

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK IMPROPERLY CLAIMED
MEDICAID REIMBURSEMENT FOR
SOME BRIDGES TO HEALTH WAIVER
PROGRAM SERVICES THAT WERE
NOT IN ACCORDANCE WITH AN
APPROVED PLAN OF CARE AND DID
NOT MEET DOCUMENTATION
REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

January 2020
A-02-18-01003

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief

Date: January 2020

Report No. A-02-18-01003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

During prior reviews, we determined that New York claimed Medicaid reimbursement for home and community-based services (HCBS) under Medicaid waiver programs that did not comply with Federal requirements.

New York's Bridges to Health (B2H) was an HCBS waiver program. As of April 1, 2019, New York discontinued the B2H waiver program and transitioned these services into a comprehensive child-focused waiver known as The Children's Waiver. Our objective was to determine whether New York claimed Medicaid reimbursement for B2H waiver program services in accordance with certain Federal and State requirements.

How OIG Did This Audit

Our review covered New York's claims for Medicaid reimbursement for HCBS provided under the B2H waiver program during calendar years 2015 through 2017 (audit period) for 105,703 beneficiary-months totaling \$149 million (Federal share). We reviewed a random sample of 100 beneficiary-months.

New York Improperly Claimed Medicaid Reimbursement for Some Bridges to Health Waiver Program Services That Were Not in Accordance With an Approved Plan of Care and Did Not Meet Documentation Requirements

What OIG Found

During 8 of 100 sampled beneficiary-months, New York claimed Medicaid reimbursement for some B2H waiver program services that did not comply with Federal and State requirements. Specifically, services were not provided in accordance with the beneficiary's plan of care (four beneficiary-months), provider documentation did not support services billed (three beneficiary-months), and services were not provided in accordance with an approved level-of-care assessment (one beneficiary-month). In addition, during 32 beneficiary-months, New York claimed Medicaid reimbursement for B2H waiver program services in excess of the monthly allotment of services authorized in the associated beneficiaries' plans of care.

On the basis of our sample results, we estimated that New York improperly claimed at least \$614,530 in Federal Medicaid reimbursement for services that did not comply with certain Federal and State requirements and claimed \$3.3 million in Federal Medicaid reimbursement for services that exceeded the monthly allotment of services authorized in beneficiaries' plans of care.

What OIG Recommends and New York's Comments

We recommend that New York (1) refund \$614,530 to the Federal Government; (2) work with CMS to develop guidance through The Children's Waiver on claiming Federal Medicaid reimbursement for HCBS according to the monthly allotment authorized in beneficiaries' plans of care, which could have reduced or eliminated an estimated \$3.3 million in payments made during our audit period; and (3) ensure providers claim Federal Medicaid reimbursement only for services in accordance with beneficiaries' plans of care and maintain the required documentation to support claims for services provided and level-of-care assessment approvals, according to the provisions in The Children's Waiver.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our first and second recommendations, generally agreed with our third recommendation, and described actions that it had taken or planned to take to increase its oversight of HCBS provided under The Children's Waiver. After reviewing New York's comments and additional documentation provided under separate cover, we revised our findings and related recommendations. We maintain that our findings and recommendations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

During prior Office of Inspector General (OIG) reviews, we determined that the New York State Department of Health (State agency) claimed Medicaid reimbursement for home and community-based services (HCBS) under Medicaid waiver programs that did not comply with Federal requirements.¹

OBJECTIVE

Our objective was to determine whether the State agency claimed Medicaid reimbursement for Bridges to Health (B2H) waiver program services in accordance with certain Federal and State requirements.

BACKGROUND

The Medicaid Program

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 applicable Federal requirements.

Home and Community-Based Services Waivers

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

¹ *New York's Claims for Medicaid Nursing Home Transition and Diversion Waiver Program Services Generally Complied With Federal and State Requirements but Had Reimbursement Errors That Resulted in a Minimal Amount of Overpayments (A-02-17-01005)*, issued July 2, 2019; and *Some of New York's Claims for Medicaid Long-Term Home Health Care Program Waiver Services Were Unallowable (A-02-13-01030)*, issued April 7, 2016.

