Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID SERVICES PROVIDED IN AN ADULT DAY HEALTH SETTING

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EXECUTIVE SUMMARY

OBJECTIVES

1. To describe the types of services reimbursed by Medicaid adult day health programs in the 12 States that provide nursing- and therapy-focused adult day health services through a State plan benefit.
2. To determine whether nursing and therapy services are provided by staff who are qualified and/or supervised in accordance with State licensing requirements.
3. To determine whether beneficiary records contain required documentation.

BACKGROUND

Adult day health centers are organized outpatient programs that provide health, therapeutic, and social services and activities to program participants. Federal and State reviews of Medicaid adult day health services have identified vulnerabilities with reimbursement systems and questionable billings. The Centers for Medicare & Medicaid Services (CMS) and State Medicaid programs do not receive information about the individual services provided to beneficiaries in the 12 States included in our review because reimbursement is based on bundled payment rates.

Within broad Federal Medicaid requirements, individual States establish the specific requirements that must be met for Medicaid reimbursement of adult day health services. In general, adult day health services need to be (1) ordered or requested by a physician or other medical practitioner; (2) provided to eligible beneficiaries, as determined by a patient assessment; (3) included in or consistent with a plan of care; (4) rendered by staff whose qualifications and/or supervision meet State licensing requirements; and (5) supported by appropriate documentation.

Using medical reviewers, we reviewed beneficiary and other facility records associated with a random sample of 300 adult day health service days from the last 6 months of 2007. We focused on the 12 States that, as of December 31, 2007, provided nursing- and therapy-focused adult day health services through a State plan benefit to primarily elderly or disabled individuals.

FINDINGS

Beneficiaries received at least one health service on 60 percent of service days. Nursing services, documented on 59 percent of service days, were the most commonly documented services. Beneficiaries received therapy, primarily maintenance care, on approximately 32 percent of service days. On 40 percent of service days, beneficiaries received no documented health services, including 34 percent of service days on which meals and/or snacks were the only documented services. Most States do not require that beneficiaries receive a health service each day in an adult day health setting. Section 1905(a) of the Social Security Act does not include adult day health services as a specific coverable State plan service and, therefore, no specific Federal requirement for health services exists.

Approximately 43 percent of therapy services were provided by staff who lacked required supervision. Of the documented physical therapy services, 54 percent did not have any documentation indicating that the appropriately qualified staff were available to supervise the service where required under State law and regulation. Approximately 32 percent of the documented occupational therapy services had no documentation that appropriately qualified staff were available to supervise the service in accordance with State law and regulation.

Documentation included timely assessments, but in some cases it lacked appropriate physician orders or was inconsistent with plans of care. Records for approximately 90 percent of service days included timely assessments. Records for approximately 21 percent of service days did not include a physician order or request signed before the start of treatment. Approximately 22 percent of nursing and therapy services received on service days were not included in the beneficiaries' most recent plans of care and, therefore, may be inconsistent with their treatment goals.

RECOMMENDATIONS

On many service days, beneficiaries' only documented services were meals and/or snacks. Many also received therapy services from staff who were not supervised in accordance with State requirements. Our findings indicate the need for (1) explicit requirements regarding the provision of health services in Medicaid adult day health centers and (2) enforcement of current therapy supervision requirements. Therefore, we recommend that CMS:

Specify what services are required for Medicaid reimbursement of adult day health services.

Direct States to enforce supervision requirements for staff who provide therapy services in Medicaid adult day health centers.

Take appropriate action to address the centers that did not respond to repeated data requests.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, CMS concurred with all of our recommendations. In response to our first recommendation, CMS stated that it will educate States on the proper authorities by which services in an adult day health setting may be covered under Medicaid. In response to our second recommendation, CMS stated that it will ensure that each State plan includes assurances that services are provided in accordance with Federal regulations. In response to our third recommendation, CMS stated that it will follow up with the appropriate States to discuss whether they have policies and procedures in place that require Medicaid providers to allow State Medicaid agencies access to data and records that can be used to support appropriate reimbursement for services.

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3. To determine whether beneficiary records contain required documentation.

