Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK STATE IMPROPERLY CLAIMED MEDICAID REIMBURSEMENT FOR SOME ADULT DAY HEALTH CARE SERVICES

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Office of Inspector General

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EXECUTIVE SUMMARY

New York State claimed at least $70.4 million in Federal Medicaid reimbursement over a 3-year period for adult day health care services that were unallowable.

WHY WE DID THIS REVIEW

Federal and State reviews of Medicaid adult day health care (ADHC) services have identified vulnerabilities with reimbursement systems and questionable billings. In addition, Office of Inspector General reviews at two ADHC providers in New York State identified a significant number of unallowable ADHC services claimed for Federal Medicaid reimbursement. Based on preliminary findings at these two providers, we decided to review the rest of the providers in New York.

The objective of this review was to determine whether the New York State Department of Health's (State agency) claims for Medicaid reimbursement for ADHC services provided by New York providers complied with certain Federal and State requirements.

BACKGROUND

In New York, the State agency administers the Medicaid program. The State's ADHC program provides medically supervised services for beneficiaries with physical or mental impairments who are not residents of a residential health care facility and who are not homebound.

Admission to New York's ADHC program is based on (1) a recommendation from a physician, a nurse practitioner, or a physician's assistant with physician oversight and (2) a comprehensive needs assessment. In addition, providers are required to conduct (i.e., provide or arrange for) a medical history and physical examination of each beneficiary within 6 weeks before or 7 days after the beneficiary is admitted to the ADHC program. Further, services must be provided in accordance with an individualized care plan, and a reevaluation must be completed by the ADHC provider at least every 6 months addressing the beneficiary's continued stay in the program. Services must also be supported by adequate documentation.

HOW WE CONDUCTED THIS REVIEW

We reviewed Medicaid payments to the State agency for ADHC services during calendar years 2008 through 2010. For this period, the State agency claimed $545,620,776 ($272,802,088 Federal share) for 346,165 claims for ADHC services provided by 67 providers in New York. We reviewed a random sample of 100 of these claims. A claim includes all payments for ADHC services for one beneficiary in a single month.

WHAT WE FOUND

The State agency claimed Medicaid reimbursement for some ADHC services that did not comply with certain Federal and State requirements. Of the 100 claims in our random sample, the State agency properly claimed Medicaid reimbursement for 60 claims. However, the State agency claimed Medicaid reimbursement for services that were unallowable for the remaining 40 claims.

The claims for unallowable services occurred because the State agency did not ensure that providers complied with Federal and State requirements for: (1) examining and assessing beneficiaries before or shortly after admitting them to the ADHC program, (2) providing ADHC services in accordance with individualized care plans, (3) maintaining documentation to support services billed, (4) reevaluating beneficiaries for their continued stay in the ADHC program in a timely manner, and (5) claiming reimbursement only for services actually provided.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $70,486,492 in Federal Medicaid reimbursement for ADHC services that did not comply with certain Federal and State requirements.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $70,486,492 to the Federal Government and

- improve its monitoring of the ADHC program to ensure that providers comply with Federal and State requirements for: (1) examining and assessing beneficiaries before or shortly after admitting them to the ADHC program, (2) providing ADHC services in accordance with individualized care plans, (3) maintaining documentation to support services billed, (4) reevaluating beneficiaries for their continued stay in the ADHC program in a timely manner, and (5) claiming reimbursement only for services actually provided.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation. Specifically, the State agency stated that the New York State Office of the Medicaid Inspector General (OMIG) was able to obtain evidence to dispute 16 of the 42 findings associated with our first recommendation. The State agency also said that OMIG would work with the Centers for Medicare & Medicaid Services to resolve seven claims associated with our draft report's second recommendation.

Although the State agency did not agree or disagree with our second recommendation, it stated that its survey process has not historically been used to monitor billing and payment-related items but that its ADHC program surveillance process is consistent with well-established survey protocols employed at the Federal and State levels. The State agency also said that an internal review of the ADHC program's survey protocols and tools identified an opportunity to refine the

level of detail that surveyors review. Finally, the State agency described steps that it has taken to enhance its oversight of Medicaid ADHC providers.

After reviewing the State agency's comments and additional documentation subsequently submitted by OMIG under separate cover, we revised our findings for four sample claims classified as unallowable (two of which remained unallowable because they each had multiple deficiencies) and for the seven claims classified as potentially unallowable in our draft report. We revised modified our statistical estimates and revised our recommendations accordingly. We recognize the State agency's efforts to enhance its oversight of ADHC providers in the Medicaid program.

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WHY WE DID THIS REVIEW

Federal and State reviews of Medicaid adult day health care (ADHC) services have identified vulnerabilities with reimbursement systems and questionable billings. In addition, Office of Inspector General reviews at two ADHC providers in New York State identified a significant number of unallowable ADHC services claimed for Federal Medicaid reimbursement. Based on preliminary findings at these two providers, we decided to review the rest of the providers in New York.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health's (State agency) claims for Medicaid reimbursement for ADHC services provided by New York providers complied with certain Federal and State requirements.