New York's Bridges to Health Waiver Program

In New York, the State agency administers the Medicaid program, including services that were provided under its B2H waiver program (an HCBS waiver program).² The B2H waiver program was administered by the State agency through provider agreements between its Office of Children and Family Services (OCFS) and not-for-profit health care integration agencies (case management agencies) that provide operational and administrative functions.

The B2H waiver program used Medicaid funding to provide supports and services to children in foster care who have significant mental health or developmental disabilities, or health care needs, with services to help them live in a home or community-based setting. Specifically, it helped improve the health and well-being of these children and avoid, delay, or prevent medical institutional care. Children were initially eligible to participate in the B2H waiver program if they were in foster care, were Medicaid-eligible, had a qualifying diagnosis, and met level-of-care and age requirements.

Case management agencies worked with local departments of social services to make referrals to the B2H waiver program, eligibility determinations, and enrollment decisions. Once children were enrolled, a Child and Adolescent Needs and Strengths (CANS) assessment was performed to assist in the development of the plan of care and to measure children's outcomes based on waiver program services provided. B2H waiver program services were required to be furnished under a written plan of care approved by the appropriate local department of social services. B2H waiver program services (e.g., crisis response) are provided either directly by the case management agencies or through contracted waiver service providers. Further, case management agencies may increase the annual allotment of certain previously authorized waiver services in beneficiaries' plans of care after notifying the local department of social services.

HOW WE CONDUCTED THIS REVIEW

Our review covered the State agency's claims for Medicaid reimbursement for HCBS provided under its B2H waiver program during calendar years (CYs) 2015 through 2017 (audit period).³ During this period, the State agency claimed approximately \$297 million (\$149 million Federal share) for B2H waiver program services provided during 105,703 beneficiary-months. Of these claims, we reviewed a random sample of 100 beneficiary-months. A beneficiary-month is defined as all B2H waiver program services for a beneficiary during 1 month.

² The program, which was discontinued as of April 1, 2019, and combined with other waiver programs into a comprehensive child-focused waiver known as The Children's Waiver (CMS Waiver Number NY.4125; accessed at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_waivers_application_ny_4125_r05_02.pdf on August 29, 2019), consisted of separate waivers for children with serious emotional disturbances, children with developmental disabilities, and medically fragile children. The three waivers are collectively referred to as the B2H waiver program.

³ B2H waiver program claims data during CYs 2015 through 2017 was the most recent data available at the start of the audit.

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 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 State agency's claims for some B2H waiver program services did not comply with Federal and State requirements. Of the 100 beneficiary-months in our sample, the State agency properly claimed Medicaid reimbursement for all B2H waiver program services during 60 beneficiary-months. However, the State agency claimed reimbursement for some unallowable B2H waiver program services during eight beneficiary-months. Specifically, services were not provided in accordance with the beneficiary's plan of care (four beneficiary-months), provider documentation did not support services billed (three beneficiary-months), and services were not provided in accordance with an approved level-of-care assessment (one beneficiary-month). In addition, during the remaining 32 beneficiary-months, the State agency claimed reimbursement for B2H waiver program services in excess of the monthly allotment of services authorized in the associated beneficiaries' plans of care. If services provided are not aligned with beneficiaries' plans of care and CANS assessments, they may negatively impact beneficiaries' progress and outcomes.⁴

These deficiencies occurred because the State agency did not ensure that providers claimed reimbursement only for services in accordance with beneficiaries' plans of care and maintained documentation to support claims for services provided and a level-of-care assessment approval. Specifically, providers lacked proper oversight to ensure that plans of care were approved or any justification for changes to the plans of care were maintained in the beneficiaries' case files. Further, providers did not properly store or archive documentation to support B2H waiver services provided and a level-of-care assessment approval. In addition, the State agency did not require providers to bill B2H waiver program services according to the monthly allotment authorized in beneficiaries' plans of care. The State agency also did not ensure that there was documented communication (e.g., team meeting notes) between case management agencies

⁴ We are not questioning the associated Medicaid reimbursement claimed for these services because the B2H waiver program does not clarify billing for units above approved monthly unit amounts.

and local departments of social services before the case management agencies increased beneficiaries' annual allotment of waiver services in the beneficiaries' plans of care.⁵

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$614,530 in Federal Medicaid reimbursement for B2H waiver program services that did not comply with certain Federal and State requirements.⁶ In addition, we estimated that the State agency claimed \$3,281,635 in Federal Medicaid reimbursement for B2H waiver program services in excess of the monthly allotment of services authorized in beneficiaries' plans of care.