BACKGROUND

Federal and State reviews of Medicaid adult day health services identified problems with reimbursement systems and questionable billings.[1] Because reimbursement is based on bundled payment rates, the Centers for Medicare & Medicaid Services (CMS) and State Medicaid programs do not receive information about the individual services actually provided to beneficiaries in the12 States that provide nursing- and therapy-focused adult day health services through a State plan benefit. Furthermore, some adult day health centers billed Medicaid for deceased or ineligible beneficiaries or used questionable referrals for care.[2]

Medicaid Adult Day Health Services

Adult day health centers are organized outpatient programs that provide health, therapeutic, and social services and activities to program participants. The services and eligibility requirements vary

[1] See California Department of Health Services, *Medi-Cal Payment Error Study, Fee for Service and Dental Programs, 2005*, p. 15. Accessed at http://www.dhcs.ca.gov/formsandpubs/publications/Documents/ANI_MPES%202005%20Report.pdf on March 16, 2010. New Jersey State Legislature, Office of Legislative Services, Office of the State Auditor, *Department of Health and Senior Services, Division of Consumer Support, Medical Assistance to the Aged, Medical Day Care Program* (A-02-02-01026), March 24, 2003. Office of Inspector General (OIG), *Ryan White Title I Funds Claimed by an Adult Day Health Care Contractor of the San Francisco Eligible Metropolitan Area for the Fiscal Year Ended February 28, 2002* (A-09-03-01018), February 9, 2005.

[2] "Sixteen adult day centers accused of rampant fraud," *New Jersey Star-Ledger*, August 25, 2003. Reporting on a 2002 investigation by the New Jersey Department of Health Services' Program Integrity Unit and the State Attorney General's Office.

across States, but most States cover a variety of skilled nursing; health monitoring; rehabilitation services, such as physical and occupational therapy and speech-language pathology; and/or mental health counseling and support. Adult day health centers also generally provide meals, assistance with activities of daily living, social and recreational activities, and transportation to and from the center.

Eligibility for adult day health services generally is determined by an individual's assessed need for one or more offered services. A program participant may be eligible to receive adult day health services for a limited period to address a specific rehabilitative goal or for many years to address a chronic health issue, depending on the participant's assessed needs and the goals established in his or her plan of care.[3] The average age of adult day health service participants is 75; most are disabled.[4]

State Options for Medicaid Coverage of Adult Day Health Services

State Medicaid programs have options for covering adult day health services, including section 1915(c) home- and community-based services waivers, optional State plan benefits, and home- and community-based State plan benefits.

Most States provide adult day health services through one or more section 1915(c) home- and community-based services waiver(s). Section 1915(c) waivers allow States to target services to the population thought most likely to benefit. To be eligible for 1915(c) waiver services, beneficiaries must require an institutional level of care.[5]

States, including the 12 in our review, also may cover adult day health services under an optional benefit through their Medicaid State plan.[6] Section 1905(a) of the Social Security Act does not include adult day

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[3] Plans of care, typically developed by a nurse, therapist, or interdisciplinary team of health care providers, identify problem areas for beneficiaries, list measurable goals, and describe treatments to be provided by center staff to enable beneficiaries to achieve these goals.

[4] J.A Lucas, N.S Rosato, J.A. Lee, and S. Howell-White, *Adult Day Health Services: A Review of the Literature*, Rutgers Center for State Health Policy, August 2002. Accessed at http://www.cshp.rutgers.edu/PDF/AdultDaycareLitRev.pdf on June 15 2010.

[5] Under this requirement, a beneficiary must, in the absence of the specified home- and community-based service, require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded. Social Security Act, § 1915(c)(1).

[6] States outline their Medicaid programs in their State plans. The State plan, once approved by CMS, specifies eligibility requirements, the level and type of benefits, payment rates and methodology, and the administrative structure for the State's Medicaid program.

health services as a specific coverable State plan service, but State Medicaid programs may pay for these services under an appropriate State plan benefit, such as personal care services, physical therapy, or nursing services. Generally, a benefit provided through the Medicaid State plan is available to all categorically eligible Medicaid beneficiaries who meet the conditions of coverage for the benefit.[7]

Provisions in the Deficit Reduction Act of 2005 expanded State options for covering adult day health benefits in State plans. Pursuant to section 1915(i) of the Social Security Act,[8] States can elect to provide home- and community-based State plan services (including adult day health services) to elderly and disabled beneficiaries. To cover services under this authority, States must meet conditions not required for other State plan benefits.[9] As with other State plan benefits, beneficiaries are not required to meet the established institutional level of care to be eligible for section 1915(i) services although, unlike with other State plan benefits, beneficiaries' income must not exceed 150 percent of the Federal poverty level.

As of December 31, 2007, the last date of the 6-month period covered by our review, 47 State Medicaid programs provided some form of adult day health services to eligible beneficiaries, in most cases through a 1915(c) home- and community-based services waiver or through an optional State plan benefit.[10]

Adult Day Health Requirements

Within broad Federal Medicaid requirements, individual States establish the specific requirements that must be met for Medicaid reimbursement of adult day health State plan benefits. Each State plan

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[7] 42 CFR § 440.240.

[8] 42 U.S.C. § 1396n(i).

