OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

Department of Health

Enhanced Medicaid Payments to Selected Home Health Care Service Providers

2009-S-25

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

September 24, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Albany, New York 12237

Dear Dr. Daines:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of Enhanced Medicaid Payments to Selected Home Health Care Service Providers. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution, and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

EXECUTIVE SUMMARY

Audit Objective

The objective of our audit was to determine whether selected home health care providers properly used the supplementary Medicaid funds they received for the recruitment, training and retention of direct care staff. Our objective was also to determine whether the Department of Health was effectively overseeing this funding. Our audit covered the period June 1, 2006 through August 25, 2009.

Audit Results-Summary

Home health care services enable individuals with certain medical conditions to continue living at home and avoid costly institutional care. In accordance with an amendment to the State's Public Health Law, between 2006 and 2011, an additional $500 million in Medicaid funding is to be paid to organizations that provide certain home health care services to Medicaid recipients. The providers are to use these supplementary funds to improve their recruitment, training and retention (RTR) of direct care staff in order to meet more of the demand for home care services.

We visited a sample of the providers to determine whether they are using their $39 million of RTR funds as intended. We found indications that the providers we visited are using some of the funds, at least, for the recruitment, training and retention of direct care staff, as intended. However, we were unable to fully account for their use of RTR funds, because their RTR funds are commingled with their other funds and are not accounted for separately from the other funds. As a result, there is inadequate assurance that these providers are, in fact, using all their RTR funds for their intended purposes. Additionally, the Department disbursed the RTR funds to the providers retroactively due to delays in federal approval. However, one provider we visited reported that they began spending the RTR funds before receiving the funds. These timing differences between when funds are received and reportedly spent further reduce effective accountability over the funds.

We attribute these deficiencies to the Department providing insufficient guidance to the providers, and weak oversight of providers' use of the funds. To promote accountability for RTR funds, we recommend that the Department monitor the providers to ensure they separately track the use of RTR funds (e.g., a provider's RTR receipts and disbursements could be coded to distinguish them from non-RTR receipts and disbursements). We also recommend that the Department provide detailed guidance to the providers on the allowable uses of RTR funds and proper methods for determining the amount of funds spent on RTR activities. The providers we visited indicated that

such guidance would be welcome, because it was not always clear how the funds could be used. We further recommend that the Department strengthen its oversight of RTR funds, as it did not always follow up with providers when they failed to submit a required statistical report describing their use of the funds and it did not require all the providers to submit such a report.

Our report contains a total of four recommendations for improving the Department of Health's oversight of RTR funds and for providing assurance that the funds are, in fact, being used as intended. Department officials agreed with our recommendations.

This report, dated September 24, 2010, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Introduction

Background

Home health care services are services that enable individuals with certain medical conditions to continue living at home and avoid costly institutional care. The services range from skilled nursing care to everyday housekeeping assistance. Many of these services are eligible for reimbursement in New York State's Medicaid program at rates approved by the Department of Health (Department).

Home health care services are often provided by organizations that hire or contract with home health aides and other such caregivers. To improve these organizations' ability to hire and retain such direct care staff, New York State amended its Public Health Law (section 3614.9-10) effective June 1, 2006 to increase the Medicaid funding that is provided in support of such staff.

Specifically, for the period June 1, 2006 through March 31, 2011, an additional $500 million in Medicaid funding is to be paid to organizations that provide certain home health care services to Medicaid recipients, and the organizations are to use these supplementary funds to improve their recruitment, training and retention (RTR) of direct home health care staff (i.e., not administrative or supervisory staff).

The total $500 million in supplementary RTR funding is to be paid out in various allotments covering specific time periods. The first $50 million was to cover the seven months ended December 31, 2006, the second $50 million was to cover the six months ended June 30, 2007, and the remaining $400 million is to be divided into four $100 million allotments covering the following time periods:

Time Period	**Amount (millions)**
7/1/07 to 3/31/08	$100
4/1/08 to 3/31/09	$100
4/1/09 to 3/31/10	$100
4/1/10 to 3/31/11	$100

Each funding allotment is to be divided among the eligible home health care providers in a proportional manner, on the basis of the amount of home health care services provided by each organization during the period. For example, if a total of 100,000 hours of eligible home health care services is provided during an allotment period, an organization providing 10 percent of these hours is to receive 10 percent of the total supplemental funding for the period.