BACKGROUND

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 Federal requirements.

New York's Adult Day Health Care Services Program

In New York, the State agency administers the Medicaid program. The State's ADHC program provides medically supervised services for beneficiaries with physical or mental impairments who are not residents of a residential health care facility and who are not homebound. The State agency conducts onsite reviews at ADHC facilities; however, its reviews are primarily reviews of the quality of care, health, and safety of the ADHC program registrants. These reviews generally do not address whether payments for ADHC services complied with Federal and State requirements. Services and activities are provided to enable beneficiaries to remain in the community. Examples of ADHC services include nursing, transportation, physical therapy, speech pathology, nutrition assessment, occupational therapy, medical social services, psychosocial assessment, dental service, and coordination of referrals for outpatient treatment.

Federal and State Requirements Related to Adult Day Health Care Services

States are required to establish requirements in their Medicaid State plans (State plans) that must be met for Medicaid reimbursement of services, including ADHC services. Each State plan must

specify the amount, duration, and scope of each service that it provides for; it must also ensure that each service is sufficient in amount, duration, and scope to reasonably achieve its purpose.

New York's State plan requires ADHC providers to obtain prior authorization from a physician based on medical necessity. The State plan also requires ADHC services to be delivered in accordance with State regulations. Admission to New York's ADHC program is based on (1) a recommendation from a physician (or a nurse practitioner or a physician's assistant with physician oversight—herein described as a physician) and (2) a comprehensive needs assessment.[1] In addition, providers are required to conduct (i.e., provide or arrange for) a medical history and physical examination of each individual within 6 weeks before or 7 days after the individual is admitted to the ADHC program. Further, ADHC services must be provided in accordance with an individualized care plan, and reevaluations must be completed by the ADHC provider every 6 months addressing the beneficiary's continued stay in the ADHC program. Also, services must be supported by appropriate documentation, and Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services provided by certified providers.[2]

For details on Federal and State requirements related to ADHC services, see Appendix A.

HOW WE CONDUCTED THIS REVIEW

We reviewed Medicaid payments to the State agency for ADHC services provided by New York providers during calendar years (CYs) 2008 through 2010. For this period, the State agency claimed $545,620,776 ($272,802,088 Federal share) for 346,165 claims for ADHC services provided by 67 ADHC providers in New York.[3] Of these claims, we reviewed a random sample of 100 claims. A claim includes all payments for ADHC services for one beneficiary in a single month.

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

[1] State regulations on ADHC services are codified at title 10, part 425 of the New York Compilation of Codes, Rules, & Regulations (NYCRR).

[2] Effective September 10, 2014, amended State regulations for the ADHC program allow managed care plans to coordinate the care of enrolled beneficiaries with ADHC providers.

[3] Our review excluded payments during this period totaling $83,520,141 ($41,760,070 Federal share) made to the 2 providers that we previously reviewed, as well as 16 providers under investigation.

FINDINGS

The State agency claimed Medicaid reimbursement for some ADHC services that did not comply with certain Federal and State requirements. Of the 100 claims in our random sample, the State agency properly claimed Medicaid reimbursement for 60 claims. However, the State agency claimed Medicaid reimbursement for services that were unallowable for the remaining 40 claims. Appendix E contains a summary of deficiencies, if any, identified for each sampled claim.

Of the 40 noncompliant claims, 13 claims contained more than 1 deficiency. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[4]
Medical history and physical examination not documented or not conducted in a timely manner	14
Provider's assessment or physician's recommendation not documented or not obtained before admission	11
Evaluations of need for nursing services and reviews of pharmaceutical services not documented	8
Care plan not documented or prepared in a timely manner	7
Continued-stay evaluation not documented	6
Initial nursing evaluation not documented or not performed by a registered professional nurse	4
Services not provided	3

The claims for unallowable services occurred because the State agency did not ensure that providers complied with Federal and State requirements for: (1) examining and assessing beneficiaries before or shortly after admitting them to the ADHC program, (2) providing ADHC services in accordance with individualized care plans, (3) maintaining documentation to support services billed, (4) reevaluating beneficiaries for their continued stay in the ADHC program in a timely manner, and (5) claiming reimbursement only for services actually provided.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $70,486,492 in Federal Medicaid reimbursement for ADHC services that did not comply with certain Federal and State requirements.

[4] The total exceeds 40 because 13 claims contained more than 1 deficiency.