[9] States must meet the following conditions: (1) establish needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home- and community-based services and, if the individual is eligible for such services, the specific home- and community-based services that the individual will receive; (2) establish needs-based criteria for institutionalized care that are more stringent than needs-based criteria for section 1915(i) home- and community-based services; (3) project the number of individuals to be provided home- and community-based services; and (4) use independent assessments to determine the individual's eligibility for the services.

[10] Department of Health & Human Services, Assistant Secretary for Planning and Evaluation; K. Siebenaler, J. O'Keeffe, C. O'Keeffe, D. Brown, and B. Koetse, *Regulatory Review of Adult Day Services: Final Report*, August 2005, pp. 2–24. Accessed at http://aspe.hhs.gov/daltcp/reports/adultday.pdf on March 16, 2010; OIG review of State plans and Medicaid waivers.

must specify the "amount, duration, and scope for each service that it provides for" and ensure that "each service [is] sufficient in amount, duration, and scope to reasonably achieve its purpose."[11] Of the 50 States and the District of Columbia, 12 States provided nursing- and therapy-focused adult day health services through a State plan benefit as of December 31, 2007.[12, 13]

Most State regulations include requirements related to patient eligibility, coverage of services, physician orders, plans of care, documentation of services, and provider qualifications. All States included in our review required that Medicaid adult day health services be:

(1) ordered or requested by a physician or other medical practitioner;

(2) provided to eligible beneficiaries, as determined by a patient assessment;

(3) included in or consistent with a plan of care;

(4) rendered by staff whose qualifications and/or supervision meet State licensing requirements; and

(5) supported by appropriate documentation, such as progress notes, flowcharts, and treatment logs.

State requirements also outline the authorized services and attendance requirements for adult day health service participants. Requirements in the 12 States included in our review outline which services are authorized within adult day health programs, but generally do not specify, with the exception of transportation services and meals, the frequency and duration of particular services that must be provided to participants. States also determine the minimum amount of time a beneficiary must be present for the center to bill for Medicaid reimbursement for full or half days. Depending on the State,

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[11] 42 CFR § 440.230.

[12] These States were California, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Nevada, Texas, Washington, and Vermont. Maryland eliminated its State plan adult day health benefit after December 31, 2007, and began covering adult day health services through a 1915(c) waiver.

[13] The remaining 39 States and the District of Columbia (1) provided an adult day health service benefit through at least one 1915(c) or 1115 waiver, but not through their State plan; (2) provided a State plan adult day health service benefit that was not nursing and therapy focused; or (3) did not provide a Medicaid adult day health benefit.

beneficiaries typically must be present for 4 to 8 hours for the center to receive Medicaid reimbursement for a full day of service.

Proposed Requirements

In August 2007, CMS promulgated a Notice of Proposed Rulemaking concerning coverage for Medicaid rehabilitative services.[14] The proposed rule specified the types of services that would be eligible for Medicaid reimbursement under the rehabilitative benefit. In particular, it indicated that:

> rehabilitative services would not include recreational and social activities that are not specifically focused on the improvement of a physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan, and provided by a Medicaid qualified provider recognized under State law.[15]

The proposed rule would have required States that include adult day health (among other services) as a rehabilitative service benefit in their State plan, including nine States in our review, to alter the scope and/or documentation requirements of these services.

Concerned that beneficiaries would lose access to rehabilitative services, Congress enacted section 5003(d) of the American Recovery and Reinvestment Act of 2009, which states that "it is the sense of Congress that the Secretary of Health & Human Services should not promulgate as final any of the following proposed Medicaid regulations …," including the proposed rehabilitative services regulation published on August 13, 2007.[16] CMS withdrew the proposed rehabilitative services rule in November 2009. As a result, although States have established requirements for services (such as adult day health) that are covered under the rehabilitative benefit, there are no explicit Federal requirements concerning the types of services that are eligible for Medicaid reimbursement under the rehabilitative benefit.

Reimbursement Methodologies for Adult Day Health Services

Although specific reimbursement methodologies for adult day health services vary, the 12 States that provided a nursing- and therapy-focused adult day health benefit through their State plans reimbursed providers based on bundled payment rates. A bundled

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[14] 72 Fed. Reg. 45201 (Aug. 13, 2007).

[15] 72 Fed. Reg. 45201, 45206 (Aug. 13, 2007).

[16] P.L. 111-5 (Feb. 17, 2009).

payment covers all services provided to a beneficiary within a specified period. The actual bundled rates and means of calculating the rates varied across the States. For example, in 2007, daily adult day health rates were $63.16 for a full day in Missouri and $76.88 in California and ranged from approximately $70 to more than $200 in New York.[17] In Texas, the bundled reimbursement rate varied based on the beneficiaries' level of need and the number of hours spent at the center. During our period of review, Medicaid claims for adult day health services, even when based on daily rates, often were submitted for reimbursement on a weekly, monthly, or other less frequent basis.

