Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED MEDICAID REIMBURSEMENT FOR SOME ADULT DAY HEALTH CARE SERVICES PROVIDED BY METROPOLITAN JEWISH HEALTH SYSTEM THAT WERE UNALLOWABLE

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Office of Inspector General

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EXECUTIVE SUMMARY

New York State claimed at least $1.1 million in Federal Medicaid reimbursement over a 3-year period for adult day health care services provided by Metropolitan Jewish Health System 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 one of Metropolitan Jewish Health System's (MJHS's) ADHC centers because the facility 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 MJHS 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 one of MJHS's AHDC centers during calendar years 2008 through 2010. For this period, the State agency claimed approximately $18,945,717 ($9,472,858 Federal share) for 7,991 claims for ADHC services provided by MJHS. 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 MJHS 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 80 claims.

However, the State agency claimed Medicaid reimbursement for services that were unallowable or potentially unallowable for the remaining 20 claims. Specifically, 18 claims contained services that did not comply with Federal and State requirements, and, for 2 claims, 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 MJHS 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 $1,179,261 in Federal Medicaid reimbursement for ADHC services provided by MJHS that that did not comply with certain Federal and State requirements.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $1,179,261 to the Federal Government and

- improve its monitoring of the ADHC program to ensure that MJHS 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.

METROPOLITAN JEWISH HEALTH SYSTEM COMMENTS AND OUR RESPONSE

In written comments on our draft report, MJHS disagreed with our findings and first recommendation (financial disallowance). MJHS did not indicate concurrence or nonconcurrence with our second recommendation. Specifically, MJHS asserted that the State regulations cited for noncompliance only establish requirements for the operation of an ADHC program, not conditions of payment. In addition, MJHS asserted that for three sampled claims, a single regulatory violation does not warrant multiple cited deficiencies for the same registrant. MJHS also asserted that State regulations do not require ADHC providers to conduct medical histories and physical examinations.

After reviewing MJHS's comments, we maintain that our findings and recommendations 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 New York Compilation of Codes, Rules, & Regulations. In addition, we independently assessed each sampled claim to determine whether it complied with applicable criteria. We agree that ADHC providers are not required to conduct medical histories and physical examinations, and acknowledge that MJHS obtained medical histories and physical examinations for the beneficiaries associated with the sampled claims. However, we found that medical histories and physical examinations were not provided or arranged for in a timely

manner.

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 one of Metropolitan Jewish Health System's (MJHS's) ADHC centers because the facility 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 MJHS 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, 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.

Metropolitan Jewish Health System

MJHS 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, New York. During calendar years (CYs) 2008 through 2010, the State agency claimed Medicaid

reimbursement for 7,991 claims totaling approximately $18,945,717 ($9,472,858 Federal share) for ADHC services provided by MJHS[1] at its location in the Bensonhurst section of Brooklyn.

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.[2] 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.[3]

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 MJHS at its Bensonhurst location during CYs 2008 through 2010. For this period, the State agency claimed approximately $18,945,717 ($9,472,858 Federal share) for 7,991 claims for ADHC services provided by MJHS. 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

[1] The claim ID number in the State agency's Medicaid Management Information System for each of these claims indicated that MJHS was the provider of record; however, Menorah Center for Rehabilitation and Nursing Care (Menorah) operated the ADHC program. MJHS is a non-operating entity and parent of Menorah.

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

[3] 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.

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.

FINDINGS

The State agency claimed Medicaid reimbursement for some ADHC services provided by MJHS 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 80 claims. However, the State agency claimed Medicaid reimbursement for services that were unallowable or potentially unallowable for the remaining 20 claims. Specifically, 18 claims contained services that did not comply with Federal and State requirements, and, for 2 claims, 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 18 noncompliant claims, 2 claims contained more than 1 deficiency:

- For 15 claims, MJHS did not ensure that the medical history and physical examination was conducted in a timely manner.
- For two claims, MJHS did not document the beneficiary's continued-stay evaluation.
- For two claims, MJHS did not document the beneficiary's care plan.
- For one claim, MJHS did not document the review of the beneficiary's pharmaceutical services.

