DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

April 19, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP (A-02-10-01002)

Attached, for your information, is an advance copy of our final report on selected Medicaid home health services claims made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP. We will issue this report to the New York State Department of Health within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-10-01002.

Attachment

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, NY 10278

April 20, 2012

Report Number: A-02-10-01002

Nirav R. Shah, M.D., M.P.H.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kevin W. Smith, Audit Manager, at (518) 437-9390, extension 232, or through email at Kevin.Smith@oig.hhs.gov. Please refer to report number A-02-10-01002 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations (CMCHO)
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SELECTED MEDICAID HOME HEALTH SERVICES CLAIMS MADE BY JEWISH HOME AND HOSPITAL LIFECARE COMMUNITY SERVICES – MANHATTAN LTHHCP

Daniel R. Levinson
Inspector General

April 2012
A-02-10-01002

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), 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 Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, provided, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAP.

In New York State (the State), the Department of Health (State agency) administers the Medicaid program. The Long Term Home Health Care Program (LTHHCP) is a Home and Community Based Services Medicaid waiver program approved by CMS and operated by the State agency's Office of Long Term Care. The LTHHCP provides Medicaid beneficiaries with community-based services as an alternative to institutional care. LTHHCP providers furnish both waiver services and State plan services to waiver participants.

Pursuant to Federal regulations, home health services are services provided to a beneficiary at the beneficiary's place of residence and on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days. Many providers use Form CMS-485, Home Health Certification and Plan of Care, to document physicians' orders for home health services.

Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP (Jewish Home) is one of two long-term home health care programs operated by Jewish Home Lifecare, a not-for-profit corporation based in New York, New York.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for selected State plan home health services claims submitted by Jewish Home in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not claim Federal Medicaid reimbursement for some home health services claims submitted by Jewish Home in accordance with Federal and State requirements. Of the 100 claims in our random sample, 61 claims complied with Federal and State requirements, but 39 claims did not. Of the 39 claims, 2 contained more than 1 deficiency. Specifically:

- For 39 claims, the care plan was not reviewed.
- For one claim, there was no documentation that the service was provided.
- For one claim, the home health aide did not receive basic training.

These deficiencies occurred because (1) Jewish Home and its contracted home health providers did not comply with certain Federal and State requirements and (2) the State agency did not effectively monitor Jewish Home for compliance with certain Federal and State requirements.

Based on our sample results, we estimate that the State agency improperly claimed $8,177,970 in Federal Medicaid reimbursement during our January 1, 2006, through June 30, 2009, audit period.

RECOMMENDATIONS

We recommend that the State agency:

- refund $8,177,970 to the Federal Government and
- improve its monitoring of Jewish Home and its contracted home health providers to ensure compliance with Federal and State requirements.

JEWISH HOME COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, Jewish Home disagreed with our findings and recommended financial disallowance. Specifically, Jewish Home stated that our application of Federal and State regulations was "hyper-technical" and that our interpretation of the regulations was both incorrect as a matter of law and inconsistent with the State's LTHHCP audit standards.

After reviewing Jewish Home's comments and the additional documentation provided, we revised our findings and modified our statistical estimates accordingly. Jewish Home's comments appear as Appendix D. We did not include portions of attachments to the comments that contained voluminous amounts of personally identifiable information or described internal policies of the State's Office of Medicaid Inspector General.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with both of our recommendations. The State agency stated that our first recommendation (financial disallowance) is based on a misinterpretation of program requirements. Specifically, the State agency stated that neither Federal regulations at 42 CFR § 440.70(a)(2) or State regulations at 10 NYCRR § 763.7(a)(3) "implicitly require a physician's *signature* on the plan of care; only a physician's *review* is required." (*Emphasis* added by the State agency.) Regarding our second recommendation, the State agency stated that its program monitoring is effective and that Jewish Home complied with program requirements by implementing a system to track care plans (Forms CMS-485).

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. While we agree that neither Federal or State regulations require a physician's signature on the care plan, for home health services to be allowable under 42 CFR § 440.70, the State must document that services were furnished to a recipient "on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days …." If the physician did not sign and date the form that Jewish Home used as the plan of care (i.e., Form CMS-485), Jewish Home must otherwise document that the physician reviewed the plan of care every 60 days–a requirement for Federal reimbursement for Medicaid State plan home health services.

We disagree that the State agency's program monitoring is effective, as evidenced by the high error rate at Jewish Home. We found Jewish Home's tracking system to be unreliable for several claims reviewed, as the dates on the tracking system did not match the dates on the care plans. Also, the tracking system did not ensure that care plans were reviewed every 60 days as required.

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

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APPENDIXES

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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 Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, provided, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAP.

New York State's Medicaid Program

In New York State (the State), the Department of Health (State agency) administers the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims, including claims for home health services. Prior to the recession adjustment period, from January 1, 2006, through September 30, 2008, the FMAP in the State was 50 percent. From October 1, 2008, through June 30, 2010, the FMAP in the State varied from 58.78 percent to 61.59 percent.[1]

New York State's Long Term Home Health Care Program

In the State, the Long Term Home Health Care Program (LTHHCP) is a Home and Community Based Services Medicaid waiver program approved by CMS and operated by the State agency's Office of Long Term Care. The LTHHCP provides Medicaid beneficiaries with community-based services as an alternative to institutional care. LTHHCP providers furnish both waiver

[1] Specifically, from October 1, 2008, through March 31, 2009, the FMAP was 58.78 percent; from April 1, 2009, through June 30, 2009, the FMAP was 60.19 percent; and from July 1, 2009, through June 30, 2010, the FMAP was 61.59 percent.

services and State plan services to LTHHCP participants. Waiver services include moving assistance, nutritional counseling, and respiratory therapy. State plan services include personal care, nursing, home health aide, physical therapy, occupational therapy, and speech therapy.

Reimbursement under the Medicaid program is available for LTHHCP services provided by residential health care facilities and hospitals, as well as home health agencies certified by the State agency. Under the approved State Medicaid plan, State plan services must be furnished by a certified home health agency.