Related Reviews

Previous reviews in two States included in this latest review have indicated that adult day health services may be vulnerable to improper billing. The California Department of Health Services found that among all Medicaid providers, adult day health service providers had the "highest percentage of claims completely in error and the greatest number of errors" related to the provision of medically unnecessary care in 2005.[18]

In addition, in 2003, the New Jersey Office of the State Auditor, in partnership with the Department of Health & Human Services' OIG, released a report on the administration of New Jersey's Medical Day Care program.[19] The report indicated that reviewers could not determine the reasonableness of the payments because the program regulations did not define adequately the population to be served. The study also identified a large number of ineligible clients in some facilities and incomplete attendance records. The report concluded that the Medical Day Care program had evolved from an alternative to nursing home care to a program that provided services to any beneficiary enrolled in Medicaid because the State requirements did not

[17] In New York, maximum daily adult day health rates are based on the sponsoring skilled nursing facilities' established facility rate.

[18] California Department of Health Services, *Medi-Cal Payment Error Study, Fee for Service and Dental Programs, 2005*, p. 15. Accessed at http://www.dhcs.ca.gov/formsandpubs/publications/Documents/ANI_MPES%202005%20Report.pdf on March 16, 2010.

[19] New Jersey State Legislature, Office of Legislative Services, Office of the State Auditor, *Department of Health and Senior Services, Division of Consumer Support, Medical Assistance to the Aged, Medical Day Care Program* (A-02-02-01026), March 24, 2003.

explicitly define the types of medical conditions that warranted Medical Day Care services.

A 2002 investigation by the New Jersey Department of Health Services' Program Integrity Unit and the Division of Criminal Justice in the State Attorney General's Office identified at least $600,000 in questionable billings by adult day health service centers.[20] These centers billed Medicaid for deceased patients, patients who did not require services, and patients who attended centers for only a fraction of the minimum time required by the State. Some of these centers did not have a nurse on duty, as required, or encouraged patients to attend with promises of toaster ovens, fruit, or trips to Atlantic City.

METHODOLOGY

Scope

We reviewed beneficiary and facility records associated with a random sample of adult day health service days from the last 6 months of 2007. We focused on the 12 States that, as of December 31, 2007, provided nursing- and therapy-focused adult day health services through a State plan benefit to primarily elderly or disabled individuals.[21]

We selected the 12 States to ensure consistency in the types of services and populations included in our review. We focused on States that structured their adult day health benefit to provide rehabilitative and other health services to a primarily elderly or disabled population. Including States that offer different types of adult day health benefits, such as through 1915(c) waivers, would have made a multi-State review impractical. States have a great deal of flexibility in designing 1915(c) waiver benefits, and as a result, waiver services and requirements generally vary across States. Similarly, the services provided and populations served through adult day health benefits focused on mental health rehabilitation differ significantly from nursing- and therapy-focused adult day health services provided through either State plans or waivers.

[20] "Sixteen adult day centers accused of rampant fraud," *New Jersey Star-Ledger*, August 25, 2003.

[21] These States were California, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Nevada, Texas, Washington, and Vermont. Maryland eliminated its State plan adult day health benefit after December 31, 2007, and began covering adult day health services through a 1915(c) waiver.

Sample Selection

We requested that the 12 States provide all adult day health service claims with dates of service in the last 6 months of 2007 maintained in their Medicaid Management Information Systems (MMIS). We requested the following information about adult day health claims: [22]

- the associated service date(s);
- the beneficiary's name, date of birth, and Medicaid identification number; and
- the Medicaid provider name, provider number, and mailing address.

Using this information, we created a database of 8,522,935 service days, each of which represented a unique combination of a service day and a beneficiary Medicaid identification number. From this database, we selected a simple random sample of 400 service days. Because the MMIS data in some States did not contain a separate claim for each service day, in some cases we estimated likely service days based on the MMIS claim dates and reimbursement information. As a result, in these cases, sampled service days may not reflect days on which a beneficiary actually was present in an adult day health center. For example, an adult day health claim could have a claim date from September 3 to September 7, 2007. We would have sampled 1 day within this time period, for example, September 4. It is possible that the beneficiary was not present in the center on September 4, but attended only on September 3, 5, and 7.