For the remaining two claims, we could not determine whether MJHS conducted the 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 MJHS 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 the services billed.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $1,179,261 in Federal Medicaid reimbursement for ADHC services provided by MJHS that that did not comply with certain Federal and State requirements.[4]

[4] 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.

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 (10 NYCRR §425.9(c)).

For 15 sampled claims, MJHS did not conduct a medical history and a physical examination of the beneficiary within the required timeframe.[5]

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 two sampled claims, MJHS did not document that a continued-stay assessment for our sampled service period was performed.

CARE PLAN 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 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 two sampled claims, MJHS did not maintain documentation that the care plan for the 6-month period covering our sampled service period had been reviewed.

REVIEW OF PHARMACEUTICAL SERVICES 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 are required to ensure that each

[5] For the 15 claims for which medical histories and physical examinations were not conducted in a timely manner, the medical histories and physical examinations occurred between 44 and 481 days (median of 263 days) before the beneficiary was admitted to the ADHC program.

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 one sampled claim, MJHS did not maintain documentation to support that the beneficiary's drug regimen was reviewed within 6 months of our sampled service period.

CLAIMS WERE POTENTIALLY UNALLOWABLE BECAUSE DATES OF MEDICAL HISTORY AND PHYSICAL EXAMINATION WERE 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 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 two sampled claims, we could not determine whether the services complied with Federal and State requirements. For these two sampled claims, MJHS conducted a medical history and physical examination for the associated beneficiary; however, MJHS's records did not document the dates on which the medical history and physical examination were provided. Therefore, we could not determine whether MJHS conducted a medical history and physical examination within the required timeframe.

CONCLUSION

These deficiencies occurred because the State agency did not ensure that MJHS 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 $1,179,261 in Federal Medicaid reimbursement for ADHC services provided by MJHS that that did not comply with certain Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,179,261 to the Federal Government and

- improve its monitoring of the ADHC program to ensure that MJHS 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.

METROPOLITAN JEWISH HEALTH SYSTEM COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, MJHS disagreed with our findings and first recommendation (financial disallowance). MJHS did not indicate concurrence or nonconcurrence with our second recommendation. Specifically, MJHS asserted that the State regulations cited for noncompliance only establish requirements for the operation of an ADHC program, not conditions of payment. In addition, MJHS asserted that a single regulatory violation (untimely medical history and physical examination) does not warrant multiple cited deficiencies for the same registrant. MJHS also asserted that State regulations do not require ADHC providers to conduct medical histories and physical examinations.

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

After reviewing MJHS's comments, we maintain that our findings and recommendations 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 New York Compilation of Codes, Rules, & Regulations. In addition, we independently assessed each sampled claim to determine whether it complied with applicable criteria. If more than one claim was selected for a single beneficiary and all claims were covered by the same medical history and physical examination, then all claims would have been incorrectly paid. If there are specific concerns about the determination made regarding a particular sample claim, the auditee has the right to appeal that specific determination through the normal appeals process. We agree that ADHC providers are not required to conduct medical histories and physical examinations, and acknowledge that MJHS obtained medical histories and physical examinations for the beneficiaries associated with the sampled claims. However, we found that medical histories and physical examinations were not provided or arranged for in a timely manner.

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 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 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 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 in accordance with 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, Attachment 3.1A, page 6 and Attachment 3.1B, page 6.

[7] New York State Medicaid Plan, Attachment 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 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 and 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 MJHS during CYs 2008 through 2010. For this period, the State agency claimed $18,945,717 ($9,472,858 Federal share) for 7,991 claims for ADHC services provided by MJHS at its Bensonhurst facility. 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 MJHS'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 MJHS's ADHC Bensonhurst facility in Brooklyn, New York from February 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 MJHS 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 Medicaid Management Information System a sampling frame of 7,991 claims totaling $18,945,717 ($9,472,858 Federal share) for which the State agency claimed reimbursement for ADHC services provided by MJHS's Bensonhurst facility 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 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 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 7,991 claims; and
- discussed the results of the review with MJHS 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 MJHS for ADHC services during CYs 2008 through 2010 for which the State agency claimed Medicaid reimbursement. A claim is defined as all payments for one beneficiary for 1 month.