MEDICAL HISTORY AND PHYSICAL EXAMINATION NOT DOCUMENTED OR NOT CONDUCTED IN A TIMELY MANNER

New York's State plan requires ADHC providers to obtain prior authorization from a physician based on medical necessity. ADHC providers are required to conduct (i.e., provide or arrange for) a medical history and a physical examination, including diagnostic laboratory and X-ray services as medically indicated, of each registrant within 6 weeks before or 7 days after admission to the ADHC program (10 NYCRR § 425.9(c)).

For 14 sampled claims, the ADHC providers either did not document or conduct a medical history and a physical examination of the beneficiary within the required timeframe. Specifically, for five claims, the providers did not maintain documentation to support that a medical history and a physical examination were performed within the required timeframe, and, for nine other claims, medical histories and physical examinations were not conducted in a timely manner.[5]

PROVIDER'S ASSESSMENT OR PHYSICIAN'S RECOMMENDATION NOT DOCUMENTED OR NOT OBTAINED BEFORE ADMISSION

New York's State plan requires ADHC providers to obtain prior authorization from a physician based on medical necessity. ADHC providers must assess each applicant's medical needs using a State agency-designated assessment and obtain a recommendation from the applicant's physician before admitting the applicant to the ADHC program (10 NYCRR § 425.6).[6]

For 11 sampled claims, the ADHC providers did not assess the beneficiary or obtain a physician's recommendation before admitting the beneficiary to the ADHC program. Specifically:

- for six claims, the providers did not document the physician's recommendation for admitting the beneficiary to the ADHC program;
- for two claims, the providers admitted the beneficiary to the ADHC program before obtaining a physician's recommendation;
- for two claims, the providers did not document the applicant's medical needs assessment and the appropriate recommendation from the beneficiary's physician; and
- for one claim, the provider did not document that the beneficiary's medical needs assessment was performed.

[5] For five of the nine claims for which medical histories and physical examinations were not conducted in a timely manner, the medical histories and physical examinations occurred between 60 and 205 days (median of 88 days) before the beneficiary was admitted to the ADHC program. For the remaining four claims, the medical histories and physical examinations were not conducted until between 14 and 124 days (median of 36 days) after the beneficiary was admitted.

[6] A nurse practitioner or a physician's assistant with physician oversight may also recommend admission to the program.

EVALUATIONS OF NEED FOR NURSING SERVICES AND REVIEWS OF PHARMACEUTICAL SERVICES NOT DOCUMENTED

New York's State plan requires ADHC services be provided pursuant to applicable State regulations in Title 10 of the NYCRR. ADHC providers must evaluate the need for nursing care services for each registrant enrolled in the ADHC program on a periodic and continuing basis but not less often than quarterly (10 NYCRR § 425.10(a)). ADHC providers are also required to ensure that each registrant's drug regimen is reviewed at least once every 6 months by a registered pharmacist in accordance with the registrant's care plan and modified as needed following consultation with the registrant's attending physician (10 NYCRR § 425.17).

For eight sampled claims, the ADHC providers did not document the periodic evaluation of the beneficiary's need for nursing services or review the beneficiary's pharmaceutical services. Specifically, for five claims, the providers did not maintain documentation to support that the beneficiary's need for nursing care services was evaluated within 3 months of our sampled service period, and for three claims, the providers did not maintain documentation to support that the beneficiary's drug regimen was reviewed within 6 months of our sampled service period.

CARE PLAN NOT DOCUMENTED OR PREPARED IN A TIMELY MANNER

New York's State plan requires ADHC services be provided pursuant to applicable State regulations in Title 10 of the NYCRR. ADHC services must be provided in accordance with a care plan that includes the registrant's diagnoses, the medical and nursing goals, a description of all services to be provided, and the registrant's potential for remaining in the community. ADHC providers must ensure that a care plan is developed for each registrant within five visits, not to exceed 30 days from when the registrant is admitted to the ADHC program. Providers must review each registrant's care plan at least once every 6 months and document each of these reviews in the registrant's clinical record (10 NYCRR § 425.7).

For seven sampled claims, the ADHC providers did not maintain documentation that the beneficiary's care plan was completed or reviewed or that the care plan was prepared within the required timeframe. Specifically, for four claims, the providers did not document that the beneficiary's care plan had been completed or reviewed. For three of these four claims, the providers did not maintain documentation of the beneficiary's initial care plan. For the other claim, the provider did not maintain documentation that the care plan for the 6-month period covering our sampled service period had been reviewed. For the remaining three claims, the care plan was not developed within 30 days from the date the beneficiary was admitted to the ADHC program.

CONTINUED-STAY EVALUATION NOT DOCUMENTED

New York's State plan requires ADHC services be provided in accordance with applicable State regulations in Title 10 of the NYCRR. ADHC providers must perform a written assessment and evaluation at least once every 6 months for each registrant enrolled in the ADHC program that addresses the appropriateness of the registrant's continued stay in the ADHC program (10 NYCRR § 425.8). Further, the providers must obtain an appropriate recommendation from the registrant's physician for continued stay in the ADHC program (10 NYCRR §§ 425.6(a)(3) and 425.8).

