Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED MEDICAID REIMBURSEMENT FOR SOME ADULT DAY HEALTH CARE SERVICES PROVIDED BY CENTER FOR NURSING AND REHABILITATION THAT WERE UNALLOWABLE

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

James P. Edert
Regional Inspector General
for Audit Services

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A-02-12-01015

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

New York State claimed at least $283,000 in Federal Medicaid reimbursement over a 3-year period for adult day health care services provided by Center for Nursing and Rehabilitation 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. We reviewed the Center for Nursing and Rehabilitation's (CNR's) ADHC program because it ranked among the highest-paid providers of ADHC services in the New York City area.

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 CNR 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 provided by CNR during calendar years 2008 through 2010. For this period, the State agency claimed approximately $18 million ($9 million Federal share) for 9,951 claims for ADHC services provided by CNR. 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 provided by CNR 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 90 claims. However, the State agency claimed Medicaid reimbursement for services that were unallowable or potentially unallowable for the remaining 10 claims. Specifically, nine claims contained

services that did not comply with Federal and State requirements, and, for one claim, we could not determine whether the associated services complied with Federal and State requirements.

The claims for unallowable and potentially unallowable services occurred because the State agency did not ensure that CNR complied with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program, and (2) maintaining documentation to support services billed.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $283,386 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 $283,386 to the Federal Government and

- improve its monitoring of the ADHC program to ensure that CNR complies with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program and (2) maintaining documentation to support services billed.

CENTER FOR NURSING AND REHABILITATION COMMENTS AND OUR RESPONSE

In written comments on our draft report, CNR did not address our findings. However, CNR disagreed with our recommendation to the State agency that it refund the associated Medicaid reimbursement for ADHC services provided by CNR based on our findings. Specifically, CNR asserted that there is no basis in Title 10 §§ 425.9(c) or 425.6 of the New York Compilation of Codes, Rules, & Regulations (NYCRR), relied on in our draft report, or elsewhere in State regulations, to deny payment for services provided on account of the regulatory deficiencies cited in our draft report.

After reviewing CNR's comments, we maintain that our findings and the basis of our recommended financial disallowance are valid. States are required to establish requirements in their Medicaid State plans that must be met for Medicaid reimbursement of services, including ADHC services. New York's Medicaid State plan requires ADHC services to be delivered in accordance with State regulations codified at Title 10, part 425 of the NYCRR.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. Specifically, the State agency requested that we provide its Office of the Medicaid Inspector General (OMIG) with the claims information associated with the disallowed claims in our draft report in order to determine the appropriateness of a refund to the Federal Government.

In addition, the State agency stated that although its survey process has not historically been used to monitor billing and payment-related items, its ADHC program surveillance process is consistent with well-established survey protocols employed at the Federal and State levels. The State agency also stated 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, we provided the State agency with the claims information it requested. In a follow-up email, the State agency stated that it would provide the results of OMIG's review of disallowed claims to CMS for resolution. We maintain that our findings and recommendations are valid and recognize the State agency's efforts to enhance its oversight of Medicaid ADHC providers.

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INTRODUCTION

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. We reviewed the Center for Nursing and Rehabilitation's (CNR's) ADHC program because it ranked among the highest-paid providers of ADHC services in the New York City area.

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 CNR complied with certain Federal and State requirements.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

New York's Adult Day Health Care Services Program

In New York State, 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 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, coordination of referrals for outpatient treatment, and dental services.

Center for Nursing and Rehabilitation

CNR, a member of the CenterLight Health System, is a not-for-profit organization that provides a variety of healthcare services throughout the New York City area, including ADHC services at two centers in Brooklyn, and one in Queens, New York. During calendar years (CYs) 2008 through 2010, the State agency claimed Medicaid reimbursement for 9,951 claims totaling approximately $18 million ($9 million Federal share) for ADHC services provided by CNR.