Record Collection

We requested beneficiary and facility records associated with sampled service days from each center that provided the adult day health services. We forwarded the information for the service days to our medical review contractor (contractor), which sent letters to each of the centers that provided the adult day health services. The letter requested (1) all physician orders, plans of care, and assessments maintained for the beneficiary; (2) beneficiary records documenting the beneficiary's first month of attendance at the facility following initial enrollment; (3) beneficiary records documenting services,

[22] We chose the last 6 months of 2007 because we wanted all dates of service to be relatively close in time to our data. We did not expect that there would be differences in documentation at the adult day health centers in the last 6 months of 2007 when compared with the first 6 months.

progress notes, and flowcharts for the 6 months before the sampled service date;[23] and (4) facility records, such as treatment, equipment, and transportation logs; beneficiary and staff sign-in sheets; and staff schedules for the sampled service date.

We limited our review to service days for which patient or other facility records included some documentation that the beneficiary was at the facility. Because our review was based solely on information available in patient and other facility records, we wanted to ensure that documentation would be available to complete an accurate review of service days.

Of the 400 service days, we removed 57 because we deemed them ineligible (not part of our intended target population) for the following reasons:

- the provider was under OIG investigation (1 service day),
- available information indicated that the beneficiary was not in the center on the sampled service day (53 service days),[24] and
- the center did not provide primarily nursing and therapy services to an elderly and/or disabled population (3 service days).

The remaining 343 service days constituted our eligible sample size (sample units deemed part of the intended study population). We received responses for 300 of these 343, a response rate of 88 percent, and the contractor reviewed records associated with all 300 service days. The contractor did not complete reviews for the other 43 service days for the following reasons:

- the center did not respond to repeated requests for records (37 service days),[25]

[23] If the beneficiary attended the center for fewer than 6 months, we asked that the center provide all records documenting services, progress notes, and flowcharts before the sampled service date for that beneficiary.

[24] In these cases, our service day did not reflect a day on which the beneficiary actually received an adult day health service, whether because the beneficiary was absent or the sampled service day fell on a Saturday or Sunday and the center was closed.

[25] With no contact from the center, we could not confirm that the beneficiary was present on the sampled service day. As a result, we assumed these service days were part of our intended study population and treated them as nonrespondents missing completely at random in our analysis. This means our results are based only on the 300 responding service days.

- incomplete records did not allow medical reviewers to conduct their reviews (5 service days), or
- the center reported that the beneficiary listed on the claim never attended the facility (1 service day).

Medical Record Review

The medical record review was completed in two parts. For the first part, a nurse-screener reviewed records associated with each service day to determine whether the following was included: (1) physician orders or requests, (2) initial assessments, and (3) plans of care.

The nurse-screener also identified all individual services received on each service day, categorized the individual services into one of 13 service types or into an "other" category,[26] and indicated whether each individual service was included in the beneficiary's plan of care. The 13 service types were:

- nursing,
- physical therapy,
- occupational therapy,
- speech-language pathology,
- therapeutic activity,
- recreational/social activity,
- assistance with activities of daily living (ADL),
- dietician/nutritionist education,
- meal,
- snack,
- mental health/psychiatric service,
- pharmacy service, and
- social work service.

[26] We instructed the nurse-screener to categorize services as "other" if they did not fall into one of the established service types. The nurse-screener included four psychiatric-related services in the "other" category. For analysis to determine the percentage of health and nonhealth services received on sampled service days, we included these services in the "mental health/psychiatric" service type. The nurse-screener also included four "nonspecific" services in the "other" service type, which we categorized as nonhealth for the analyses on health and nonhealth services.

We instructed the nurse-screener to be as inclusive as possible in categorizing each service as a therapy service or therapeutic activity. The nurse-screener was instructed that, if there was any possibility, as determined by the nurse-screener, that an activity, such as group exercise or gardening, targeted a beneficiary's functional goals, that service should be categorized as therapy or therapeutic activity, even if the record did not explicitly indicate that the activity targeted the beneficiary's goals. After completing the first part of the review, the nurse-screener forwarded records to one or more subject matter experts if they contained at least one of the following services: nursing, physical therapy, occupational therapy, or a therapeutic activity.[27, 28]

For the second part of the review, subject matter experts completed a focused review of nursing and therapy services. Two registered nurses, two physical therapists, and two occupational therapists completed our focused nursing and therapy reviews. The registered nurses determined (1) whether documented nursing services were skilled or nonskilled nursing services[29] and (2) whether the qualifications and/or delegation of staff met State licensing requirements. Physical and occupational therapy reviewers determined whether (1) documented therapy services were rehabilitative/restorative or maintenance services, (2) services were provided one-on-one or in a group, and (3) the qualifications and/or supervision of staff met State licensing requirements.