SAMPLING FRAME

The sampling frame was an Excel file containing 7,991 claims. The total amount of the payments for claims submitted by MJHS for ADHC services during CYs 2008 through 2010 in the sampling frame was $18,945,717 ($9,472,858 Federal share). 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 1: 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)
7,991	$9,472,858	100	$121,839	18	$23,873

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

Point estimate	$1,907,674
Lower limit	$1,179,261
Upper limit	$2,636,087

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	Continued-stay evaluation not documented
3	Care plan not documented
4	Review of pharmaceutical services not documented

Table 2: Office of Inspector General Review Determinations for the 100 Sampled Claims

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

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
26					
27				X	1
28					
29					
30					
31					
32	X				1
33					
34					
35					
36					
37		X	X		2
38					
39					
40					
41					
42					
43					
44	X				1
45					
46					
47					
48					
49					
50					
51					
52	X				1
53					
54					
55					
56					
57					
58					
59	X				1
60					
61					

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
62					
63					
64	X				1
65					
66	X				1
67					
68					
69					
70					
71					
72					
73					
74					
75					
76					
77					
78					
79					
80					
81					
82					
83					
84					
85					
86	X				1
87					
88					
89					
90	X				1
91					
92					
93					
94					
95					
96					
97					

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
98					
99					
100					
Category Totals	**15**	**2**	**2**	**1**	**20**[9]
18 Claims with Deficiencies					

[9] Two claims contained more than one deficiency.

APPENDIX F: METROPOLITAN JEWISH HEALTH SYSTEM COMMENTS

Menorah Center for Rehabilitation and Nursing Care
a member of the MJHS family

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May 22, 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 Metropolitan Jewish Health System That Were Unallowable*" Dated April 2015 [Report No. A-02-01024]

Dear Mr. Edert:

This submission is made on behalf of Menorah Home and Hospital for the Aged and Infirm ("Menorah") in response to your letter dated April 23, 2015, addressed to Metropolitan Jewish Health System[1], and enclosing and requesting comments to the above-referenced draft report. The draft report identifies 18 allegedly unallowable claims based on 20 alleged deficiencies out of a sample of 100 claims for adult day health services paid by Medicaid during the 2008-2010 period. From the 20 disallowed sampled claims, the OIG extrapolated to the universe of 7,991 claims paid in 2008-10 and has recommended that the State of New York Medicaid program refund $1,179,261 in Federal Medicaid reimbursement for ADHC services provided in that service period.

Menorah submits that the proposed disallowances and requested refund are inappropriate for the reasons set forth below.

1. The Regulations Cited for Alleged Non-Compliance Are Not Conditions of Payment. According to the draft report, the OIG reviewed the ADHC program's records to determine whether the program complied with certain regulations contained in Part 425 of 10 N.Y.C.R.R. governing the operation of ADHC programs in New York State. The alleged violations include: (1) the program's alleged failure to "conduct" a medical history and physical examination in a timely manner (10 N.Y.C.R.R. § 425.9(c)); (2) alleged failure to document a written assessment and evaluation at least once every six months per registrant (10 N.Y.C.R.R.

[1] Menorah is the current operator of the adult day health care ("ADHC") program audited by the Office of Inspector General ("OIG"). Metropolitan Jewish Health System ("MJHS") is a non-operating entity and the parent of Menorah. MJHS has never owned or operated the ADHC program.

§ 425.6(a) and (3) and 425.8); (3) alleged failure to document the care plan for the six-month period covered by the sampled claim (10 N.Y.C.R.R. § 425.7); and (4) the failure to maintain documentation to support the registrant's drug regimen within six months of the sampled service period. These regulations, among others, establish the requirements for the operation of an adult day health care program; they do not establish the conditions for payment of an ADHC program. That is, not every regulatory violation justifies the denial of payment in full, particularly where there is no dispute that the program provided medically necessary services to the registrant.

In particular, the Department of Health's regulations specify the conditions of payment that, if satisfied, entitle an operator of an adult day health care program to Medicaid reimbursement. Specifically, the regulations unambiguously declare that a "program may only bill for one visit per registrant" and "the majority of registrants for whom the program receives a payment made by a government agency must be in attendance for a least five hours." 10 N.Y.C.R.R. 425.23(a). More generally, the regulations also specify "[a]s a condition of payment," that "all providers of medical assistance must take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services." 18 N.Y.C.R.R. 540.6(e)(1) (emphasis added).