NEW YORK CLAIMED REIMBURSEMENT FOR UNALLOWABLE BRIDGES TO HEALTH WAIVER PROGRAM SERVICES

Services Not Provided in Accordance With an Approved Plan of Care

B2H waiver program services were required to be furnished under a written plan of care subject to approval by the State agency.⁷ In addition, in its waiver agreements with CMS, New York stated that all B2H waiver program services would be furnished pursuant to a written plan of care and that Federal financial participation would not be claimed for services not included in the plan of care. The plan of care must have specified the services to be provided, their frequency, and the type of provider.⁸ Local departments of social services were responsible for reviewing and authorizing each beneficiary's plan of care.

During four sampled beneficiary-months, the State agency claimed reimbursement for B2H waiver program services not provided in accordance with the beneficiary's plan of care. Specifically, providers claimed reimbursement for services that were not authorized in the plan of care (three beneficiary-months) and for which there was a lapse in approved plans of care (one beneficiary-month).⁹

⁵ According to the State agency's *B2H HCBS Medicaid Waiver Program Manual* (January 2011), pages 4-12, 6-5, 9-2 and 9-8, the case management agency must convene a team meeting and submit a revised plan of care to the local department of social services. We accepted any documented communication that notified the local department of social services of the case management agency's decision to increase beneficiaries' annual allotment of waiver services.

⁶ We estimated that the State agency was overpaid \$4,572,178; however, to account for the precision of our design, we are only recommending recovery of \$614,530, which is the lower limit of a two-sided 90 percent confidence interval.

⁷ 42 CFR § 441.301(b)(1)(i).

⁸ CMS's *State Medicaid Manual* § 4442.6.

⁹ We only questioned the services that were provided during the lapse of time.

Provider Documentation Did Not Support Services Billed

Expenditures are allowable if supported by adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (CMS's *State Medicaid Manual* § 2497.1). B2H waiver program service providers must submit service summary forms that document services provided and support services billed.¹⁰ The forms must be signed by the provider and submitted to the supervisor of the associated beneficiary's case management agency.¹¹

During three sampled beneficiary-months, the State agency claimed reimbursement for some B2H waiver program services for which service summary forms were not signed by the service provider (two beneficiary-months) or not provided (one beneficiary-month).

Services Not Provided in Accordance With an Approved Level-of-Care Assessment

To be eligible for HCBS, a beneficiary's plan of care must include a level-of-care assessment that includes the services needed to prevent the beneficiary from requiring institutionalization. Each beneficiary receiving HCBS must also have periodic reevaluations, at least annually, to determine whether the beneficiary continues to need the level of care provided.¹² For HCBS provided under the B2H waiver program, the level-of-care assessment was required to be approved by the local department of social services.¹³

During one sampled beneficiary-month, the State agency claimed reimbursement for B2H waiver program services when the beneficiary's level-of-care assessment was not approved by the local department of social services.¹⁴

BRIDGES TO HEALTH WAIVER PROGRAM SERVICES EXCEEDED THE MONTHLY ALLOTMENT OF SERVICES AUTHORIZED IN PLAN OF CARE

HCBS services must be furnished under a written plan of care subject to approval by the State agency.¹⁵ A plan of care must specify the services to be provided, their frequency, and the type of provider (CMS's *State Medicaid Manual* § 4442.6). The State agency's manual for B2H waiver

¹⁰ The State agency's *B2H HCBS Medicaid Waiver Program Manual* (January 2011), page 13-2.

¹¹ The State agency's *B2H HCBS Medicaid Waiver Program Manual* (January 2011), page 6-8.

¹² 42 CFR § 441.302(c).

¹³ New York's B2H waiver for children with developmental disabilities (CMS waiver number 0470.R01.00), Appendix B-6(f).

¹⁴ The beneficiary was enrolled under New York's B2H waiver for children with developmental disabilities during our sampled beneficiary-month.