Medical reviewers referred to the State-specific requirements we identified when assessing the appropriateness of staff qualifications. We reviewed State requirements for adult day health services and providers of nursing, physical and occupational therapy, and speech-language pathology services for the 12 States included in our review. In particular, in consultation with the medical review

[27] Therapeutic activities received further review by a subject matter expert if they were mentioned in the beneficiary's plan of care or were provided by a physical therapist, occupational therapist, or a therapy assistant or aide.

[28] Patient records contained no documented speech-language pathology services on sampled service days. Records with these services on service days also would have been forwarded to subject matter experts for further review.

[29] Based on CMS's definition of skilled nursing service in the *Medicare Benefit Policy Manual*, ch. 7, Home Health Services, section 40.1, Skilled Nursing Care, we defined skilled nursing services as those that must, given the nature of the service or the condition of the patient, be provided by a registered nurse or a licensed practical/vocational nurse. State definitions of skilled nursing care may vary.

contractor, we identified State adult day health requirements for physician orders, initial assessments, plans of care, and staff qualifications, including the appropriate supervision and delegation of services.

Analysis

The results presented in the findings are based on analysis of the medical review results. The results are projected to all service days during the last 6 months of 2007 in the 12 States that provided nursing- and therapy-focused adult day health services through a State plan benefit to primarily elderly or disabled individuals.

Some of the estimates are based on service-level data. Our nurse-screener recorded all services that were documented on the 300 service days, accounting for 2,829 services. The service-level results are projected to all documented services on service days in the last 6 months of 2007 in the 12 States.

Appendix A lists the confidence intervals for all estimates in this report. We determined the following for sampled service days:

- what services were documented;
- the extent to which documented therapy services were rehabilitative and documented nursing services were skilled;
- the extent to which services were provided in one-on-one or group settings;
- the extent to which the qualifications and/or supervision of staff providing services met State licensing requirements; and
- the extent to which physician orders, initial assessments, plans of care, and other documentation were maintained in the patient and other facility records associated with sampled service days.

To determine the percentage of service days on which beneficiaries received a health or nonhealth service, we categorized all services documented on sampled service days as either health or nonhealth. Health services were defined as those that must be provided directly by, or under supervision or delegation of, a licensed practitioner. We indentified nursing, physical and occupational therapy, speech-language pathology, therapeutic activities, pharmacy, dietician/nutritionist education, and certain "other" services (e.g.,

psychiatric services) as health services.[30] Nonhealth services were defined as recreational and social activities, assistance with ADLs,[31] meals, snacks, and social work. We categorized the services in this way to distinguish between services serving primarily a health or medical function and those serving primarily a support function. With the exception of meals and snacks, all of these health and nonhealth services could meet the definition of a Medicaid-covered service.

Limitations

We limited our review to service days for which available documentation indicated that beneficiaries were present in centers. Beyond reviewing available facility documentation, we did not attempt to verify provider statements that a beneficiary was not in a center on the sampled service day. In addition, we were not able to determine the extent to which adult day health centers may have been reimbursed for service days on which beneficiaries were not at centers because State MMIS data included claims that covered more than 1 day of service.

CMS has no standard definition or guidance regarding what constitutes either a health or nonhealth service. Therefore, we categorized each of the 13 service types as either a health or a nonhealth service. The results in the first finding reflect this categorization and could vary if the service types were categorized differently.

Our results may underestimate the number of nonhealth services and overestimate the number of health services received on service days. We reviewed only those services documented in beneficiaries' records. Documentation requirements for recreational, social, and other nonhealth services, when they exist, generally are less clear than those for health services. In some cases, particularly for nonhealth services, such as recreational and social activities, beneficiaries may have received services that were not documented in records maintained by adult day health centers. In addition, because we instructed the nurse-

[30] In some cases, beneficiaries received services related to ADLs, such as ADL training, education, and monitoring, that medical reviewers categorized as a nursing or therapy service. We classified these ADL-related services as health services because they are intended to provide beneficiaries the information and training needed to achieve rehabilitative goals.

[31] We classified assistance with ADLs as a nonhealth service because such assistance is intended to enable beneficiaries to perform everyday self-care activities, such as eating, bathing, and dressing.

screener to be inclusive when classifying a service as either a therapy service or a therapeutic activity, we may have classified some services with an exclusively social or recreational function as health services.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Beneficiaries received at least one health service on 60 percent of service days

On approximately 60 percent of service days, beneficiaries received at least one documented health service. Table 1 highlights the percentage of service days on which beneficiaries received the most common types of services. The total number of documented services on service days ranged from 0 to 55. On average, nine health and nonhealth services were documented in beneficiaries' records each service day. On service days with at least 1 documented health service, the number of health services ranged from 1 to 47, with an average of 11.

