fraud referrals by Integra for this focused review period.

Integra has a process implemented to perform database exclusion checks on enrolled PCS providers upon initial credentialing, re-credentialing, and on a monthly basis. The following websites are being used to perform the required screening on a monthly basis: HHS-OIG's LEIE, New York Office of Medicaid Inspector General Exclusions Listing, and the SAM.

Integra contracts with Relay Health to provide business process outsourcing and system support services. These services include: claims receipt, data entry, provider inquires and claims processing for providers. Integra's payment system has PCS edits that prevents duplicate and inaccurate billing. Integra has not developed a formal mandatory provider training program; in the past providers have been trained informally via mail, email, and telephone.

Section 5: Electronic Visit Verification

Overview of the State's EVV System

New York does utilize an electronic visit verification (EVV) system for in-home scheduling, tracking, and billing of PCS in some parts of the state. According to state regulations, a verification organization (VO) is an entity that uses data captured by EVV software to verify whether a service, or item, was provided to an eligible Medicaid beneficiary across all their participating providers. The VO uses an electronic program to verify whether a service was provided to an eligible Medicaid recipient. EVV is used to capture the services provided to a Medicaid beneficiary at the point of service.

Summary of Information Reviewed

In 1995, the use of EVV began in New York City on a limited basis. The EVV is now mandated by the New York City HRA. The LDSS does not mandate EVV to be utilized statewide, however providers with total Medicaid reimbursements exceeding 15 million dollars annually are required to use EVV. The CMS team was informed that some providers and MCEs, not meeting the 15 million dollar threshold, are electing to use EVV at their discretion. Pursuant to Section 12006 of the 21st Century Cures Act all states are required to implement an EVV system for PCS by January 1, 2019.

Recommendations for Improvement

- Consider developing detailed oversight responsibilities of each SDOH unit responsible for oversight and administration of PCS. A MOU, or an interagency agreement that specifies which state unit(s) are responsible for all aspects of PCS monitoring, oversight, and lines of communication between the agencies may be beneficial towards creating a more unified understanding regarding PCS monitoring and oversight responsibilities. Currently, administration of PCS is spread across several SDOH units, and approximately 60 proxy agencies.
- Take actions, or conduct audits, to ensure that FIs have proper safeguards from employing individual PCAs who may have been terminated by Medicare, Medicaid or other state Medicaid programs, as well as those that may have been convicted of a health-care related criminal offense.
- The state should require the use of an EVV system as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify: the date of service; location of service; individual providing the service; type of service; individual receiving the service; and the time the service begins/ends.
- Initiate regular audits and investigations of self-directed PCS. Services are not being verified and zero investigations have been conducted. As a result, there is a lack of oversight of this service which creates a vulnerability for the state.
- Consider providing routine training to PCS providers on updated rules and regulations to ensure appropriate billing, reducing improper payments.
- Encourage PCS agencies to conduct unannounced visits to ensure that accurate billing by PCAs and services are rendered according to SDOH guidelines.
- Consider creating a reconciliation report to validate the number of hours billed against the hours authorized.
- Ensure SDOH Program Integrity related staff, administration staff, program staff, and provider enrollment staff, review and revise policies related to oversight efforts. Consider developing strategies to add more focus on MCO oversight or enhance collaboration with MCOs.
- Ensure MCOs enhance oversight efforts to keep pace with larger shifts of beneficiaries from state administered FFS programs into MCOs. MCOs should consider adding more resources and FTEs and enhance data mining activities to identify aberrant billing trends.

Section 6: Status of Corrective Action Plan

New York's last CMS program integrity review was in September 2014, and the report for this review was issued in March 2016. The report contained three vulnerabilities. During the onsite review in August 2017, the CMS review team conducted a thorough review of the corrective actions taken by New York to address all issues reported in calendar year 2014. The findings of this review are described below.

Vulnerabilities –

1. Revisit the formal revalidation plan and make revisions to ensure that all eligible providers are properly revalidated by September 25, 2016. This plan must include the proper risk-based revalidation screening for individual providers that have had their risk level elevated beyond the level currently associated with their provider class. Ensure that adequate staff resources are allocated to meet this requirement.