Federal Requirements Related to Home Health Services

Section 1905(a)(7) of the Act authorizes home health care services under the Medicaid State plan. Pursuant to 42 CFR § 440.70(a), "home health services" are services provided to a beneficiary at the beneficiary's place of residence and "[o]n his or her physician's orders as part of a written plan of care that the physician reviews every 60 days …." Many providers use Form CMS-485, Home Health Certification and Plan of Care, to document physicians' orders for home health services.[2] Line 3 of the Form CMS-485 is titled "Certification Period" and includes spaces for providers to enter "From" and "To" dates for valid home health services.

Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c of Attachment A of the Circular provides that to be allowable, costs must be authorized or not prohibited under State or local laws or regulations. Pursuant to 42 CFR § 433.32, services claimed for Federal Medicaid reimbursement must be documented.

State Requirements Related to Home Health Services

New York's approved State Medicaid Plan (SPA 07-13) provides that home care services are medically necessary services (physician order required) provided by a certified home health agency to individuals in the home and community. State regulations relating to home health services covered under the State plan are set forth at Title 18 § 505.23 of the New York Compilation of Codes, Rules, & Regulations (NYCRR). Pursuant to 18 NYCRR § 505.23(a)(3), only persons who meet State agency training requirements may provide home health aide services. Further, pursuant to 10 NYCRR § 700.2 (b)(9), "[h]ome health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the department and possess written evidence of such completion." Pursuant to 18 NYCRR § 504.3(a), by enrolling in the State's Medicaid program, a provider agrees to maintain records demonstrating its right to receive payment and to furnish such records to the State and to the U.S. Department of Health and Human Services (HHS).

[2] Form CMS-485 is not a required form. Home health agencies may submit any document that is signed and dated by a physician that contains all of the required data elements in a readily identifiable location within the medical record and in accordance with the current rules governing the home health plan of care.

Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP

Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP (Jewish Home) is one of two long-term home health care programs operated by Jewish Home Lifecare, a not-for-profit corporation based in New York, New York.[3] Jewish Home contracts with licensed nursing and home health agencies, including a subsidiary of its parent corporation, to provide home health services. As a policy, Jewish Home uses the Form CMS-485 to document a physician's certification for home health services and plan of care for each Medicaid beneficiary. (See Appendix A for the CMS form.)

Office of Inspector General Audits

This audit is one of a series of audits that address Medicaid home health services providers that we identified as high-risk. We are conducting these audits in response to the estimated $87 billion in increased FMAP under the Recovery Act.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for selected State plan home health services claims submitted by Jewish Home in accordance with Federal and State requirements.

Scope

Our audit period covered January 1, 2006, through June 30, 2009. Our review covered 414,633 claim lines, totaling $54,411,000 ($28,366,886 Federal share), submitted by Jewish Home. (We refer to these lines in this report as claims.) We limited our review to claims for the following State plan services: home health aide, nursing, occupational therapy, physical therapy, and speech therapy.

During our audit, we did not review the overall internal control structure of Jewish Home, the State agency, or the Medicaid program. Rather, we limited our internal control review to those controls related to the objective of our audit.

We performed fieldwork at the State agency's offices in Albany, New York, at the MMIS fiscal agent in Rensselaer, New York, at Jewish Home's offices in New York, New York, and at 10 home health agencies contracted by Jewish Home located throughout New York City.

[3] During our audit period, Jewish Home Lifecare operated as Jewish Home and Hospital Lifecare. Jewish Home Lifecare also operates Jewish Home and Hospital Lifecare Community Services – Bronx LTHHCP, a long-term home health program in The Bronx, and Home Assistance Personnel, Inc., a licensed home care services agency.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- held discussions with officials of the State agency and county social service districts to gain an understanding of home health services furnished by LTHHC providers;
- held discussions with Jewish Home officials to gain an understanding of Jewish Home's procedures for claiming Medicaid reimbursement for home health services;
- identified a sampling frame of 414,633 selected State plan home health services claims, totaling $54,411,000 ($28,366,886 Federal share), that Jewish Home submitted;
- selected a simple random sample of 100 claims[4] from the sampling frame of 414,633 claims;
- reviewed Jewish Home's and/or the corresponding contracted agency's documentation supporting each of the 100 sampled claims; and
- estimated the unallowable Federal Medicaid reimbursement paid in the population of 414,633 claims.

Appendix B contains the details of our sample design and methodology.

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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not claim Federal Medicaid reimbursement for some home health services claims submitted by Jewish Home in accordance with Federal and State requirements. Of the 100 claims in our random sample, 61 claims complied with Federal and State requirements, but 39 claims did not. Of the 39 claims, 2 contained more than 1 deficiency. The following table summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

[4] The 100 sampled claims comprised 87 home health aide services and 13 long-term nursing services.

Summary of Deficiencies in Sampled Claims

Deficiency	Unallowable Claims[5]
Care plan not reviewed	39
No documentation to support service	1
Aide did not receive basic training	1

These deficiencies occurred because (1) Jewish Home and its contracted home health providers did not comply with certain Federal and State requirements and (2) the State agency did not effectively monitor Jewish Home's compliance with certain Federal and State requirements.

Based on our sample results, we estimate that the State agency improperly claimed $8,177,970 in Federal Medicaid reimbursement during our January 1, 2006, through June 30, 2009, audit period.

CARE PLAN NOT REVIEWED

Pursuant to 42 CFR § 440.70(a)(2), home health services are services provided to a beneficiary on his or her physician's orders as part of a written care plan that the physician reviews every 60 days. As a policy, Jewish Home uses Form CMS-485 to document a physician's certification for home health services and plan of care for each Medicaid beneficiary.

For 39 of the 100 claims in our sample, the corresponding care plan was not reviewed by a physician within the 60-day certification period indicated on the corresponding Form CMS-485. For 16 of the 39 claims, we were unable to determine when the physician reviewed the applicable Form CMS-485. For the remaining 23 claims, the physician reviewed the Form CMS-485 an average of 177 days after the certification period ended.