¹⁵ 42 CFR § 441.301(b)(1)(i).

program providers stated that a detailed service plan must be included in the plan of care and include a CANS assessment that determines the beneficiary's needs.¹⁶ These CANS assessments directly related to the B2H waiver services that should have been provided and their associated frequency.¹⁷ If the case management agency increases and provides already authorized services to a beneficiary, it must convene a team meeting and submit a revised plan of care to the local department of social services.¹⁸

During 32 sampled beneficiary-months, the State agency claimed reimbursement for B2H waiver program services that exceeded the monthly allotment of services authorized in beneficiaries' plans of care. For example, one beneficiary's plan of care indicated that he should receive a maximum of 3 hours of crisis management each month; however, the provider billed for 6 hours of crisis management during the sampled month. The same beneficiary's plan of care indicated that he should receive a maximum of 5 hours of special needs support services each month; however, the provider billed for 8 hours of special needs support services in the sampled month. In addition, there was no documented communication between case management agencies and local departments of social services before beneficiaries' annual allotment of waiver services was increased in the beneficiaries' plans of care.

The State agency did not require providers to bill B2H waiver program services according to the monthly allotment authorized in beneficiaries' plans of care. Additionally, the State agency did not ensure that there was documented communication between providers and local departments of social services before they increased beneficiaries' annual allotment of waiver services in the beneficiaries' plans of care. As a result, excess waiver services were being provided before beneficiaries' annual allotments of waiver services in the beneficiaries' plans of care were increased. Specifically, the State agency indicated that, as long as the number of services billed by providers was less than the plan of care's annual allotment of services, the providers could exceed monthly allotments authorized in the plan of care, regardless of when the annual allotment of services was increased. As a result, beneficiaries received services that did not align with their plans of care and CANS assessments, which may negatively impact their progress and outcomes.

RECOMMENDATIONS

We recommend that the New York Department of Health:

- refund \$614,530 to the Federal Government;

¹⁶ The State agency's *B2H HCBS Medicaid Waiver Program Manual* (January 2011), page 2-9.

¹⁷ For example, one beneficiary was determined to need crisis management services based on a score of "1" in a section of the CANS assessment. Also, based on this score, the State agency determined that the frequency and duration of the crisis management services needed would be 3 hours per month.

¹⁸ The State agency's *B2H HCBS Medicaid Waiver Program Manual* (January 2011), pages 4-12, 6-5, 9-2, and 9-8.

- work with CMS to develop guidance through The Children’s Waiver on claiming Federal Medicaid reimbursement for HCBS according to the monthly allotment authorized in beneficiaries’ plans of care, which could have reduced or eliminated an estimated \$3,281,635 in payments made during our audit period; and
- ensure providers claim Federal Medicaid reimbursement only for services in accordance with beneficiaries’ plans of care and maintain the required documentation to support claims for services provided and level-of-care assessment approvals, according to the provisions in The Children’s Waiver.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our first and second recommendations, generally agreed with our third recommendation, and described actions that it had taken or planned to take to increase its oversight of HCBS provided under The Children’s Waiver. Under separate cover, the State agency provided additional documentation related to six beneficiary-months that we identified in our draft report as containing some unallowable B2H waiver program services.

Additionally, the State agency indicated that HCBS waiver provisions covering the B2H program during our audit period stated that units for waiver services billed adhered to annual service budgets—not monthly maximum service limits. The State agency indicated that CMS recently approved an amendment to The Children’s Waiver to have HCBS (which includes the B2H program) covered under the State agency’s managed care program. The State agency explained that this change will ensure proper oversight of services being provided according to beneficiaries’ plans of care, along with ensuring that required documentation to support claims for services provided and level-of-care assessment approvals are maintained. Finally, the State agency indicated that it will continue to work with CMS to develop policies, procedures, and internal controls guidance on appropriately claiming Federal Medicaid reimbursement for services provided through The Children’s Waiver. The State agency’s comments appear in their entirety as Appendix D.

Based on our review of the State agency’s comments and additional documentation provided, we revised our findings and related recommendations for two beneficiary-months.¹⁹ Specifically, for one beneficiary-month, the State agency provided the missing section of the beneficiary’s plan of care that detailed the approved waiver services. For the other beneficiary-month, the State agency provided documentation that the beneficiary’s plan of care was appropriately approved. We maintain that our findings and recommendations, as revised, are valid.