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 and 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 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 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 at least 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 CNR during CYs 2008 through 2010. For this period, the State agency claimed approximately $18 million ($9 million Federal share) for 9,951 claims for ADHC services provided by CNR. 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.

FINDINGS

The State agency claimed Medicaid reimbursement for some ADHC services provided by CNR 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 90 claims. However, the State agency claimed Medicaid reimbursement for services that were unallowable or potentially unallowable for the remaining 10 claims. Specifically, nine claims contained services that did not comply with Federal and State requirements, and, for one claim, we could not determine whether the associated services complied with Federal and State requirements. Appendix E contains a summary of deficiencies, if any, identified for each sampled claim.

Of the nine noncompliant claims, one claim contained more than one deficiency:

- For eight claims, CNR did not ensure that the medical history and physical examination was conducted in a timely manner.

- For two claims CNR did not document the physician's recommendation for admission to the ADHC program.

For the remaining claim, we could not determine whether CNR provided or arranged for a medical history and physical examination in a timely manner.

The claims for unallowable and potentially unallowable services occurred because the State agency did not ensure that CNR complied with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program, and (2) maintaining documentation to support services billed.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $283,386 in Federal Medicaid reimbursement for ADHC services provided by CNR that did not comply with certain Federal and State requirements.[3]

MEDICAL HISTORY AND PHYSICAL EXAMINATION NOT CONDUCTED IN A TIMELY MANNER

New York's State plan requires ADHC providers to obtain prior authorization 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 (Title 10 §425.9 (c) of the New York Compilation of Codes, Rules, & Regulations (NYCRR)).

For eight sampled claims, CNR did not ensure that a medical history and physical examination of the beneficiary was conducted within the required timeframe. Specifically, for seven claims,

[3] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

CNR did not conduct a medical history and a physical examination within the required timeframe, and, for the remaining claim, CNR did not document that a physical examination was performed upon readmission of a beneficiary who returned to the ADHC program after a 1-month stay in a long-term care facility.[4]

PHYSICIAN'S RECOMMENDATION NOT DOCUMENTED

New York's State plan requires ADHC providers to obtain prior authorization based on medical necessity. ADHC providers must obtain a recommendation from the applicant's physician before admitting the applicant to the ADHC program. (10 NYCRR §425.6).[5]

For two sampled claims, CNR did not document the physician's recommendation for admitting the beneficiary to the ADHC program.

CLAIM WAS POTENTIALLY UNALLOWABLE BECAUSE DATES OF MEDICAL HISTORY AND PHYSICAL EXAMINATION WERE 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 conduct (i.e., provide or arrange for) a medical history and physical examination within 6 weeks before or 7 days after a registrant is admitted to the ADHC program (10 NYCRR §425.9).

For one sampled claim, we could not determine whether the services complied with Federal and State requirements. Specifically, CNR conducted a medical history and physical examination for the beneficiary. However, CNR's records did not document the dates on which the medical history and physical examination were provided. Therefore, we could not determine whether CNR conducted a medical history and physical examination within the required timeframe.

CONCLUSION

These deficiencies occurred because the State agency did not ensure that CNR complied with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program, and (2) maintaining documentation to support services billed.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $283,386 in Federal Medicaid reimbursement for ADHC services that did not comply with certain Federal and State requirements.

[4] For the seven claims for which medical histories and physical examinations were not conducted in a timely manner, the medical histories and physical examinations occurred, on average, either 94 days before or 17 days after the beneficiary was admitted to the ADHC program.

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

RECOMMENDATIONS

We recommend that the State agency:

- refund $283,386 to the Federal Government and

- improve its monitoring of the ADHC program to ensure that CNR complies with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program and (2) maintaining documentation to support services billed.