For six sampled claims, the ADHC providers did not document the beneficiary's continued-stay evaluation. Specifically:

- for three claims, the providers did not document that a continued-stay assessment covering our sampled service period was performed;

- for two claims, the providers did not document a physician's recommendation for the beneficiary's continued stay in the ADHC program during our sampled service period; and

- for one claim, the provider did not document either that the beneficiary was assessed for continued-stay in the ADHC program or that a physician recommended continued stay in the ADHC program for our sampled service period.

INITIAL NURSING EVALUATION NOT DOCUMENTED OR NOT PERFORMED BY A REGISTERED PROFESSIONAL NURSE

New York's State plan requires ADHC services be provided in accordance with applicable State regulations in Title 10 of the NYCRR. ADHC providers must ensure that an onsite registered professional nurse performs a nursing evaluation at the time a registrant is admitted to the ADHC program (10 NYCRR § 425.10(b)).

For four sampled claims, the ADHC providers did not ensure that an onsite registered professional nurse performed a nursing evaluation at the time a beneficiary was admitted to the ADHC program. Specifically, for two claims, the providers did not document that a nursing evaluation was performed, and for two others, that a licensed practical nurse performed the nursing evaluation.[7]

[7] There are four distinct nursing professions in New York: registered professional nurses, clinical nurse specialists, nurse practitioners, and licensed practical nurses. Licensed practical nurses provide skilled nursing care tasks and procedures under the direction of a registered nurse, nurse practitioner, clinical nurse specialist, physician, or other authorized health care provider (New York's Education Law, article 139).

SERVICES NOT PROVIDED

Federal requirements state that Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services provided by certified providers (Social Security Act§ 1903 (a)(1); CMS's *State Medicaid Manual*, section 2497.1).

For three sampled claims, the State agency claimed reimbursement for ADHC services that were not provided. Specifically, for two claims, the beneficiary was absent from the ADHC program on the days services were claimed. For the remaining claim, the ADHC provider received a duplicate payment for certain days during our sampled service period.[8]

CONCLUSION

These deficiencies occurred because the State agency did not ensure that providers complied with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program, (2) providing ADHC services in accordance with individualized care plans, (3) maintaining documentation to support services billed, (4) reevaluating beneficiaries' continued stay in the ADHC program in a timely manner, and (5) claiming reimbursement for services actually provided.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $70,486,492 in Federal Medicaid reimbursement for ADHC services that did not comply with certain Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $70,486,492 to the Federal Government and

- improve its monitoring of the ADHC program to ensure that providers comply with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program, (2) providing ADHC services in accordance with individualized care plans, (3) maintaining documentation to support services billed, (4) reevaluating beneficiaries for their continued stay in the ADHC program in a timely manner, and (5) claiming reimbursement only for services actually provided.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation. Specifically, the State agency stated that the New York State Office of the Medicaid Inspector General (OMIG) was able to obtain evidence to dispute 16 of the 42 findings

[8] We questioned only the dollar amounts associated with each duplicate payment for AHDC services claimed during our sampled service period.

associated with our first recommendation. The State agency also stated that OMIG would work with CMS to resolve seven claims associated with our draft report's second recommendation.[9]

Although the State agency did not agree or disagree with our second recommendation, it stated that its survey process has not historically been used to monitor billing and payment-related items but that its ADHC program surveillance process is consistent with well-established survey protocols employed at the Federal and State levels. The State agency also said that an internal review of the ADHC program's survey protocols and tools identified an opportunity to refine the level of detail that surveyors review. Finally, the State agency described steps that it has taken to enhance its oversight of Medicaid ADHC providers.

We contacted the State agency and OMIG to obtain the evidence described in the State agency's comments. After reviewing the State agency's comments and additional documentation subsequently submitted by OMIG under separate cover, we revised our findings for four sample claims classified as unallowable (two of which remained unallowable because they each had multiple deficiencies) and for the seven claims classified as potentially unallowable in our draft report. We revised modified our statistical estimates and revised our recommendations accordingly. We recognize the State agency's efforts to enhance its oversight of ADHC providers in the Medicaid program.

The State agency's comments are included in their entirety as Appendix F.

ADDITIONAL DOCUMENTATION PROVIDED BY OFFICE OF THE MEDICAID INSPECTOR GENERAL

State Agency Comments

Regarding our first recommendation, the State agency stated that OMIG was able to obtain evidence to dispute 16 sample claims for which we identified a deficiency. OMIG provided, under separate cover, documentation related to 20 of our sample claims.[10] Table 2 summarizes the deficiencies noted and the number of claims for which the State agency stated that OMIG obtained evidence.