Table 1: Service Types Documented on at Least 10 Percent of Service Days

Service Type[32]	Health/Nonhealth	Percentage of Service Days (n=300)
Nursing	Health	59%
Meal	Nonhealth	45%
Snack	Nonhealth	35%
Occupational therapy	Health	29%
Physical therapy	Health	29%
Assistance with ADLs	Nonhealth[33]	27%
Social work service	Nonhealth	19%
Recreational/social activities	Nonhealth	18%

Source: OIG analysis of adult day health medical review results, 2010.

[32] No speech-language pathology services were documented on service days.

[33] Excludes services related to ADLs that medical reviewers categorized as nursing or therapy services.

Nursing services were the most commonly documented services

Nursing services were documented on approximately 59 percent of service days. Beneficiaries received nursing services on almost all service days with at least one documented health service. The most frequently documented nursing services included vital signs checks (28 percent of service days), pain assessments (22 percent), blood sugar checks (13 percent), medication administration (12 percent), and monitoring of food intake (11 percent).

Beneficiaries typically received nursing services in combination with other services. On approximately 49 percent of service days, beneficiaries received nursing care along with at least one other service, such as a meal or assistance with ADLs. On a small number of service days (1 percent), beneficiaries received physical and/or occupational therapy without a nursing service. Beneficiaries received only nursing services on approximately 10 percent of service days.

Beneficiaries received both skilled and nonskilled nursing care. Among all nursing services received on service days, approximately 48 percent were skilled nursing services (e.g., monitoring the signs and symptoms of an allergy, assessing a beneficiary's mental status, or assessing medication side effects), whereas 52 percent were nonskilled services (e.g., conducting a pain assessment, checking a beneficiary's blood sugar level, or monitoring a beneficiary's food intake).

Beneficiaries received therapy, primarily maintenance care, on approximately 32 percent of service days

Beneficiaries received physical and/or occupational therapy on approximately one-third of all service days. Physical and occupational therapy each were documented on 29 percent of service days; beneficiaries received both physical and occupational therapy services on 25 percent of service days.[34] Typically, beneficiaries received therapy in addition to one or more nursing service(s).

Maintenance care was the most frequently documented type of physical and occupational therapy service. Maintenance care was documented in 88 percent of the physical therapy services and 79 percent of the

[34] Beneficiaries received physical therapy with no occupational therapy on approximately 4 percent of service days and, similarly, occupational therapy with no physical therapy on approximately 4 percent of service days. Because of rounding, the percentage of service days with only physical therapy, only occupational therapy, and both physical and occupational therapy does not total 32 percent.

occupational therapy services. Maintenance care generally refers to treatments and activities, often repetitive, that are planned by a licensed therapist to maintain a beneficiary's level of function when no additional improvement is expected.[35] Commonly documented physical therapy maintenance services included general conditioning exercises, strengthening exercises, ambulation, and endurance exercises. Commonly documented occupational therapy maintenance services included general conditioning, Thera-Band®[36] exercises/activities, cognitive skills development, and seated active range-of-motion exercises. Both physical and occupational therapy maintenance services were provided primarily in a group setting.

A smaller proportion of the documented physical and occupational therapy services were for rehabilitative or restorative care. Documented rehabilitative or restorative care, such as balance exercises, physical therapy evaluations or reevaluations, and gait training, represented 10 percent of the physical therapy services. Seventeen percent of the occupational therapy services were for rehabilitative or restorative care, such as ADL training, occupational therapy reevaluations, endurance training, and breathing exercises.

On 40 percent of service days, beneficiaries received no documented health services, including 34 percent of days on which meals and/or snacks were the only documented services

On 40 percent of adult day health service days, beneficiaries received no documented health services. On approximately 1 in 3 service days (34 percent), meals and/or snacks were the only services documented in beneficiaries' records. The 12 States included in our review do not all require that beneficiaries receive a health service each day of attendance at an adult day health facility. Furthermore, there is no standard CMS definition or guidance regarding what constitutes a health service. Therefore, findings about the health and nonhealth services that beneficiaries received could vary if the service types were categorized differently. In addition, with the exception of meals and/or

[35] CMS describes a maintenance therapy program as one intended to maintain functional status and prevent decline in function in its *Medicare Benefit Policy Manual*, ch. 15, § 220.2, Reasonable and Necessary Outpatient Rehabilitation Therapy Services. State Medicaid definitions of maintenance therapy may vary. Accessed at http://www.cms.gov/manuals/downloads/bp102c15.pdf on December 14, 2010.