CENTER FOR NURSING AND REHABILITATION COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CNR did not address our findings. However, CNR disagreed with our recommendation to the State agency that it refund the associated Medicaid reimbursement for ADHC services provided by CNR based on our findings. Specifically, CNR asserted that there is no basis in 10 NYCRR §§ 425.9 (c) or 425.6, relied on in our draft report, or elsewhere in State regulations, to deny payment for services provided on account of the regulatory deficiencies cited in our draft report.

After reviewing CNR's comments, we maintain that our findings and the basis of our recommended financial disallowance are valid. States are required to establish requirements in their Medicaid State plans that must be met for Medicaid reimbursement of services, including ADHC services**.** New York's Medicaid State plan requires ADHC services to be delivered in accordance with State regulations codified at Title 10, part 425 of the NYCRR.

CNR's comments are included in their entirety as Appendix F.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. Specifically, the State agency requested that we provide its Office of the Medicaid Inspector General (OMIG) with the claims information associated with the disallowed claims in our draft report in order to determine the appropriateness of a refund to the Federal Government.

In addition, the State agency stated that although its survey process has not historically been used to monitor billing and payment-related items, its ADHC program surveillance process is consistent with well-established survey protocols employed at the Federal and State levels. The State agency also stated 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, we provided the State agency with the claims information it requested. In a follow-up email, the State agency stated that it would provide the results of OMIG's review of disallowed claims to CMS for resolution. We maintain that our findings and recommendations are valid and recognize the State agency's efforts to enhance its oversight of Medicaid ADHC providers.

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

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 pt. 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 in order to be allowable under Federal awards (2 CFR section 225, Appendix A). CMS instructs States to report only expenditures for which all supporting documentation, in readily reviewable form, has been complied 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 adult day health care (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 based on medical necessity.[6] The State plan also requires ADHC services to be provided pursuant to applicable State regulations in Title 10 of the NYCRR.[7] Title 10, section 425 of the NYCRR describe the State agency's requirements for its ADHC program.[8]

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 patient-

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

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

[8] 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.

needs assessment performed by the provider, 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 and not to 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 on-site 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 on-site 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 CNR during CYs 2008 through 2010. For this period, the State agency claimed $18,009,961 ($9,004,980 Federal share) for 9,951 claims for ADHC services provided by CNR at its three locations— two in Brooklyn and one in Queens, New York. 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.

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 CNR's 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 CNR's three[9] locations throughout New York City from April 2012 through January 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 CNR 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;

[9] At the time of our review, CNR maintained two ADHC centers in Brooklyn and a third in Queens. During our fieldwork, CNR was in the process of closing one of its Brooklyn locations.

- obtained from New York State's Medicaid Management Information System a sampling frame of 9,951 claims totaling $18,009,961 ($9,004,980 Federal share) for which the State agency claimed reimbursement for ADHC services provided by CNR during CYs 2008 through 2010;

- 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 CNR 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 on-site registered professional nurse at the time of admission,

    - an individual plan of care was developed for the beneficiary within the required time frame and reviewed at least every 6 months,

    - a continued-stay evaluation was performed for the beneficiary and documented within the required time frame,

    - 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 9,951 claims; and

- discussed the results of the review with CNR officials.

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

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

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of claims submitted by CNR 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 one month.

SAMPLING FRAME

The sampling frame was an Excel file containing 9,951 claims. The total amount of the payments for claims submitted by CNR for ADHC services during CYs 2008 through 2010 in the sampling frame was $18,009,961 ($9,004,980 Federal share). The data for these claims were extracted from the New York State Medicaid Management Information System.