NO DOCUMENTATION TO SUPPORT SERVICE

Pursuant to 42 CFR § 433.32, services claimed for Federal Medicaid reimbursement must be documented. Pursuant to 18 NYCRR § 504.3(a), by enrolling in the State's Medicaid program, a provider agrees to maintain records demonstrating its right to receive payment and to furnish such records to the State and to HHS. Pursuant to 18 NYCRR § 505.23(e)(1), payments for home health services are prohibited unless the claims for payment are supported by documentation of the time spent providing services.

For 1 of the 100 sampled claims, Jewish Home did not provide documentation that the related service (long-term nursing) was provided.

AIDE DID NOT RECEIVE BASIC TRAINING

Pursuant to 18 NYCRR §505.23(a)(3)(iii), home health services under the Medicaid program include home health aide services "as defined in the regulations of the Department of Health, provided by a person who meets the training requirements of the Department of Health …."

[5] The total exceeds 39 because 2 claims contained more than 1 deficiency.

Pursuant to 10 NYCRR §700.2, "home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the department [of Health] and possess written evidence of such completion."

For 1 of the 100 sampled claims, Jewish Home's contracted home health agency did not provide any evidence that the aide who provided the corresponding service completed a basic training program in home health aide services or an equivalent exam.

CAUSES OF UNALLOWABLE CLAIMS

Noncompliance With Certain Federal and State Requirements

As described above, 39 of the 100 sampled claims that Jewish Home submitted for Federal Medicaid reimbursement did not comply with Federal and State requirements. Jewish Home officials stated that they were aware of these requirements and attempted to comply with them.

Ineffective State Agency Monitoring

During our audit period, the only monitoring that the State agency performed was a recertification survey conducted in October 2008. As part of this survey, the State agency reviewed eight records and found the provider to be in "substantial compliance" with all Federal Conditions of Participation.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 home health services claims sampled, 39 were not made in accordance with Federal and State requirements. Based on our sample results, we estimate that the State agency improperly claimed $8,177,970 in Federal Medicaid reimbursement from January 1, 2006, through June 30, 2009, for selected State plan home health services claims submitted by Jewish Home. The details of our sample results and estimates are shown in Appendix C.

RECOMMENDATIONS

We recommend that the State agency:

- refund $8,177,970 to the Federal Government and

- improve its monitoring of Jewish Home and its contracted home health providers to ensure compliance with Federal and State requirements.

JEWISH HOME COMMENTS

In its comments on our draft report, Jewish Home disagreed with our findings and recommended financial disallowance. Specifically, Jewish Home stated that our application of Federal and State regulations was "hyper-technical" and that our interpretation of these regulations was both incorrect as a matter of law and inconsistent with the State's LTHHCP audit standards.

Jewish Home stated that 42 CFR § 440.70(a)(2) is "simply a definitional section relating to home health services" and "provides only that the care plan must be *reviewed* by the physician every 60 days" (emphasis in original) and does not require a signature. However, Jewish Home stated that each of the beneficiaries associated with our sampled claims had care plans that were, "in the vast majority of cases, ultimately signed by the physician" and that its staff made every reasonable effort to ensure that those care plans were reviewed and signed by physicians.

Jewish Home also stated that, because the LTHHCP is "a creature of New York State law," State law should govern the issue of when physician signatures are needed on clinical records, and Jewish Home cited 10 NYCRR § 763.7(a)(3)(iii), which requires that beneficiary's care plan be "renewed … as frequently as indicated by the patient's condition but at least every 62 days." According to Jewish Home, "there is no requirement for a physician signature simply to renew a plan of care or that related paperwork must be finalized within the same timeframe."

Jewish Home also stated that our draft report improperly applied "conditions of participation" in the Medicaid program as "conditions of payment" and that only administrative sanctions were appropriate.

Jewish Home stated that, for three sample claims (numbers 45, 53, and 93), its tracking records indicated that the corresponding physician's order was signed during the 60-day window. For eight other sample claims, Jewish Home stated that the claims met the State's Office of Medicaid Inspector General's (OMIG) 90-day requirement for plans of care to be signed and should therefore be allowed. Jewish Home also stated that it had plans of care for two other sample claims (numbers 35 and 72) and that claim number 34 was properly documented. In addition, Jewish Home stated that it made every reasonable effort to ensure that aides are properly trained. Finally, Jewish Home provided us with additional documentation for certain sampled claims.

Jewish Home's comments appear as Appendix D. We did not include portions of attachments to the comments that included voluminous amounts of personally identifiable information or described OMIG internal policies.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Jewish Home's comments and the additional documentation provided, we revised our findings and modified our statistical estimates accordingly.

Jewish Home furnishes Medicaid State plan home health services to LTHHCP participants. Federal regulations define the home health services that constitute "medical assistance" under the State plan pursuant to § 1905(a)(7) of the Act. Federal Medicaid reimbursement is available only for home health services that meet the definition set forth at 42 CFR § 440.70(a)(2). For home health services to be allowable under 42 CFR § 440.70, the State must document that services were furnished to a recipient "on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days …." If the physician did not sign and date the form that Jewish Home used as the plan of care (i.e., Form CMS-485), Jewish Home must otherwise document that the physician reviewed the plan of care every 60 days. This

requirement is not a condition of participation, but rather a requirement for Federal reimbursement for Medicaid State plan home health services.

We did not rely on Jewish Home's tracking system to document the physician's review for any of the three sample claims because we noted multiple errors in the data within the system that led us to question the system's validity. Regarding claim number 53, we did not accept tracking system records as evidence that the physician signed and dated the document within the 60-day window. For claim number 45, the applicable care plan was not signed by the physician within the 60-day window. We accepted claim number 93 because, as part of its additional documentation, Jewish Home provided an acceptable copy of the care plan.