[9] In our draft report, we recommended that the State agency work with CMS to resolve the claims totaling at least $8,325,650 for which Medicaid reimbursement may have been unallowable and refund any unallowable amounts.

[10] The documentation provided related to 13 unallowable claims associated with our first recommendation and 7 potentially unallowable claims associated with the second recommendation in our draft report.

Table 2: Deficiencies for Which the State Agency Said It Had Evidence

Type of Deficiency for Which the Office of the Medicaid Inspector General Obtained Evidence	Number of Claims
Medical history and physical examination not documented or not conducted in a timely manner	4
Provider's assessment or physician's recommendation not documented or not obtained before admission	3
Evaluations of need for nursing services and reviews of pharmaceutical services not documented	3
Care plan not documented or prepared in a timely manner	2
Services not provided	1
Claims for which ADHC provider paid restitution	3

Regarding the second recommendation in our draft report, the State agency stated that OMIG would provide evidence to CMS to resolve seven claims associated with the dates of medical history and physical examination not having been documented, and the initial nursing evaluation having not appropriately documented error categories. The State agency said that OMIG had already obtained evidence to dispute six of these claims.

Office of Inspector General Response

After reviewing the documentation that OMIG provided, we revised our findings for four sample claims classified as unallowable (two of which remained unallowable because they each had multiple deficiencies) and for the seven claims classified as potentially unallowable in our draft report. In addition, we revised our statistical estimates and recommendations related to our findings.

Claims Determined To Be Unallowable in the Draft Report

Although the State agency stated that OMIG was able to obtain evidence to dispute 16 sample claims, OMIG provided documentation related to 13 claims we classified as unallowable in our draft report. After reviewing the additional documentation, we revised our findings for four of these claims. For the remaining nine claims, we maintain that our findings are valid. Specifically:

- *Medical history and physical examination not documented or not conducted in a timely manner*. We accepted the State agency's documentation for one claim in this error category and revised our finding for that claim. However, the claim contained a different deficiency that we maintain was valid; because of that deficiency, the claim remains unallowable. In addition, we maintain that our findings are valid for the remaining claims in this error category.

- *Provider's assessment or physician's recommendation not documented or not obtained before admission.* We accepted the State agency's documentation for one claim in this error category and revised our finding for that claim. However, the claim contained a different deficiency that we maintain was valid; because of that deficiency, the claim remains unallowable. In addition, we maintain that our findings are valid for the remaining claims in this error category.

- *Evaluations of need for nursing services and reviews of pharmaceutical services not documented*. We revised our findings for one claim in this error category to indicate that this claim is allowable. We maintain that our findings are valid for the remaining claims in this error category.

- *Care plan not documented or prepared in a timely manner*. We revised our finding for one claim to indicate that this claim is allowable. We maintain that our finding is valid for the remaining claims in this error category.

- *Services not provided.* We maintain that our finding in the "services not provided" error category is valid. The initial documentation we reviewed indicated that the beneficiary was absent on the dates of service of the sampled claim. The additional documentation provided by OMIG does not indicate that the beneficiary was provided ADHC services on the dates of service of the sampled claim.

- *Claims for which the State agency stated that the ADHC provider paid restitution.* For three claims, the State agency said that OMIG previously reviewed documentation related to these claims and the associated provider paid restitution. After reviewing documentation provided by OMIG, we maintain that our findings regarding these claims are valid. The documentation submitted by OMIG related to its review of a specific ADHC provider. The OMIG review was conducted outside of our audit period and did not contain findings related to any of our sampled claims. Therefore, we maintain that our findings regarding these claims are valid.

Claims Determined To Be Potentially Unallowable in Our Draft Report

In our draft report, we classified seven claims as "potentially unallowable," and on the basis of these sample results, we estimated the amount of potential overpayments and recommended the State agency work with CMS to resolve the claims. OMIG subsequently provided additional documentation for the seven claims. After reviewing the additional documentation provided, we eliminated the finding and recommendation from our report.

APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO ADULT DAY HEALTH CARE SERVICES

FEDERAL REQUIREMENTS

States must have agreements with Medicaid providers that providers keep records that fully disclose the extent of the services provided to individuals receiving assistance under a State plan (Social Security Act, 1902 § (a)(27)). Costs must be adequately documented to be allowable under Federal awards (Title 2 CFR part 225, App. A section C.1.j, *Cost Principles for State, Local, and Tribal Governments* (Office of Management and Budget Circular A-87, Att. A, § C.1.j)).

Costs must be adequately documented to be allowable under Federal awards (2 CFR § 225, Appendix A). CMS instructs States to report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Supporting documentation includes at minimum the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service, nature, extent, or units of service; and the place of service (CMS, *State Medicaid Manual* § 2500.2).