¹⁹ We are continuing to question one of the two sampled beneficiary-months because it contained multiple deficiencies.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered the State agency's claims for Medicaid reimbursement for HCBS provided under its B2H waiver program during CYs 2015 through 2017 (audit period). This was the most recent B2H waiver program claims data available at the start of our audit. During this period, the State agency claimed approximately \$297 million (\$149 million Federal share) for B2H waiver program services provided during 105,703 beneficiary-months. Of these claims, we reviewed a random sample of 100 beneficiary-months. A beneficiary-month is defined as all B2H waiver program services for a beneficiary during 1 month.

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for B2H waiver program services claimed for reimbursement. We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. We reviewed the case management agencies' and providers' internal controls for documenting B2H waiver program services billed and claimed for reimbursement. We did not assess the appropriateness of HCBS payment rates.

We performed fieldwork at the State agency's office in Albany, New York, and at 27 case management agencies and providers throughout New York State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- met with CMS financial and program management officials to gain an understanding of the B2H waivers' approval, administration, and assessment processes;
- met with State agency officials to discuss the State's administration and monitoring of the B2H waiver program;
- obtained from New York's Medicaid Management Information System (MMIS) a sampling frame of 105,703 beneficiary-months for B2H waiver services for which the State agency claimed reimbursement totaling \$296,933,956 (\$149,021,836 Federal share) during our audit period;
- reconciled the B2H waiver services that the State agency claimed for Federal Medicaid reimbursement on the Form CMS-64, *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program*, to the sampling frame of all payments for B2H waiver services obtained from New York's MMIS file for our audit period;

- selected a random sample of 100 beneficiary-months from our sampling frame, and for each beneficiary-month:
 - determined whether the beneficiary was assessed to be eligible for the B2H waiver program,
 - determined whether services were provided in accordance with an approved plan of care and level-of-care assessment, and
 - determined whether documentation supported services billed;
- estimated the total unallowable Federal Medicaid reimbursement in the sampling frame of 105,703 beneficiary-months;
- estimated the total Federal Medicaid reimbursement claimed in excess of the monthly allotment of services authorized in the associated beneficiaries' plans of care in the sampling frame of 105,703 beneficiary-months; and
- discussed the results of the review with State agency officials.

See Appendix B for 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

TARGET POPULATION

The population consisted of beneficiary-months of service provided under New York's B2H waiver program for which the State agency received Medicaid reimbursement during the audit period. A beneficiary-month is defined as all B2H waiver program services for a beneficiary during 1 month.

SAMPLING FRAME

The sampling frame was an Access database containing 105,703 beneficiary-months totaling \$296,933,956 (\$149,021,836 Federal share) for which the State agency received Medicaid reimbursement for B2H waiver services provided during the audit period. We extracted the data for the beneficiary-months from the New York MMIS.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the 105,703 beneficiary-months. After generating 100 random numbers, we selected the corresponding beneficiary-months in the frame for our sample.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicaid overpayments for which the State agency claimed reimbursement for unallowable B2H waiver program services. We also used this software to estimate the total value of services in excess of the

monthly allotted units. For each estimate, we calculated a point estimate and a two-sided 90-percent confidence interval.

To be conservative, we recommend recovery of overpayments made to the State agency for unallowable B2H waiver program services using the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE DETAILS AND RESULTS

Table 1: Sample Details and Results for Beneficiary-Months with Unallowable Services (Federal Share)

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	No. of Beneficiary-Months With Unallowable Services	Value of Unallowable Services
105,703	\$149,021,836	100	\$140,556	8	\$4,326

Table 2: Sample Details and Results for Beneficiary-Months with Services in Excess of the Monthly Allotted Units (Federal Share)

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	No. of Beneficiary-Months With Services in Excess of the Monthly Allotted Units	Value of Services in Excess of the Monthly Allotted Units
105,703	\$149,021,836	100	\$140,556	32	\$3,105

ESTIMATES

**Table 3: Estimated Value of Unallowable Services (Federal share)
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$4,572,178
Lower limit	\$614,530
Upper limit	\$8,529,826

**Table 4: Estimated Value of Services in Excess of the Monthly Allotted Units (Federal share)
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$3,281,635
Lower limit	\$2,056,441
Upper limit	\$4,506,830

APPENDIX D: STATE AGENCY COMMENTS



ANDREW M. CUOMO
Governor

Department
of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 9, 2019

Ms. Brenda Tierney
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-02-18-01003