Nowhere in the regulations cited by the OIG for its findings nor elsewhere in the Department's regulations does it make the timeliness of the medical history and physical examination or associated documentation a condition of payment. Nor do the conditions of payment, discussed above, encompass compliance with the regulations cited under OIG's findings. See 10 N.Y.C.R.R. 425.23(a); 18 N.Y.C.R.R. 540.6(e)(1). Notably, OIG made no finding that the adult day health care program had billed for more than one visit per registrant; that the majority of registrants were in attendance for less than five hours; or that a third party, such as a managed long term care plan, was liable for the payments. Rather, the OIG's findings were each premised on technical violations of regulations unrelated to the conditions of payment.

Recognizing the limitations of OIG's audit and recoupment authority to the conditions of payment does not render unenforceable the New York State regulations relied on by the OIG in this audit. Indeed, an operator of an adult day health care program still must comply with those regulations as "conditions of participation" in the Medicaid program, enforceable by the Department of Health. Failure to comply with these regulations may subject an operator to sanctions on survey, but not to a total denial of reimbursement for services provided, as OIG has effected on this audit.

2. A Single Regulatory Violation Does Not Warrant Multiple Cited Deficiencies. It appears that the OIG's sample includes more than one claim for a single registrant. While it is theoretically possible that a random sample could capture more than one claim per registrant, the inclusion of multiple claims per registrant does not justify disallowing all of them for a single deficiency. With regard to disallowance category (1), referenced in the prior section, the OIG cited the program for not timely conducting a medical history and physical examination at the time of the registrant's admission to the program. However, the OIG then cited that same deficiency multiple times in disallowing any and all claims submitted for that registrant, presumably on the theory that the registrant's entire history of services was forever tainted and all associated payments invalid based on that one, purportedly incurable deficiency. This position is taken even though there is no dispute that the registrant received the services billed for and was overseen by the program once admitted.

Such an approach by OIG improperly compounds the penalty imposed for a single deficiency and is excessive and unfair. The OIG's compounding error affects the following disallowed sampled claims:

Disallowed Sample Claim	Duplicate Disallowed Sample Claim
No. 8	No. 52
No. 19	No. 32
No. 20	No. 59

Accordingly, the duplicate disallowed sampled claims should be reversed on that basis as well.

3. The Regulations do not Require the ADHC Program to "Conduct" a Medical History and Physical Examination. In the draft report, the OIG asserts that the ADHC program did not comply with 10 N.Y.C.R.R. 425.9(c) on the ground that it did not "conduct" a medical history and physical exam of the registrant within six weeks before or seven days after admission to the program. Section 425.9(c), however, requires ADHC programs to "obtain" medical history and, if medically indicated, physical exam. The regulation does not require the program to actually "conduct" such a history or examination:

> The operator must . . . provide or arrange for the personal, staff or other designated practitioner to obtain a medical history and a physical examination of each registrant . . . as medically indicated, within six weeks before or seven days after admission to the program.

The records of the ADHC program reflect that it did obtain a medical history for the sampled registrants; the fact that the medical history was conducted by the registrant's physician or another practitioner unaffiliated with the program is not evidence of non-compliance so long as the program timely obtained the medical history. Nor is a physical examination upon admission required in all cases. Rather, the regulation requires a physical examination only "as medically indicated".

The interpretation error described above affects the disallowance of sampled claims Nos. 4, 21, 25, 64 and 86.

* * *

We thank you for the opportunity to provide these comments, and look forward to receiving a revised draft report eliminating the disallowed sampled claims noted above.

Respectfully,

Katie Murtagh

Katie Murtagh RN, MSN
Vice President ADHC

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-02-12-01024

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-02-12-01024 entitled, "New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Metropolitan Jewish Health System 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
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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-02-12-01024 entitled
"New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Metropolitan Jewish Health System 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-02-12-01024 entitled, "New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Metropolitan Jewish Health System That Were Unallowable."

Recommendation #1

Refund $1,179,261 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 MJHS 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.