Status at time of the review: Corrected

The SDOH has developed the following processes to comply with the revalidation requirement:

a. An eMedNY system project is in development to automate revalidation procedures.
b. The SDOH has prioritized Medicaid-only providers for revalidation ahead of providers who have already been screened by Medicare.
c. The SDOH continues to revalidate providers on a five-year cycle. The OHIP and OMIG continue to evaluate adjusting its risk level criteria

2. CMS recommends that New York mandate the minimum size of plan SIUs based on standard measures and a level of effort for staff that will ensure adequate program integrity oversight of network providers.

Status at time of the review: Corrected

Pursuant to 10 NYCRR § 98-1.21(d), each of these MCOs are required to submit an annual report which describes the MCO's experience, performance and cost effectiveness in implementing the Federal Aids Policy Partnership (FAPP). This report must include any changes or proposals to change organizational structure and staffing levels that would affect the operations of the SIU going forward. This also includes a description and totals of the full time equivalent (FTE) investigators and other staff working in SIU operations. In January 2017, each MCO that was required to submit a report was found to have a range of 1 to 19 FTE investigators and 1 to 13 staff working in FAPP implementation.

In February 2017, the Department conducted research regarding a minimum SIU staffing requirement established by other states. States included in this review were California, Massachusetts, Pennsylvania, Ohio, Missouri, Illinois, West Virginia, Kentucky, Florida, Texas and New Jersey. The only state found to have a requirement was New Jersey, which required SIUs to employ 1 FTE investigator per 60,000 enrollees. All other states researched stated that the SIU must have adequate staffing, had no requirements for staffing size or had no information available.

State regulations allow MCOs to determine their own rationale regarding staffing levels, based upon enrollee population, claims or volume of suspected fraud and abuse claims. Research has not allowed the Department to conclude which metric should be used to establish a standard. In addition, while SIUs employ both FTE investigators and other staff, there is no standard upon which to include in the requirement. Without guidance from CMS or widely accepted standards for staffing criteria, a minimum SIU staffing size cannot be mandated.

3. CMS recommends that New York verify that identified and collected overpayments are fully reported by the MCEs and that they are incorporated into the rate-setting process along with the overpayments determined by state-initiated reviews. Reported overpayments should include those identified by MCE subcontractors such as pharmacy and dental benefit managers. The state should also ensure that individual pharmacists implicated in fraudulent activities during audits and investigations are removed from all MCE provider networks. Terminations should not only apply to the pharmacies where the fraud occurred. Lastly, the state should work with the plans to develop standard definitions of cost avoidance and return on investment to facilitate uniform reporting.

Status at time of the review: Corrected

In the course of negotiations with the MCOs, OMIG agreed to require the submission of the (overpayment) report on a quarterly basis. The OMIG has worked with DOH to develop a form and format for the report. The amendment to the March 1, 2014 Model Contract, currently under review by CMS. The amendment outlines liquidated damages for the MCO's failure to report recoveries on its MMCOR, and/or its quarterly provider investigative report.

The state also requires its MCOs to submit quarterly provider network information. The reported network provider status is checked against federally mandated databases, as per the model contract, and plans are required to terminate contracts with providers, and providers are also removed from participation in an MCO network, if they do not have a valid license (as verified by the license check), and/or their license has been temporarily or permanently suspended and/or terminated. The state can impose sanctions on both Medicaid and non-Medicaid providers that can include a censure, exclusion, termination, or conditional or limited participation in the Medicaid program pursuant to 18 NYCRR Part 515. The OMIG conducts investigation and imposes exclusions based upon:

- Felony indictments and convictions of crime relating to the furnishing or billing for medical care, services, or supplies;
- A final decision or determination of professional misconduct or unprofessional conduct by either the New York State Education Department or the Department's Office of Professional Medical Conduct;
- A determination that a person may pose an imminent danger to the public health or welfare or the health or welfare of a beneficiary;

- Information received from the federal HHS OIG that a person or entity has been excluded from all federal health care plans;
- A finding that a person or entity committed unacceptable practices under the Medicaid program; and/or,
- Enrollment files and eMedNY data, which provides relative ownership information to determine affiliates of excluded providers.

When an administrative action is taken by the Department or OMIG against a provider, it is also the contractual responsibility of the MCOs to verify and remove any provider who has had an exclusionary action taken against them.

Technical Assistance Resources

Technical Resources should be specific to areas identified during the onsite review as a finding, vulnerability, or risk. Choose any of the following. This list is not all inclusive.

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for New York to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to New York are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html.

Conclusion

CMS supports New York efforts and encourages it to explore additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for corrected the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already take action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with New York to build an effective and strengthened program integrity function.