Regarding the eight claims that Jewish Home stated met OMIG's 90-day requirement for plans of care to be signed, 42 CFR § 440.70 requires review every 60 days, and that is the standard we used in reviewing the claims. Also, two of the eight sample claims did not have a signature date; therefore, Jewish Home relied on its tracking system for this information. Jewish Home did provide care plans for claim numbers 35 and 72; however, the care plan for number 35 was not signed or dated by a physician, and the care plan for number 72 was signed more than 3 years after the end of the authorization period. Regarding claim number 34, our sample date of service was April 21, 2006. However, Jewish Home provided a note for the preceding day, April 20, 2006. Because a nursing service was provided on our sampled service date, a nursing note is required for that date.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with both of our recommendations. The State agency stated that our first recommendation (financial disallowance) is based on a misinterpretation of program requirements. Specifically, the State agency stated that neither Federal regulations at 42 CFR § 440.70(a)(2) or State regulations at 10 NYCRR § 763.7(a)(3) "implicitly require a physician's *signature* on the plan of care; only a physician's *review* is required." (*Emphasis* added by the State agency.) Regarding our second recommendation, the State agency stated that its program monitoring is effective and that Jewish Home complied with program requirements by implementing a system to track care plans (Forms CMS-485).

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. While we agree that neither Federal or State regulations require a physician's signature on the care plan, for home health services to be allowable under 42 CFR § 440.70, the State must document that services were furnished to a recipient "on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days …." If the physician did not sign and date the form that Jewish Home used as the plan of care (i.e., Form CMS-485), Jewish Home must otherwise document that the physician reviewed the plan of care every 60 days–a requirement for Federal reimbursement for Medicaid State plan home health services.

We disagree that the State agency's program monitoring is effective, as evidenced by the high error rate at Jewish Home. We found Jewish Home's tracking system to be unreliable for several claims reviewed, as the dates on the tracking system did not match the dates on the care plans. Also, the tracking system did not ensure that care plans were reviewed every 60 days as required.

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

APPENDIXES

APPENDIX A: FORM CMS-485, HOME HEALTH CERTIFICATION AND PLAN OF CARE

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Date of Birth	9. Sex ☐M ☐F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies	15. Safety Measures:
16. Nutritional Req.	17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation	5 ☐ Paralysis	9 ☐ Legally Blind			
2 ☐ Bowel/Bladder (Incontinence)	6 ☐ Endurance	A ☐ Dyspnea With Minimal Exertion			
3 ☐ Contracture	7 ☐ Ambulation	B ☐ Other (Specify)			
4 ☐ Hearing	8 ☐ Speech				

18.B. Activities Permitted

1 ☐ Complete Bedrest	6 ☐ Partial Weight Bearing	A ☐ Wheelchair			
2 ☐ Bedrest BRP	7 ☐ Independent At Home	B ☐ Walker			
3 ☐ Up As Tolerated	8 ☐ Crutches	C ☐ No Restrictions			
4 ☐ Transfer Bed/Chair	9 ☐ Cane	D ☐ Other (Specify)			
5 ☐ Exercises Prescribed					

19. Mental Status:	1 ☐ Oriented	3 ☐ Forgetful	5 ☐ Disoriented	7 ☐ Agitated			
	2 ☐ Comatose	4 ☐ Depressed	6 ☐ Lethargic	8 ☐ Other			
20. Prognosis:	1 ☐ Poor	2 ☐ Guarded	3 ☐ Fair	4 ☐ Good	5 ☐ Excellent		

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT

24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was selected State plan home health claim lines (claims) submitted by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP (Jewish Home) during our January 1, 2006, through June 30, 2009, audit period that were claimed for Federal Medicaid reimbursement by the New York State Department of Health.

SAMPLING FRAME

The sampling frame was a computer file containing 414,633 detailed paid claims for selected State plan home health services that Jewish Home submitted during our audit period.[1] The total Medicaid reimbursement for the 414,633 claims was $54,411,000 ($28,366,886 Federal share). The Medicaid claims were extracted from the claim files maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample to evaluate the population of Federal Medicaid claims.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services' statistical software, RAT-STATS. We used the random number generator for our sample.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the 414,633 detailed claims. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

[1] We limited our review to claims for the following State plan services: home health aide, nursing, occupational therapy, physical therapy, and speech therapy.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
414,633	$28,366,886	100	$7,125	39	$2,530

Estimated Value of Unallowable Costs
(Limits Calculated for the 90-Percent Confidence Interval)

Point estimate	$10,492,288
Lower limit	8,177,970
Upper limit	12,806,606

APPENDIX D: JEWISH HOME COMMENTS

Jewish Home Lifecare

September 19, 2011

Mr. James P. Edert
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region II
Jacob Javits Federal Building
26 Federal Plaza-Room 3900
New York, NY 10278

Re: *Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services - Manhattan LTHHCP*
Report Number A-02-10-01002

Dear Mr. Edert:

This submission is in response to your draft July 2011 Report titled, "Review of Selected Medicaid Home Health Services Claims Made By Jewish Home And Hospital Lifecare Community Services -- LTHHCP" (the "Draft Report"). We appreciate the opportunity to respond to the Draft Report, which as detailed below, contains a number of proposed findings that should be revised in the final report. The great majority of the recommended disallowances in the Draft Report center on The Department of Health & Human Services' ("HHS") findings that, of the 100 claims reviewed, 38 cases were not reviewed by a physician within a 60-day certification period. The Draft Report also asserts that for two claims no care plan was provided, for one claim there was no documentation of service and in one case an aide did not receive the requisite training. Based on these findings, the Draft Report concludes that each of these claims for reimbursement should be disallowed and the Medicaid funds associated with these claims returned to the Federal Government by the State of New York. As detailed below, we believe that these conclusions are incorrect and that the reimbursements were proper.

Significantly, the Draft Report does not assert that any of the reimbursed services were not provided, were not needed or that the patients were improperly in the Long Term Home Health Care Program ("LTHHCP"). The reason for this is clear. In the vast majority of cases, the care plans were eventually signed, and the prior and subsequent care plans also were authorized by the physician. Moreover, the record shows that in many of the cases, during the period when the care plan was unsigned, the physicians were interacting with the nurses as issues arose and were providing verbal orders of care demonstrating their approval of the need for LTHHCP services. In short, there is no factual basis to conclude that the services in question were not necessary.