The Department is to calculate the amount of supplemental RTR funding to be paid to each eligible home health care provider, and make the payments to each provider. The payments were made in lump sums as soon as possible after the end of each allotment period. The payments for the first two allotment periods ($50 million for the seven months ended December 31, 2006, and $50 million for the six months ended June 30, 2007) were combined, and were made in August 2007. The payments for the third allotment period ($100 million for the period July 1, 2007 through March 31, 2008) were made in January 2009. According to Department officials, the payments for the first and third allotment periods were delayed because of approval delays at the federal level.

In accordance with the Public Health Law, the Department is responsible for ensuring that the providers use the supplemental funding solely for the recruitment, training and retention of appropriate direct care staff. The Department is authorized by the Law to audit the providers for compliance with this requirement and recover any funds not used for the purposes specified by the Law. The providers are also required to submit written certifications to the Department attesting that they will use the funds only for the purposes specified in the Law.

In addition, if the providers contract with any licensed home care service agencies to provide home care services to Medicaid recipients, they are required by the Public Health Law to pass their RTR funding on to the contracted agencies in proportion to the amount of services they provide. The contracted agencies are required to submit written certifications to the providers attesting that they will use the funds for their intended purposes. Contracted agencies must also maintain expenditure plans specifying how the funds will be used.

Audit Scope and Methodology

We audited the $50 million of supplemental RTR funding that covered the six month allotment period ended December 31, 2006 and the $50 million of supplemental RTR funding that covered the six month allotment period ending June 30, 2007. We evaluated the Department's oversight of the use of this $100 million in RTR funding. In addition, we judgmentally selected the two home health care provider organizations that received the largest amounts of this RTR funding and examined their use of the funds. These two provider organizations together received more than $39 million of the $100 million in RTR funds and each are "parent" organizations that operate multiple home health care service agencies. In addition, we judgmentally selected four home health care service agencies that contracted with one or both of the two provide organizations to examine their use of RTR funds. We also surveyed one additional provider organization to assess its methods for accounting for RTR funds. Our audit covered the period June 1, 2006 through August 25, 2009. Our objectives were to determine whether the

Department was effectively overseeing RTR funding and whether the selected provider and service agency organizations were appropriately using RTR funding for its intended purposes

To accomplish our objectives, we reviewed the applicable sections of the Public Health Law. We also interviewed Department officials and reviewed Department policies, procedures and records. In addition, we visited the two selected home health care providers and four selected licensed home care service agencies, and interviewed officials and reviewed records at these six entities. We did not review the use of the $100 million in RTR funding that was paid out in January 2009, because there was limited documentation of the use of these funds at the time of our audit.

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

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

We performed this audit pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

A draft copy of the matters discussed in this report were provided to Department officials for their review and comment. We have considered their comments in preparing this audit report and they are included in their entirety at the end of this report. Our rejoinders to Department official's comments are included thereafter in our State Comptroller's Comments. Department official's generally agreed with our recommendations.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health

shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Contributors to the Report

Major contributors to this report include Steven Sossei, Marty Chauvin, Steve Goss, Paul Alois, Kathleen Hotaling, Wendy Matson, Laurie Burns, Constance Walker, Sally Perry, Natalie Sherman, Trina Clarke, Jonathan Bernstein, and Dana Newhouse.

Audit Findings and Recommendations

Use of RTR Funding By Selected Providers

In August 2007, the Department paid out the first installment of supplemental RTR Medicaid funds, paying 223 home health care providers a total of $100 million in such funds. In accordance with the Public Health Law, the amounts paid to each provider were based on the number of hours of home health care services provided during the period June 1, 2006 through June 30, 2007. The providers were required by the Law to use the funds for certain authorized purposes only (i.e., to improve their recruitment, training and retention of direct care staff).