States must establish in their State Medicaid plan requirements that must be met for Medicaid reimbursement of services, including ADHC services (42 CFR §§ 430.10 and 440.2). Each State plan must specify the "amount, duration, and scope of each service that it provides for" and ensure that "each service [is] sufficient in amount, duration, and scope to reasonably achieve its purpose" (42 CFR § 440.230).

Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services provided by certified providers (Social Security Act, § 1903(a)(1); CMS, *State Medicaid Manual* § 2497.1).

STATE REQUIREMENTS

New York's State plan requires ADHC providers to obtain prior authorization from a physician based on medical necessity.[11] The State plan also requires ADHC services to be provided pursuant to applicable State regulations in Title 10 of the NYCRR.[12] Title 10, section 425 of the NYCRR, describes the State agency's requirements for its ADHC program.[13]

Medicaid ADHC services must be recommended by the applicant's physician, nurse practitioner, or physician's assistant with physician oversight (10 NYCRR § 425.6(a)). ADHC services must be provided only to individuals who can benefit from the services, as determined by a

[11] New York State Medicaid Plan, Attachment 3.1A, page 6 and Attachment 3.1B, page 6.

[12] New York State Medicaid Plan, Attachment 4.19B, page 7(a).

[13] Effective September 10, 2014, amended State regulations for the ADHC program allow managed care plans to coordinate the care of enrolled beneficiaries with ADHC providers.

patient-needs assessment performed by the provider and using an instrument designated by the State agency. The assessment must address medical needs and include a determination of whether the applicant is expected to need continued services for 30 or more days from the date of the assessment. A minimum of one ADHC program visit per week is required.

The provider of ADHC services must arrange for services appropriate to each registrant in accordance with the individual's needs assessment and comprehensive care plan (10 NYCRR § 425.5). A care plan, based on an interdisciplinary assessment, must also be developed within five visits; the plan must not exceed 30 days from registration in the ADHC program (10 NYCRR § 425.7 (a)).

The operator of a ADHC program is required to perform a written comprehensive assessment and evaluation at least once every 6 months to address the registrant's continued stay in the ADHC program (10 NYCRR §425.8).

ADHC providers must obtain a medical history and a physical examination, including diagnostic laboratory and x-ray services as medically indicated, of each registrant within 6 weeks before or 7 days after admission to the ADHC program (10 NYCRR § 425.9 (c)).

ADHC providers must provide nursing services to evaluate the need of each registrant for nursing care on at least a quarterly basis. The ADHC provider must ensure that a registered professional nurse is onsite and performs a nursing evaluation of each new registrant at the time of admission to the ADHC program. Furthermore, the ADHC provider must ensure that all nursing services are provided to registrants under the direction of a registered professional nurse who is onsite during all hours of the ADHC program operation (10 NYCRR § 425.10).

ADHC providers must ensure that each registrant's drug regimen is reviewed at least once every 6 months by a registered pharmacist in accordance with the registrant's care plan and otherwise modified as needed following consultation with the registrant's attending physician. All modification to the drug regimen must be documented in the registrant's clinical record and included as a revision to the registrant's care plan (10 NYCRR § 425.17(c)).

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid payments to the State agency for ADHC services provided by New York providers during CYs 2008 through 2010. For this period, the State agency claimed $545,620,776 ($272,802,088 Federal share) for 346,165 claims for ADHC services provided by 67 providers throughout New York. Of these claims, we reviewed a random sample of 100 claims. A claim included all payments for ADHC services for one beneficiary in a single month.

Our review allowed us to establish reasonable assurance of the authenticity of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State's claim for reimbursement in the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for ADHC 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 providers' internal controls for documenting ADHC services billed and claimed for reimbursement. We did not assess the appropriateness of ADHC payment rates.

We performed our fieldwork at the State agency's offices in Albany, New York, and at ADHC providers' offices located throughout New York from February through July 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with CMS financial and program management officials to gain an understanding of and to obtain information on New York's ADHC program;
- met with State agency officials to discuss the State agency's administration and monitoring of the ADHC program;
- interviewed ADHC provider officials regarding their ADHC program policies and procedures, including procedures for admitting and assessing beneficiaries, preparing plans of care and continued-stay evaluations, and documenting services billed;
- obtained from New York's MMIS a sampling frame of 346,165 claims totaling $545,620,776 ($272,802,088 Federal share) for which the State agency claimed

reimbursement for ADHC services provided by New York providers during CYs 2008 through 2010;[14]

- selected from our sampling frame a simple random sample of 100 claims and for each claim determined whether:
    - the beneficiary was Medicaid-eligible;
    - the beneficiary was admitted to the ADHC program on the basis of a recommendation of a physician, nurse practitioner, or physician's assistant;
    - the beneficiary was assessed by the provider to be eligible to participate in the ADHC program;
    - a medical history and physical examination of the beneficiary were performed within the required timeframe for admission to the ADHC program;
    - the beneficiary was evaluated by an onsite registered professional nurse at the time of admission;
    - an individual plan of care was developed for the beneficiary within the required timeframe and reviewed at least every 6 months;
    - a continued-stay evaluation was performed for the beneficiary and documented within the required timeframe;
    - ADHC program services were provided and documented in accordance with Federal and State requirements; and
    - the staff members who provided the ADHC program services met qualification and training requirements;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 346,165 claims; and
- discussed the results of the review with State agency officials.

Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

[14] The sampling frame excluded payments totaling $83,520,141 ($41,760,070 Federal share) made to 2 providers that we previously reviewed, as well as to 16 providers under investigation.

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 C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of claims submitted by New York State providers for ADHC services during CYs 2008 through 2010 for which the State agency claimed Medicaid reimbursement. A claim is defined as all ADHC services for one beneficiary for 1 month.

SAMPLING FRAME

The sampling frame was an Access file containing 346,165 claims. The total amount of the payments for claims submitted by New York providers for ADHC services during CYs 2008 through 2010 in the sampling frame was $545,620,776 ($272,802,088 Federal share). The sampling frame did not include payments totaling $46,564,463 ($23,282,232 Federal share) submitted by 16 providers under investigation and payments totaling $36,955,678 ($18,477,838 Federal share) submitted by 2 providers that we audited separately. The data for these claims were extracted from the New York MMIS.

SAMPLE UNIT

The sample unit was a claim for ADHC services.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample items in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise our sample results. We estimated the overpayment associated with the claims for unallowable ADHC services at the lower limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results for Unallowable Services

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Claims With Unallowable Services	Value of Unallowable Services (Federal Share)
346,165	$272,802,088	100	$80,153	40	$28,144

Table 4: Estimated Value of Unallowable Services (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$97,425,024
Lower limit	$70,486,492
Upper limit	$124,363,556

APPENDIX E: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Legend

Deficiency	Description
1	Medical history and physical examination not documented or not conducted in a timely manner
2	Provider's assessment or physician's recommendation not documented or not obtained before admission
3	Evaluations of need for nursing services and reviews of pharmaceutical services not documented
4	Care plan not documented or prepared in a timely manner
5	Continued-stay evaluation not documented
6	Initial nursing evaluation not documented or not performed by a registered professional nurse
7	Services not provided

Table 5: Office of Inspector General Review Determinations for the 100 Sampled Claims

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
1						X		1
2							X	1
3								
4								
5							X	1
6								
7			X					1
8								
9			X	X				2
10							X	1
11								
12		X						1
13								
14								
15								
16						X		1
17								
18	X							1
19		X						1
20	X	X						2
21								

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
22					X			1
23								
24								
25					X			1
26				X				1
27		X						1
28								
29								
30								
31								
32	X							1
33								
34								
35			X					1
36								
37	X		X					2
38								
39								
40								
41								
42								
43								
44	X							1
45								
46								
47								
48								
49								
50			X					1
51			X		X			2
52				X				1
53								
54								
55								
56								

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
57								
58								
59								
60								
61								
62								
63								
64								
65	X	X						2
66								
67				X				1
68								
69								
70	X							1
71								
72	X			X				2
73								
74		X				X		2
75	X	X						2
76								
77								
78								
79								
80								
81								
82								
83								
84								
85		X	X					2
86	X							1
87					X	X		2
88								
89					X			1
90		X		X				2

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
91								
92		X		X				2
93					X			1
94	X	X						2
95	X							1
96	X							1
97			X					1
98								
99								
100	X							1
Category Totals	**14**	**11**	**8**	**7**	**6**	**4**	**3**	**53**[15]
40 Claims with Deficiencies								

[15] Thirteen claims contained more than one deficiency.

APPENDIX F: STATE AGENCY COMMENTS

ANDREW M. CUOMO
Governor

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

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

May 8, 2015

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

Ref. No: A-02-13-01016

Dear Mr. Edert:

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-02-13-01016 entitled, "New York State Improperly Claimed Medicaid Reimbursement for Some Adult Day Health Care Services."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
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New York State Department of Health
Comments on the
Department of Health and Human Services
Office of the Inspector General
Draft Audit Report A-02-13-01016 entitled
New York State Improperly Claimed Medicaid Reimbursement for
Some Adult Day Health Care Services

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-02-13-01016 entitled, "New York State Improperly Claimed Medicaid Reimbursement for Some Adult Day Health Care Services."

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), for 2009 through 2013, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. For 2011 through 2013, the administration's Medicaid enforcement efforts recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,330,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1

Refund $71,984,226 to the Federal Government.