In order to reach its conclusion, HHS has applied a hyper-technical requirement that patient care plans must be signed by the physician every 60 days. Putting aside that this interpretation is both incorrect as a matter of law and inconsistent with the New York State audit standards of LTHHCP programs, by taking this position the Draft Report ignores the reality of how LTHHCP programs operate. The doctors are not employees of Jewish Home Lifecare ("JHL") and do not work in JHL facilities. As such, JHL has no ability to force these professionals to sign the care plans in any set time frame. Instead, JHL can only send the forms to these doctors and press them to return the form. The record shows that this is exactly what was done.

For each and every sample, JHL not only sent the care plan to the doctor prior to the care plan taking effect, but also re-sent the form within the 60-day period and made several additional attempts to gain the signature through repeated contacts. In cases where these diligent efforts failed, the matter was then assigned to a Director of Patient Services, who made further attempts. Ultimately, as a result of these efforts, the vast majority of the care plans at issue were signed by the doctor, verifying that they were appropriate. What the Draft Report fails to state is what additional course of action JHL could or should have taken, or where JHL was deficient in its actions.

The consequences of allowing the Draft Report to remain in its current form are significant and almost certainly unacceptable as a legal, fiscal and policy matter. Followed to its logical conclusion, if the doctor fails to sign the current plan of care within a 60-day window, a provider would be left with two choices: (1) continue to provide the medically necessary services understanding that it would receive no reimbursement, or (2) refuse to provide this necessary care and initiate steps to discharge the patient. Either of these actions would ultimately be detrimental to the patient. Under the first scenario JHL and all other LTHHCP providers would be left in the untenable position of bearing the cost for these essential services, a decision which would quickly make participation in the program fiscally impractical for all providers. Under such circumstances, many of these patients would instead end up in a nursing home -- the very outcome that the LTHHCP was intended to prevent. Under the second scenario, patients would be forced into hospitals or nursing homes simply through the lack of diligence of their doctors. Of course, there also would be numerous fair hearings and other legal challenges to the discontinuance of LTHHCP services. In either case, the result would be to undermine the worthy goals that led to the establishment of the LTHHCP.

The Draft Report also imposes a requirement on providers to obtain a signature in a time frame that is both absent from the relevant statutes and inconsistent with the New York Office of the Medicaid Inspector General's ("OMIG") audit standards for the LTHHCP. The law is clear that no signature or date is required. Instead, as discussed below all that is required is that the plan be reviewed. Given that the audit staff did not interview any of the doctors, each of whom received a copy of the plan of care during the time period at issue and did not give any indication of disagreement with the plan, there is no basis for asserting that the plans were not in fact reviewed. Further, the LTHHCP audit standards in force and publicized by OMIG made clear that in cases in which the care plan was reviewed within 90 days -- which occurred in multiple cases -- there would be no disallowance.

Finally, the Draft Report misinterprets conditions for participation with conditions of payment. Relevant case law and handbooks are very clear that where proper services were provided, the fact that a technical condition of participation was not met cannot be used as a basis for a disallowance.

For these reasons and as set forth in more detail below, the Draft Report is fatally flawed in both its approach and its findings. While JHL recognizes the importance of obtaining timely signatures, the inability to obtain such a signature should not be a basis for disallowance of payment to a provider who was unable to compel a third-party to act. Rather, the Draft Report should consider other ways to strengthen the process to engender physician compliance.

I. The Long Term Home Health Care Program

The importance of the LTHHCP cannot be overstated. Through its coordinated plan of care, services are provided to individuals who would otherwise be eligible for placement in hospitals or residential treatment facilities for a protracted time period. LTHHCP providers deliver a variety of services to ill or disabled individuals in their homes or adult care facilities. These services include case management, nursing, therapy, medical supplies and equipment, and homemaker and housekeeper services. The LTHHCP has operated successfully in New York for over 27 years and serves over 22,000 patients. The program enables individuals to avoid institutionalization and most patients remain in the program for multiple years. People of all ages benefit from the services of the LTHHCP, but the most common recipients of LTHHCP services are frail, elderly individuals who would have difficulty acclimating to an unfamiliar health facility.

In addition to the benefits the patient receives, the program also provides significant savings to the Medicaid program. Indeed, one of the goals of the LTHHCP is "to prevent or reduce the costs associated with unnecessary hospitalization and the unnecessary utilization of other costly health services, through provision of close case management and monitoring." *See* LTHHC Program Reference Manual, at 1-2. The New York Social Services Law mandates that the cost of LTHHCP services generally cannot exceed 75% of the cost of care in a skilled nursing facility ("SNF") or a health-related facility ("HRF"). *See* N.Y. Soc. Servs. Law § 367-c. For individuals living in an adult care facility, Medicaid expenditures cannot exceed 50% of the cost of care in a SNF or HRF. *See id;* 18 NYCRR 505.21. These cost limitations and attendant savings allow the State to direct much-needed Medicaid resources to other critical services and programs.

Under the program, there are two separate methods by which a patient is certified as being properly placed in the LTHHCP. First the overseeing physician is supposed to review the plan of care every 60 days. *See* LTHHC Program Reference Manual, at 2-19. In addition, every 120 days, a complete reassessment of each individual is jointly conducted by the nurse representative of the individual's LTHHCP provider and LDSS representative. *See id.*, at 2-21.

II. Each of the Patients Was Appropriately Receiving LTHHCP Care

As set forth in detail in Appendix A and the accompanying documents, each of the patients at issue was appropriately receiving LTHHCP services. In most cases, these were elderly patients who, without these services, would have had to have been transferred to a hospital or a nursing home. All of the patients had signed care plans enrolling the patient in the program. Each of the patients (including those who the Draft Report claims did not have care plans during the time period at issue) had care plans that were, in the vast majority of cases, ultimately signed by the physician. In no case did the physician question whether LTHHCP care was appropriate, or seek to discharge the patient. Moreover, by signing the care plan for the dates at issue, the physicians were certifying the care was appropriate. Whether the plan was signed contemporaneously or at a later point, this signature makes clear that the doctors believed the care was appropriate, and had JHL discontinued care because of the lack of the signature, it would have potentially been harmful to the patient. In addition, the vast majority of the patients had care plans after the time period at issue which were also signed by the physician, thereby demonstrating that LTHHCP care continued to be appropriate. Finally, meeting the second requirement for placement, each patient was certified by the Local Department of Social Services' representative and JHL that they were eligible for the LTHHC program. Accordingly, any conclusion that the patients were receiving services that they were not entitled to or were inappropriate is simply without foundation.