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-18-01003 entitled, "New York Improperly Claimed Medicaid Reimbursement for Some Bridges to Health Waiver Program Services That Were Not in Accordance With an Approved Plan of Care and Did Not Meet Documentation Requirements."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Geza Hrazdina
Dan Duffy
Jeffrey Hammond
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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-02-18-01003 entitled,
“New York Improperly Claimed Medicaid Reimbursement for Some
Bridges to Health Waiver Program Services That Were Not in
Accordance With an Approved Plan of Care and Did Not Meet
Documentation Requirements”**

The following are the New York State Department of Health’s (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-18-01003 entitled, “New York Improperly Claimed Medicaid Reimbursement for Some Bridges to Health Waiver Program Services That Were Not in Accordance With an Approved Plan of Care and Did Not Meet Documentation Requirements.”

Recommendation #1:

Refund \$2,259,580 to the Federal Government.

Response #1:

The Office of Children and Family Services (OCFS) staff reviewed the findings and contacted the Healthcare Integration Agencies and Local Departments of Social Services to determine if the missing information or documentation was available to support services provided to recipients. As soon as OCFS has concluded gathering and organizing that documentation, OCFS will provide it to the OIG. OCFS believes that information will substantially reduce the calculated refund amount.

Recommendation #2:

Work with CMS to develop guidance through The Children’s Waiver on claiming Federal Medicaid reimbursement for HCBS according to the monthly allotment authorized in beneficiaries’ plans of care, which could have reduced or eliminated an estimated \$3,281,635 in payments made during our audit period.

Response #2:

During the period reviewed by the OIG, the Bridges to Health (B2H) program was operating under two 1915 (c) Home and Community Based Services (HCBS) Waiver Reauthorization periods. The first was approved by CMS with an effective date of January 1, 2011 through September 30, 2017 and makes no reference to monthly maximum service limits, only annual service budgets. The second waiver, which was approved by CMS with an effective date of October 1, 2017 through March 31, 2019, states: “The maximum allowed number of service units . . . are capped by the Bridges to Health annual budget at \$51,600 for each enrolled child . . .”

The Department has been in continuous discussions with the Centers for Medicare & Medicaid Services (CMS) regarding the new 1915(c) consolidated Children’s Waiver which began April 1, 2019. CMS has recently approved an amendment to the Children’s Waiver to have HCBS carved into Medicaid Managed Care Plans (MMC). A process has already been developed to ensure oversight and monitoring of a member’s plan of care and access to such services. MMCs will have oversight to ensure that services are being provided as outlined in the plan of care and will provide utilization review of the HCBS and payment to the providers based upon the services provided.

OCFS will work with the Department and CMS to develop guidance and internal controls on claiming Federal Medicaid reimbursement to reduce or eliminate misunderstandings regarding the intent of the Children's Waiver.

Recommendation #3:

Ensure providers claim Federal Medicaid reimbursement only for services in accordance with beneficiaries' plans of care and maintain the required documentation to support claims for services provided and level-of-care assessment approvals, according to the provisions in The Children's Waiver.

Response #3:

The HCBS level-of-care (LOC) Eligibility Determination must occur prior to HCBS being provided. This determination is now performed in a system called the Uniform Assessment System whereas previously the B2H program was paper generated. The MMC, the lead Health Home, and State agencies all have access to this system to confirm a member's eligibility and the member's acceptance of services. Additionally, a HCBS plan of care workflow policy has been developed that incorporates the Health Home or the Independent Entity of Children and Youth Evaluation Services verification of HCBS LOC eligibility and referrals to HCBS providers and then HCBS providers providing information to the MMC to seek authorization of HCBS. All information is entered in the Health Home plan of care, which is reviewed and utilized by the Health Home care team, all involved community providers including HCBS providers, and the MMC, to ensure compliance with the plan of care and services being delivered for payment.

The HCBS LOC Eligibility Determination does not specify the type, level or specific services the member should receive. Once a member is found eligible for HCBS, a person-centered plan of care is developed based upon the review of the member's needs and then by choice of the family and member for whom the services will be referred.

OCFS will work with the Department and the CMS to develop policies, procedures, and internal controls to ensure providers claim Federal Medicaid reimbursement only for services in accordance with beneficiaries' plans of care and maintain the required documentation to support claims for services provided and level-of-care assessment approvals, according to the provisions in the Children's Waiver.