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 1: Sample Details and Results

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)
9,951	$9,004,980	100	$94,668	9	$6,999

Table 2: Estimated Value of Unallowable Services (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$696,433
Lower limit	$283,386
Upper limit	$1,109,481

APPENDIX E: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Legend

Deficiency	Description
1	Medical history and physical examination not conducted in a timely manner
2	Physician's recommendation not documented

Table 3: Office of Inspector General Review Determinations for the 100 Sampled Claims

Sample Claim	Deficiency 1	Deficiency 2	No. of Deficiencies
1	X		1
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

Sample Claim	Deficiency 1	Deficiency 2	No. of Deficiencies
26			
27			
28			
29			
30			
31	X		1
32	X		1
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43	X	X	2
44			
45			
46			
47			
48			
49			
50		X	1
51			
52			
53	X		1
54			
55			
56			
57			
58			
59			

Sample Claim	Deficiency 1	Deficiency 2	No. of Deficiencies
60			
61			
62			
63			
64			
65			
66			
67			
68			
69	X		1
70			
71			
72			
73			
74			
75			
76			
77			
78			
79			
80			
81			
82	X		1
83			
84			
85			
86			
87			
88			
89			
90			
91			
92			
93			

Sample Claim	Deficiency 1	Deficiency 2	No. of Deficiencies
94			
95			
96			
97			
98	X		1
99			
100			
Category Totals	**8**	**2**	**10**[10]
9 Claims with Deficiencies			

[10] One claim contained more than one deficiency.

APPENDIX F: CENTER FOR NURSING AND REHABILITATION COMMENTS

CNR™
CenterLight Health System

June 9, 2015

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, New York 10078

Re: Draft Report "*New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Center for Nursing and Rehabilitation That Were Unallowable*" Dated April 2015 [Report No. A-02-01015]

Dear Mr. Edert:

This submission is made on behalf of Center for Nursing and Rehabilitation ("CNR") in response to your letter dated April 23, 2015, addressed to CNR, and enclosing and requesting comments to the above-referenced draft report. We thank the Office of Inspector General ("OIG") for granting us an additional thirty (30) days to respond.

During the course of the OIG's audit, CNR submitted information requested by the OIG relevant to the proposed audit findings, and has no other comments to any of the specific findings. CNR, however, disagrees with the OIG's recommendation of a refund of the associated Medicaid reimbursement for adult day health care services provided by CNR based on those findings. There is no basis in 10 N.Y.C.R.R. § 425.9(c) or Section 425.6, relied on in the draft report, or elsewhere in the regulations, for denying payment in full for services rendered on account of the cited regulatory deficiencies -- in most cases, only a single deficiency in the sampled service period.

We thank you for your attention to this submission.

Respectfully,

Igor Kiprovski
Administrator

USActive 32952617.1

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APPENDIX G: STATE AGENCY COMMENTS

ANDREW M. CUOMO
Governor

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

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

September 15, 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-02-12-01015

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-02-12-01015 entitled, "New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Center for Nursing and Rehabilitation That Were Unallowable."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

cc: Jason Helgerson
Dennis Rosen
Dan Sheppard
Michael J. Nazarko
Robert Loftus
James Cataldo
Thomas Meyer
Keith Servis
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Shelly Glock
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Lori Conway
OHIP Audit SM

New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-12-01015 entitled
"New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Center for Nursing and Rehabilitation That Were Unallowable"

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-02-12-01015 entitled, "New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Center for Nursing and Rehabilitation That Were Unallowable"

Recommendation #1

Refund $283,386 to the Federal Government.

Response #1

The Office of the Medicaid Inspector General (OMIG) formally requests the claims for review, in order to determine the appropriateness of a refund to the Federal Government.

Recommendation #2

Improve its monitoring of the ADHC program to ensure that CNR complies with Federal and State requirements for: (1) examining and assessing beneficiaries before admitting them to the ADHC program and (2) maintaining documentation to support services billed.

Response #2

Adult Day Health Care (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 both of the areas included in Recommendation #2. 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 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 #2. 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 have been trained on the tool and it was implemented statewide, effective 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 admissions 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. An appropriate mechanism for communicating results is being identified.

- 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 on survey experience and findings, to help inform future areas of focus.

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, by the end of the year, the Department will send a Dear Administrator Letter to ADHC programs co-signed by OPCHSM and OHIP, reinforcing documentation requirements and billing guidelines.