III. Review of the Care Plans at Issue Complied with all Applicable Legal Requirements

The Draft Report relies exclusively on the CMS-485 form to support its requirement of a mandatory signature within 60 days. In footnote 2, however, the Draft Report acknowledges that the Form CMS-485 is not a required form and states that "[h]ome health agencies may submit any document that is signed and dated by a physician that contains all of the required data elements . . . ." The Draft Report cites no legal authority for the purported requirement that plan of care documentation must be signed and dated by physician. Indeed, the only authority cited to, 42 C.F.R. § 440.70(a)(2), is simply a definitional section relating to home health services under waiver programs (such as New York's LTHHCP). This Regulation provides only that the care plan must be *reviewed* by the physician every 60 days. It contains no signature requirement.[1]

In any event, because the LTHHCP is a creature of New York State law (pursuant to Federal waiver approval), *see* 10 N.Y.C.R.R. § 763, *et seq.*, the issue of when physician signatures are needed on clinical records for an LTHHCP patient should be governed by State law. Section 763.7 prescribes the clinical records that an agency must maintain "for each patient admitted to care or accepted for service." Specifically, Section 763.7(a)(3)(i) and (ii) require that the "medical records and nursing diagnoses . . . medications, treatments and prognosis" must be signed by a physician "after admission" and "after issuance of any change in

[1] Other Federal Regulations explicitly contemplate the use of verbal orders by physicians in connection with the administration of drugs and treatment by agency staff, undermining any assertion that care plans must be signed by a physician. *See* 42 C.F.R. § 484.18(c).

medical orders." By contrast, Section 763.7(a)(3)(iii) requires only that the plan be "renewed . . . as frequently as indicated by the patient's condition but at least every 62 days."

Section 763.7(a)(3) thus distinguishes between when a signature is required and when mere "renewal" is sufficient. The distinction is not a matter of semantics. It reflects a recognition that LTHHCP patients are, by definition, long-term patients who would otherwise be in a nursing home and thus, their health status is unlikely to change over the course of 60 days. In short, while the State regulation clearly requires communication between the LTHHCP nurse and the treating physician at least every 62 days, there is no requirement for a physician signature simply to renew a plan of care or that related paperwork must be finalized within the same timeframe.

IV. JHL Made Every Reasonable Effort to Ensure that the Plans were Reviewed

The record demonstrates that JHL made every effort to have the care plans reviewed in a timely manner. In order to ensure that the required review of the plan of care occurred, JHL had a five-step system in place during the audit period which its employees are required to follow. *See* Exhibit A. These instructions were set out on a form given to every employee who deals with the care plans. Under this system:

1. An RN completes the 485 form two weeks prior to the certification date (the 485 cannot be completed earlier because it includes a sixty-day summary and projects the health care needs over the next 60-day period) and attempt to obtain verbal approval from the MD, indicating this on the 485.

2. Filing clerk prints and mails/faxes the form to the MD's office. The clerk enters the mailing date into the tracking system. The clerk tracks the return of the signed 485 from the MD's office.

3. If the 485 is not returned in two weeks, the clerk contacts the MD office for follow-up. If necessary, another 485 print-out is sent out via fax, mail or hand-delivery, whichever method the MD's office requests.

4. If the 485 is not received in two weeks (4 weeks have elapsed since the initial mailing), the clerk reaches out to the MD's office for follow-up, again resending as outlined above.

5. If the 485 is not received in two weeks (6 weeks since the initial mailing), the clerk alerts the DPS (Director of Patient Services) so that DPS or a designee can provide a higher-level follow-up, calling the MD's office and attempting to highlight the need for signature.

As the documents attached to Appendix A demonstrate, in addition to having these procedures in place, for each of the care plans at issue, these procedures were substantially followed. JHL employees repeatedly contacted the doctors and attempted to ensure that they reviewed the care plan. In each of these cases, the care plans were physically in the offices of the doctors for their review, and JHL never received any indication that the plans were not reviewed by the doctor or that the doctors felt that changes were needed. Ultimately, in the vast

majority of the cases, the forms were ultimately returned. It is unclear what additional steps HHS believes JHL should have taken to ensure that the plans were in fact reviewed and signed.

V. There is no Evidence That the Physicians did not Review the Care Plan Within the 60-Day Window

As was noted above, each of the care plans at issue was generated by the JHL nursing staff and then sent to the physicians for their review. As such, the plans were in their possession during the relevant period. The assumption in the Draft Report's conclusion that the physicians did not review the care plans which they had in their possession is without foundation. To our knowledge, HHS did not interview the physicians but instead simply concluded that they violated their responsibilities to their patients. To the contrary and as detailed in Appendix A and its accompanying documents, there are multiple contacts that occurred between JHL's nursing staff and physicians during the time period at issue. This coordination indicates that the physicians were aware of the patients' continued receipt of LTHHCP services and that the physicians were specifically authorizing the provision of additional care. Under these circumstances, there is no justification for determining that the plans of care were not approved by the doctors.

VI. Even if There is a Requirement That the Care Plan be Signed During the 60-day Window, Some of the Claims Were Valid

For a number of the cited claims, contrary to the Draft Report findings, there is documented evidence that the physician orders were signed during the 60-day window. For example, in sample 45, the physician signed the order on June 7, 2006. This fell into the certification period, which is listed as May 17, 2006 until July 16, 2006. Similarly, although in a number of other cases, the doctors failed to indicate the date on which they signed the record, contemporaneous computer notes from JHL's clerk of when the plan was returned indicate that this occurred during the 60-day window. As demonstrated by the tracking records in the documents attached to Appendix A, this is true for claims 45, 53, and 93.