To determine whether the funds were being used as intended, we selected a sample of two organizations that operate a total of nine providers and visited them to review their records. We selected the two organizations because they received a significant portion of the total $100 million in RTR funding, as follows:

Provider Organization	RTR Funds
Visiting Nurses Services of New York (VNS)	$29,348,533
Metropolitan Jewish Health System (Metropolitan)	$ 9,838,372
Total	$39,186,905

According to VNS's records, during the period covered by the funding (June 1, 2006 through June 30, 2007), it contracted with several licensed home care service agencies and most of the home care services provided to its Medicaid recipients were provided by these agencies. Accordingly, $19.8 million of VNS's $29.3 million in RTR funding was reportedly passed on to these agencies and the remaining $9.5 million was reportedly retained for direct use by VNS.

Similarly, according to Metropolitan's records, during the period covered by the funding, most of the home care services provided to its Medicaid recipients were provided by contracted home care agencies, and as a result, most of Metropolitan's RTR funding for the period was reportedly passed on to these agencies. However, Metropolitan's records combine RTR funds with similar Medicaid funds that are also for recruitment and retention, and are for varying time periods. Therefore, we could not isolate the amount of the RTR funds passed on to the contracted agencies and the amount it spent related to its own direct care staff for the specific RTR allocations subject to audit. The records report that it passed on about $14.2 million to the agencies for the period June 1, 2006 through June 30, 2007, and directly spent about $3.1 million for the calendar year 2007, which exceeded the RTR funds it received.

We reviewed the records at VNS and Metropolitan to determine whether they used RTR funding for the recruitment, training and retention of direct care staff, as required by the Public Health Law. We found indications that at least some of the funds were used for these purposes. For example, officials at both providers told us that RTR funds were used to support pay raises for direct care staff, thus improving recruitment and retention efforts, and payroll records at both providers showed that direct care staff did, in fact, receive pay raises in the months before and after the RTR funds were received (both providers retroactively applied RTR funds to expenses that were incurred before the funds were received, and applied RTR funds to expenses that were incurred after the funds were received).

However, we were unable to determine what portion of the pay raises and other claimed RTR expenditures were, in fact, supported by RTR funds, because RTR funds are not separately accounted for at either provider. Rather, RTR funds are commingled with the providers' other funds, and the providers calculate the portion of expenses they attribute to RTR funds. Therefore, the total amounts of RTR funds reportedly spent cannot be readily verified with expenditure records such as payrolls and payments to the contracting agencies. In the absence of such records, we were unable to precisely account for the use of all the RTR funds at either VNS or Metropolitan.

To promote accountability for RTR funds, we recommend the Department establish a process for tracking the use of the funds. For example, if a provider's RTR funds were commingled with its other funds, the provider could use a special code to distinguish RTR receipts and disbursements from other receipts and disbursements. This code would then enable the provider to track its RTR receipts and disbursements separately in its accounting records. The Department currently requires that an annual cost report be submitted by the providers showing their total receipts and expenditures for all funds. However, disbursements for RTR funds and other special Medicaid funds are not accounted for separately on this report, which is used for Medicaid rate-setting purposes.

We also reviewed the records at VNS and Metropolitan to verify that RTR funds were, in fact, passed on to their contracted home health agencies, as required by the Public Health Law. At both providers, we found indications that some RTR funds were passed on to the contracted agencies. For example, documents at both providers stated that RTR funds would be used to increase the contracted agencies' hourly reimbursement rates and other documents indicated that the agencies' hourly reimbursement rates did, in fact, increase between June 1, 2006 and December 31, 2008.

However, in the absence of accounting records precisely showing how RTR funds were passed onto the service agencies, we could not confirm whether reported amounts had, in fact, been passed on to the contracted agencies and were responsible for increases in reimbursement rates. In addition, there were inconsistencies in VNS's records that further reduced our ability to account for the RTR funds (e.g., one set of VNS records stated that RTR funds were used to increase the hourly reimbursement rates in 2007 of three of the four contracted agencies we visited by 71, 87 and 56 cents, respectively, while letters from VNS to the agencies stated that their RTR funding increases for that year were 44, 33 and 31 cents per hour, respectively).

We also noted that the methodology used by VNS and Metropolitan to calculate how much RTR funds they passed on to the contracted agencies varied. For example, VNS attributed about 75 percent of the hourly rate increase to RTR and the remaining 25 percent to a Medicaid cost of living increase that would have been paid to the agencies even if the RTR funds were not received. In contrast, Metropolitan attributed the whole rate increase to RTR funds. Metropolitan officials told us that the Department should develop a standard methodology for the providers to use.