Response #1

The Department disagrees with the recommendation for the state to refund $71,984,226 to the Federal Government. The OIG reviewed a random sample of 100 Medicaid payments for adult day health care (ADHC) services claims paid to the Department for services provided by New York providers during the calendar years 2008 through 2010. Of these 100 claims, the OIG found that 49 claims (42 related to recommendation #1 and 7 related to recommendation #2) contained services that did not comply with Federal and State requirements. The OMIG was able to obtain evidence, which will be sent to OIG under separate cover, to dispute 16 of the 42 findings based on the following deficiency types:

Medical history and physical examination not documented or not conducted in a timely manner.

The OMIG was able to obtain evidence to dispute four claims from this type of deficiency.

Provider's assessment or physician's recommendation not documented or not obtained before admission.

The OMIG was able to obtain evidence to dispute three claims from this type of deficiency.

Evaluations of need for nursing services and reviews of pharmaceutical services not documented.

The OMIG was able to obtain evidence to dispute three claims from this type of deficiency.

Care plan not documented or prepared in a timely manner.

The OMIG was able to obtain evidence to dispute two claims from this type of deficiency.

Services not provided.

The OMIG was able to obtain evidence to dispute one claim from this type of deficiency.

Other

Additionally, three claims have findings based on documentation that was previously reviewed by the OMIG, and provider has paid restitution.

Recommendation #2

Work with CMS to resolve the claims totaling at least $8,325,650 for which Medicaid reimbursement may have been unallowable and refund any unallowable amounts.

Response #2

Based on their review, the OIG was unable to determine whether the associated services complied with Federal and State requirements. The OMIG will work with the Centers for Medicare and Medicaid Services (CMS) by providing evidence to resolve the seven claims totaling at least $8,325,650, of which the OMIG already has evidence to dispute six of these claims.

Recommendation #3

Improve its monitoring of the ADHC program to ensure that providers comply with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program, (2) providing ADHC services in accordance with individualized care plans, (3) maintaining documentation to support services billed, (4) reevaluating beneficiaries for their continued stay in the ADHC program in a timely manner, and (5) claiming reimbursement only for services actually provided.

Response #3

ADHC programs must comply with all New York State regulations in 10 NYCRR Part 425, as well as relevant portions of the long-term care regulations in 10 NYCRR Part 415. The Department's ADHC program surveillance process (in place since 2005) is consistent with well-established survey protocols, employed at the federal and state levels that use a review of a sample of registrants to evaluate provider compliance with regulatory requirements. The Department

conducts onsite inspections of ADHC programs at least once every three years. The inspection (or survey) reviews the full operation of the ADHC program. These include registrant admission, care planning (development, implementation, evaluation, and refinement), case management, abuse prevention and response, staff and registrant interactions, transportation arrangements and an environmental review. The inspections include a review of policies and procedures, interviews with staff and registrants, and review of records.

In addition, ADHC providers are required to complete and submit, with an attestation, a Program Survey Report (PSR) each year. The PSR collects information on the provider's compliance with regulatory requirements.

The Department's current inspection scope includes four of the five areas included in Recommendation #3 (with the exception of claiming reimbursement). We disagree with the audit's suggestion that the Department's monitoring of these areas is not effective, based on the audit's self-described .03% sample (100/346,165) review of claims. The survey process has not historically been used to monitor billing and payment-related items.

However, an internal review of the program's survey protocols and tools has identified an opportunity to refine the level of detail that surveyors review. To build on and enhance the Department's already strong oversight of ADHC providers in the Medicaid program, the Department's Division of Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (within the Office of Primary Care and Health Systems Management [OPCHSM]) has taken the following steps:

- The ADHC program survey tool has been modified to facilitate a more rigorous review of documentation, including those areas outlined in Recommendation #3. The revisions ensure that information that is relevant to billing and payment review by other programs – such as date of service or function, name of practitioner who provides the service or performs the function, and the justification for the service or function is reviewed and evaluated during the survey. ADHC program survey staff are being trained on the tool and it will be implemented statewide by June 1 2015;

- Survey results will be communicated to the Medicaid program and OMIG. The OPCHSM will communicate the survey results, focusing on areas in which provider noncompliance potentially impacts billing and payment (e.g., unjustified admission to an ADHC program, lack of continued stay justification, provision of a service without justification), to both the Office of Health Insurance Programs (OHIP) and OMIG. Survey findings can inform OHIP or OMIG reviews already in progress, or can inform the initiation of reviews by either program.

- In February 2015, OPCHSM instituted quarterly meetings of ADHC survey staff to optimize the efficiency and effectiveness of surveys and oversight. The meetings ensure ongoing dialogue throughout the state of survey experience and findings, to help inform future areas of focus.

- Continue to educate providers. As OPCHSM has done since early 2014, it will, through its continuous dialogue with providers and the associations that represent them, focus communication and education on the common areas where providers may be out of compliance with State and Federal billing and reimbursement requirements. In addition, the Department will send a Dear Administrator Letter to ADHC programs, co-signed by OPCHSM and OHIP, reinforcing documentation requirements and billing guidelines.