VII. Applying the OMIG Standard, All Care Plans Signed Within 90 Days Should Be Accepted

Even if the applicable regulations are interpreted to require a physician signature for every 60-day renewal of a plan of care -- and putting aside the fact that such a requirement is not authorized in statute -- the entity charged with overseeing the auditing of New York's Medicaid program has indicated that it will only seek disallowance of claims when physician signatures are obtained more than 30 days after the 60-day renewal period. *See OMIG Analysis of Audit Findings--Long Term Home Health Care Programs (LTHHCP)*, Effective Feb. 2009, Finding 8, annexed hereto as Exhibit B. As this was the standard set by OMIG, it is inappropriate for HHS to apply a different standard. Accordingly, as demonstrated by Appendix A and the attached documents, claims 3, 10, 26, 41, 51, 62, 71, and 76 should not be disallowed as they were signed within the 90-day window.

VIII. HHS's Assertion That There was no Care Plan for Two Claims is Incorrect

The Draft Report asserts that in two cases, samples 35 and 72, no care plan existed. This is simply incorrect. As Appendix A's attached documents demonstrate, there were plans of care in place for both claims.

IX. The Assertion That There is no Documentation to Support Service in Connection with Claim 34 is Without Foundation

For Claim 34, the Draft Report asserts that "Jewish Home did not provide documentation that the related service (long-term nursing was provided)." This assertion is wrong. As the April 20, 2006 Home Visit Progress Note -- issued one day before the date of service at issue -- demonstrates, the patient did receive long term nursing care and this care was in fact properly documented. *See* Appendix A and accompanying documents.

X. JHL Made Every Reasonable Effort to Ensure that the Aide had the Proper Training

The Draft Report asserts that in one claim, claim 7, the home health aide did not receive basic training. Although it does appear that the aide in question only received Home Health Aide certification a few months after the date of service, JHL was reliant upon his agency and its representation that the aide was properly trained. Interviews with relevant JHL staff indicates that a qualified Home Health Aide was requested from the third party service and JHL, having worked with this service successfully for years, relied on their having complied with the request. Under these circumstances a disallowance would be improper.

XI. The Draft Report Improperly Applies Conditions of Participation in the Medicaid Program as Conditions of Payment

The deficiencies identified in the Draft Report are based on a review of isolated provisions of the applicable regulations and focus on technical issues related to the nature and timing of the documentation supporting the claims at issue. While JHL does not seek to minimize the importance of compliance with the technical requirements, there is a distinction between requiring strict compliance as a condition of continued participation in the Medicaid program and requiring that same level of compliance as a condition of payment for services provided to Medicaid beneficiaries. Here, the Draft Report's attempt to impose strict compliance with administrative requirements as a condition of payment for services provided by JHL to beneficiaries is improper and unfair.

More fundamentally, a technical documentation error should not prevent payment of a claim where services were otherwise properly rendered. The federal government itself has recognized this explicitly in connection with the Medicare program:

> The Conditions of Participation (COP) requirements *cannot be used as a basis for denying payment.* The COPs define specific quality standards that providers must

> meet to participate in the . . . Medicare program. A provider's compliance with the COPs is determined by the regional office (RO) based on the State survey agency recommendation. In cases where you believe that the COPs are not being met or when problems have been identified, you should notify your RO and the appropriate State survey agency so that they can initiate appropriate action.

Medicare Program Integrity Manual Sec. 3.4.2.1 ("Role of Conditions of Participation Requirements When Making a Payment Decision") (emphasis added).

In addition, the New York State Department of Health ("NYSDOH") has acknowledged the distinction between conditions of participation and conditions of payment and stated in response to a 2010 draft audit report concerning Medicaid claims for personal care services:

> A failure to comply 100 percent with a procedural requirement does not negate the validity of the program benefit or the beneficiary's dire need for the services. When a Medicaid beneficiary has an immediate need for services in order to remain in his or her home, a local district may have to choose between strict regulatory procedural compliance or patient health and safety. The Department hopes in such situations that the federal government will agree that patient health and safety takes priority over procedural compliance. If the OIG asserts that strict adherence to procedural requirements contained in the State's regulations is the essential criteria upon which federal funding is based, New York and other states may be forced to re-evaluate their home and community-based program/services regulations.

HHS, *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 8, 2010, app. D.

Federal courts, too, have recognized the distinction between conditions of participation and conditions of payment. In *US ex rel. Connor v. Salina Regional Health Center, Inc.*, 543 F.3d 1211 (10th Cir. 2008), a case brought under the federal False Claims Act that involved disputed Medicare claims, the court concluded that "although the government considers substantial compliance a condition of ongoing . . . *participation*, it does not require perfect compliance as an absolute condition to receiving *payments* for services rendered." 543 F.3d at 1221 (emphasis in original). *See U.S. ex rel. Wilkins v. United Health Group, Inc.*, 10-2747 (3rd Cir. 6-30-2011), at 28.

In short, while NYSDOH may appropriately impose administrative sanctions on a provider that fails to comply with certain conditions of participation, HHS should not be permitted to use that same failure to retroactively disallow payment of claims for services actually rendered.

XII. Pursuant to 18 N.Y.C.R.R. § 540.6(a)(3)(i) any Plan That was Signed Within 2 years of the Date Should not be Disallowed

Finally, the regulation governing billing under the New York Medicaid program provides that:

> all claims for payment for medical care, services or supplies furnished by non-public providers under the medical assistance program must be finally submitted to the department or its fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable as against the department or a social services district.

18 N.Y.C.R.R. § 540.6(a)(3)(i).

In short, notwithstanding any disputes over documentation provided in support of claims, a provider has two years to "finally submit[]" a claim. Here, while there may be disputes over whether JHL had certain documentation within the 60-day certification period invoked by the Draft Report, it cannot be disputed that appropriate documentation was in place for virtually all of the claims at issue within the 2-year period provided under Section 540.6. Any fair evaluation of the claims at issue should, accordingly, take into account all information and documentation obtained by JHL within two years of the date of service, rather than the 60-day period set forth in the Draft Report.