We also reviewed the records at four of the home health agencies that contracted with VNS and/or Metropolitan to determine whether they used their RTR funds for the recruitment, training and retention of direct care staff, as required by the Public Health Law. VNS reportedly disbursed $12.6 million of the $29.3 million it received in RTR funds to the four contracting agencies. Metropolitan, which combined RTR funds with similar Medicaid funds, reportedly disbursed $3.2 million of these funds to two of the agencies.

At three of the four contracting agencies, we found indications that some of the RTR funds from VNS and Metropolitan were used for the recruitment, training and retention of direct care staff, as required. Generally, officials at the four agencies told us that these RTR funds were used to support pay raises and health insurance benefit enhancements for direct care staff, and payroll and other records at three agencies showed that direct care staff did, in fact, receive pay raises and health insurance benefit enhancements in the months before and after the funds were received.

However, we could not determine whether the RTR funds were solely responsible for the pay increases and benefit enhancements and whether the entire amounts claimed had, in fact, been used for the purposes claimed, because RTR funds are not separately accounted for at any of the agencies. Rather, as is the case at VNS and Metropolitan, the RTR funds at the four home health agencies are commingled with the agencies' other funds.

We also note that some of the pay raises were negotiated well before the RTR funds were received, and as a result, it appears that the agencies may have planned to pay for these raises with other funds, such as Medicaid funds that are provided for cost of living increases. In fact, at one of the contracted agencies, we were told that they have no way of telling which employee raises were supported by RTR funds and which were supported by other funds. This agency had difficulty producing records to substantiate the expenditure of RTR funds.

In addition, at three of the contracted agencies, we identified inconsistencies between the amounts VNS reportedly passed on to the agencies and the amounts the contracted agencies reportedly received from VNS. For example, VNS reported that it passed on $1,641,014 in RTR funding to one of the agencies for the period June 1, 2006 through June 30, 2007, but a document at the agency stated that it received $1,999,440 from VNS for this period. Such inconsistencies further reduce our ability to account for the funds.

Three of the four home health agencies contract with other providers and may have received RTR funds from them. One contracted agency reportedly contracted with a total of 29 providers. We did not attempt to account for the contracted agencies' use of this other RTR funding. However, the fact that service agencies receive RTR funds from multiple providers only serves to further highlight the need for an accurate accountability over the receipt and use of all RTR funds.

Officials at both VNS and Metropolitan acknowledged the difficulty of accounting for their use of RTR funds. They noted that it can even be difficult to determine how much RTR funding they are actually receiving, because the lump sum RTR payments from the Department are usually commingled with the Medicaid service payments and other special payments and it can take significant hours to calculate the RTR portion. Another provider we surveyed estimated that one person spent nearly a week determining how much RTR money it received, and another week to prepare documentation of how the RTR funds were spent. One provider further noted that receiving the funding retroactively places them in the difficult position of justifying how the funds are spent retroactively. They said that clear direction from the Department would be helpful. One provider said the RTR funding process was very confusing and it was difficult to get clear direction from the Department in response to questions about the funding.

The officials also noted that the intermittent and retroactive nature of the funding makes it difficult to budget for RTR expenditures and sometimes makes it necessary to use other funds to "front" RTR expenses. For

example, if subsequent RTR payments are not approved timely by the federal government, the Department must undo the rate enhancement, and then reinitiate it when the approval is received. The officials also stated they believe they are spending more on RTR-type activities than they are receiving in RTR funding. VNS told us that they pay the increased rates to contracted agencies for both Medicaid and non-Medicaid services. Similarly, the contract agencies told us that they pay higher wages for both Medicaid and non-Medicaid services they provide.

Recommendation

1. Establish a process for tracking the receipt and use of RTR funding for all recipients.

Department Oversight

The Department is responsible for ensuring that RTR funds are used solely for the recruitment, training and retention of direct home health care staff. We examined the actions taken by the Department in fulfilling this responsibility.