CONCLUSION

For all of the reasons stated above, we urge you to revisit your findings and not include these disallowances in any final audit. The audit should more properly focus on the systemic challenge of obtaining timely signatures from physicians. While the accountability that is engendered by this requirement is important, this accountability could be better achieved through the establishment of mechanisms other than disallowance of payment.

Once again we thank you for the opportunity to respond to the Draft Report. Please let us know if you would like any more information. As always we are available to meet to discuss these issues.

Very Truly Yours,

Bridget Gallagher

Bridget Gallagher, GNP, MSN
Senior Vice President, Community Services
120 West 106th Street, New York, NY 10025
Direct: (212-870-4837) Email: bgallagher@jhha.org

Enclosures

1,490,446v3

EXHIBIT A

Jewish Home Lifecare

Process for 485 (MD Order) Follow-up

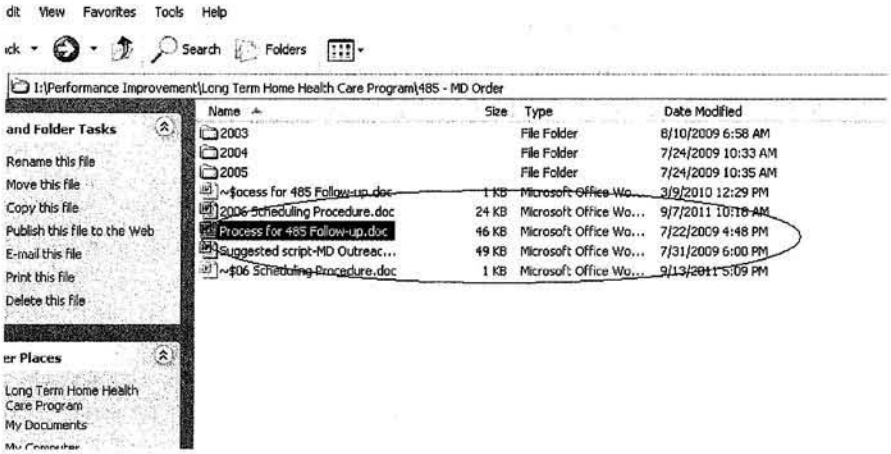
1. RN completes 485 two weeks prior to certification date (485 cannot be completed earlier secondary to the fact that it goes with a sixty day summary and predicts next 60 day health care needs) and obtains verbal approval from MD, indicating same on 485.

2. Filing clerk prints and mails/faxes to MD office. Enters date mailed into tracking system. Clerk tracks return of signed 485 from MD office.

3. If 485 is not returned in two weeks, clerk contacts the MD office for follow-up. If necessary, another 485 print out is sent out via fax, mail or hand-delivery, whcich ever method MD office requests.

4. If 485 is not received in two weeks (4 weeks have elapsed since initial mail out), the clerk reaches out to MD office for follow-up, again resending as outlined above.

5. If 485 is not received in two weeks (6 weeks since initial mailing), the clerk alerts the DPS so that DPS or designee can provide a higher-level follow-up, calling the MD office and attempting to highlight need for signature.


dit View Favorites Tools Help
Search Folders
I:\Performance Improvement\Long Term Home Health Care Program\485 - MD Order
and Folder Tasks
Rename this file
Move this file
Copy this file
Publish this file to the Web
E-mail this file
Print this file
Delete this file
er Places
Long Term Home Health Care Program
My Documents
Name
Size
Type
Date Modified
2003 File Folder 8/10/2009 6:58 AM
2004 File Folder 7/24/2009 10:33 AM
2005 File Folder 7/24/2009 10:35 AM
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2006 Scheduling Procedure.doc 24 KB Microsoft Office Wo... 9/7/2011 10:18 AM
Process for 485 Follow-up.doc 46 KB Microsoft Office Wo... 7/22/2009 4:48 PM
Suggested script-MD Outreac... 49 KB Microsoft Office Wo... 7/31/2009 6:00 PM
~$06 Scheduling Procedure.doc 1 KB Microsoft Office Wo... 9/13/2011 5:09 PM

APPENDIX E: STATE AGENCY COMMENTS

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

March 28, 2012

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-02-10-01002

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-10-01002 on "Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services Manhattan LTHHCP."

Thank you for the opportunity to comment.

Sincerely,

Robert W. LoGiudice, Esq.
Deputy Director
for Administration

Enclosure

cc: Jason Helgerson
James C. Cox
Diane Christensen
Dennis Wendell
Stephen Abbott
Stephen LaCasse
Irene Myron
John Brooks
Ronald Farrell
Barry Benner

New York State Department of Health's Comments on the Department of Health and Human Services Office of Inspector General's Draft Audit Report A-02-10-01002 on the "Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP"

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's (OIG) draft audit report A-02-10-01002 on the "Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP."

Recommendation #1:

The State agency should refund $8,177,970 to the Federal Government.

Response #1:

The Department does not agree that it should refund monies to the Federal government as this OIG recommendation is based on a misinterpretation of the program's requirements. Specifically, neither federal or state regulations implicitly require a physician's *signature* on the plan of care; only a physician's *review* is required:

- 42 CFR 440.70 (a)(2) – "on his or her physician's orders as part of a written plan of care that the physician **reviews** (emphasis added) every 60 days…"
- NYCRR10 763.7(a)(3) – "**reviewed** (emphasis added) by the authorized practitioner as frequently as indicated by the patient's condition but at least every 62 days"

Recommendation #2:

The State agency should improve its monitoring of Jewish Home and its contracted home health providers to ensure compliance with Federal and State requirements.

Response #2:

The Department maintains its monitoring is effective and that the provider did comply with the program's requirements. Prior to this audit, Jewish Home administrators implemented a system for tracking CMS-485 forms (Home Health Certification and Plan of Care). In cases where a delay is experienced in receiving the form from the physician, the provider is verifying its compliance efforts by documenting staff contacts with the physician's office. Such contacts

often result in securing interim verbal orders, thereby meeting patient service needs and safeguarding the assurance of patient health and safety.