The Department notifies all home health care providers receiving RTR funding that information about the funding, and the requirements relating to the funding, is available on its web site. We reviewed the information on the web site and found that it effectively explains the nature of RTR funding and fully informs the providers about the requirements contained in the Public Health Law.

However, the Public Health Law only states that RTR funds must be used for the "recruitment, training and retention" of certain direct care staff. The Law provides no additional guidance that would help funding recipients determine whether certain specific uses of the funds are allowable or not. When a law is lacking in such specific guidance, the responsible State agency may develop rules, regulations or other guidelines to help facilitate compliance with the law. However, the Department has developed no such rules, regulations or guidelines.

In particular, the Department has issued no guidance with examples of specific types of allowable expenses and specific types of unallowable expenses. As was previously noted, the providers we visited told us they would find such examples helpful. There is also a need for guidance in the area of time frames, as the Public Health Law does not state whether RTR funds must be spent within a certain time period or whether the funds can be retained indefinitely. It is also not clear whether the funds can be applied to expenses retroactively or must be applied only to current expenses. In the absence of such guidance, it is difficult to determine whether the funds are being used properly.

For example, the funding recipients we visited told us that they applied RTR funds to expenses that occurred one or more years before the RTR funds were received. While it is possible they were anticipating the receipt of the RTR funds, and "fronted" the expenses with other funds, it is not clear how far back such retroactive claims may go and still be reasonable.

We also note that, while the Department notifies all home health care providers receiving RTR funding about the explanatory information on its web site, it does not notify the home health agencies that contract with these providers and may often receive the bulk of the funding. We recommend that a mechanism be found for making these agencies aware of this information.

The Department's Bureau of Operations oversees most of the home health care providers receiving RTR funding (the Bureau of Managed Long-Term Care oversees the others). The Bureau of Operations required that each of its 218 providers receiving RTR funding in August 2007 submit a statistical report describing how their RTR funds were used. Such a report could be a useful monitoring tool, and at the time of our audit, 92 of the providers had submitted their reports, showing that they had spent about $30.5 million of RTR funds on the following types of activities:

Activity	RTR Funds Spent	
	Amount	Percent
Recruitment	$8,577,566	28
Education and Training	2,098,431	7
Compensation and Benefits	15,728,004	52
Additional Employee Support	4,100,339	13
Total	$30,504,340	100

The reports also contained other useful information about new hires, education and training courses, compensation (wage increases) and benefits (such as health/dental insurance, pension/retirement, and vacation time), and additional employee supports (such as child care, transportation and housing assistance) that were funded by RTR funds. The providers were also asked about outcomes of the RTR funding, such as the number of direct care staff before and after the RTR funding, and the average length of employment before and after the RTR funding. The report was well designed to enable the Bureau of Operations to capture critical performance data. However, one provider told us the Department should have provided guidance on the data expected to be reported earlier so that they could track it continuously rather than after the fact.

However, 126 of the 218 providers (58 percent) had not submitted their reports, and the Bureau of Operations had performed little or no follow-up to obtain the missing reports. We recommend the Bureau follow up with the

providers and obtain the missing reports. We also recommend that the same type of report be required by the Bureau of Managed Long-Term Care (its providers received a total of $24.7 million in RTR funding in August 2007).

The Department is authorized to audit the providers' use of RTR funds and recover any funds not used for the purposes specified in the Public Health Law. At the time of our audit, the Department had yet to complete any such audits. According to Department officials, such audits were being performed in conjunction with other regularly scheduled audits of home health care provider operations.

We conclude that the Department's oversight efforts to date have provided little assurance RTR funds are being used as intended. Department officials disagree, and stated that sufficient assurance is provided by the funding recipients' written certifications attesting that the funds will be spent in accordance with the requirements contained in the Public Health Law. We disagree and believe that more concrete assurance is needed for $500 million in public funding.

Recommendations

2. Develop specific guidance on the allowable uses and time frames for RTR funds, and make the guidance available to all home health care providers and home health agencies receiving RTR funds.

3. Develop a mechanism for making the contracted home health agencies aware of the information on the Department's web site explaining RTR funding.

4. Require all home health care providers receiving RTR funds to submit a statistical report describing how the funds were used, and follow up with the providers to obtain any reports that are not submitted on time. Use the format developed by the Bureau of Operations for the statistical report.

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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

January 20, 2010

Martin Chauvin, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Chauvin:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-25 on "Enhanced Medicaid Payments to Selected Home Health Care Service Providers."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

Cc: James Sheehan
Robert W. Reed
Mark L. Kissinger
Donna Frescatore
Diane Christensen
Nicholas Meister
Stephen Abbott
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2009-S-25 on
"Enhanced Medicaid Payments to Selected Home Health Care Service Providers"

The following are the New York State Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2009-S-25 on "Enhanced Medicaid Payments to Selected Home Health Care Service Providers," including general comments followed by responses to the specific recommendations contained in the report.

General Comments:

The Department does not agree with certain OSC statements in the report. Specifically, in the third paragraph on page 14, OSC states that recruitment, training and retention (RTR) and special Medicaid funds are not accounted for separately on the annual cost report submitted to the Department. This is incorrect as the cost report filed by each managed long term care plan requires the plan to report the RTR award amount as a discretely reported revenue item. Similarly, cost reports for Certified Home Health Agencies (CHHA) and for Long Term Home Health Care Program (LTHHCP) providers include information on revenue and expenses by type for RTR and Recruitment and Retention (RR) monies, and also ensure that funding amounts are clearly offset from allowable base year expenses for rate-setting purposes.

* Comment 1

Further, in the final paragraph on page 16, OSC makes reference to the difficulty providers have in determining how much RTR funding they actually receive. In fact, when the Department communicates the RTR funding award to each managed long term care plan, the plan is made aware of the specific dollar amount of its award, the incremental increase in its Medicaid capitation premium (per member per month). Also, as explained to OSC by Department staff during the audit process, RTR funding amounts for both CHHA and LTHHCP providers are clearly delineated as per visit/hour amounts on provider rate computation sheets. These amounts are used in conjunction with a provider's actual Medicaid billings per visit/hour to determine receipt of specific funding amounts for RTR and RR funding that the provider would apply to their actual Medicaid utilization, to determine the amount of revenue provided by each adjustment.

* Comment 2

Recommendation #1:

Establish a process to track the receipt and use of Retention, Training and Recruitment funding for all recipients.

Recommendation #4:

Require all home health care providers receiving RTR funds to submit a statistical report describing how the funds were used, and follow up with the providers to obtain any reports that

* See State Comptroller's Comments on page 25.

are not submitted on time. Use the format developed by the Bureau of Operations for the statistical report.

Response #1 and #4:

To date, the Department has relied upon the managed long term care plans' written certification, as required by statute, attesting that the funds will be used solely for the purpose of recruitment, training and retention of non-supervisory home health aides or any personnel with direct patient care responsibility, as well as the statutory authority for the Department to audit each plan to ensure compliance with the certification that funds have been spent appropriately. The Department does, however, agree with these OSC recommendations. It will direct managed long term care plans to establish a process to separately account for the receipt and disbursement of funds and develop a survey to collect statistical information, as captured by the Bureau of Operations format noted by OSC, from each plan regarding the distribution of the funds. In addition, the Department will work with all providers to ensure that all reports are submitted timely.

Recommendation #2:

Develop specific guidance on the allowable uses and time frames for RTR funds, and make the guidance available to all home health care providers and home health agencies receiving RTR funds.

Response #2:

The Department will develop and distribute guidance as needed.

Recommendation #3:

Develop a mechanism for making the contracted home health agencies aware of the information on the Department's website explaining RTR funding.

Response #3:

Currently, the statute requires subcontractors to provide written certification attesting that RTR funds will be used solely for the purpose of recruitment, training and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. Subcontractors are already aware of the statutory requirements for distribution of the funds and, therefore, managed long term care plans will be directed to forward any additional guidance provided from the Department on the use of RTR to their subcontractors.

State Comptroller's Comments

1. Changes were made to clarify the report based upon the Department's response. However, the cost reports for CHHA's and LTHHCP's combine expenditures of RTR and special Medicaid funds.

2. The Department accurately describes the process of notifying providers of their RTR funding amounts. However, the providers told us this process is burdensome and time consuming for them and increases the difficulty of accounting for the funds they received.