[36] Thera-Band® brand products are used for resistance exercises intended to restore muscle and joint function, improve balance and coordination, and build strength.

snacks, the identified nonhealth services could meet the definition of a Medicaid-covered service. As illustrated in Table 2, a meal and/or snack was the only documented service on 86 percent of service days without a health service. On 4 service days (1 percent), beneficiaries received no documented services, although facility records indicated that they were at the adult day health center.

Table 2: Service Types Documented on Days With No Documented Health Services

Service Type	Percentage of Service Days (n=191)
Meals and/or snacks only	86%
Recreational/social activities only	6%
No documented services	3%
Meals and/or snacks and recreational/social activities	1%
Meals and/or snacks and assistance with ADLs[37]	1%
Recreational/social activities and assistance with ADLs	1%
Social work services only	1%
Meals and/or snacks and undetermined services[38]	1%
Other, nonspecific services	1%
Total*	**100%**

Source: OIG analysis of adult day health medical review results, 2010.
*Total does not equal 100 percent because of rounding.

[37] Excludes services related to ADLs that medical reviewers categorized as nursing or therapy services.

[38] The record did not contain enough information for the medical reviewer to classify this service.

Approximately 43 percent of therapy services were provided by staff who lacked required supervision

Based on available documentation, approximately 43 percent of physical and occupational therapy services were provided by staff who lacked supervision, where required under State law or regulation, from appropriately qualified staff. These therapy services were provided by staff such as physical and occupational therapist assistants or aides who, under State law or regulation, required the supervision of a licensed physical or occupational therapist. Medical reviewers indicated that the records did not include the required supervisory signature to indicate that appropriately qualified staff performed or supervised the therapy in accordance with State law or requirements. In addition, the facility records contained no documentation that the appropriately qualified staff were at the center on the sampled service day, where required. Of the documented physical therapy services, 54 percent did not have any documentation[39] indicating that the appropriately qualified staff were available to supervise the services. Approximately 32 percent of the documented occupational therapy services contained no documentation that appropriately qualified staff were available to supervise the services.

Other therapy services were provided directly by qualified staff or staff who were appropriately supervised. Approximately 29 percent of physical therapy services and 33 percent of occupational therapy services were directly provided by appropriately qualified staff. An additional 16 percent of occupational therapy services were performed by staff requiring supervision, and records included documentation that supervision was available.

In addition, therapy services on sampled service dates sometimes lacked documentation about who actually provided the service. Staff qualifications were not adequately documented in beneficiaries' records for approximately 12 percent of physical therapy services and 13 percent of occupational therapy services on service days. For an additional 6 percent of physical and occupational therapy services, staff qualifications were illegible. Table 3 outlines the qualifications and supervision of staff providing therapy services.

[39] Documentation included staff schedules, staff sign-in sheets, and staff signatures or initials in beneficiaries' records.

Table 3: Documentation of Qualifications and Supervision of Therapy Staff

Therapy Documentation	Physical Therapy	Occupational Therapy
Staff provided service requiring supervision; records contain no documentation that supervision was available	54%	32%
Service directly provided by qualified staff	29%	33%
Staff provided service requiring supervision; records contain documentation that supervision was available	0%	16%
Staff qualifications not documented/description of qualifications inadequate	12%	13%
Staff qualifications illegible	6%	6%
Service provided by staff performing beyond the scope of State license (i.e., staff prohibited from providing service)	0%	1%
Total*	**100%**	**100%**

Source: OIG analysis of adult day health medical review results, 2010.

*Totals do not equal 100 percent because of rounding.

Documentation included timely assessments, but in some cases it lacked appropriate physician orders or was inconsistent with plans of care

Records associated with approximately 90 percent of service days included assessments conducted before services began. These assessments evaluated each beneficiary's need for adult day health care and provided information about what services would be included in the beneficiary's plan of care. Documentation for approximately 8 percent of service days contained an assessment that was completed after adult day health treatment started. No assessment was included in records for 1 percent of service days.[40]

Records for approximately 21 percent of service days did not include a physician order or request signed before the start of treatment. Although adult day health requirements in the 12 States included in our review specify that a physician order or request must be completed before the start of treatment, these orders and requests were

[40] For the remaining 1 percent of service days, assessments did not appear to be completed by the appropriate staff or for the correct admission date.

inappropriate or missing for approximately 21 percent of service days. Specifically,

- 11 percent were signed late, but within 2 months of the start date;
- approximately 6 percent were signed between 2 months and 1 year after services began;
- 1 percent were signed more than 1 year after treatment began;
- 1 percent included an unsigned order;
- approximately 1 percent included undated physician orders; and
- 1 percent did not include any physician order or request.

Records for approximately 79 percent of service days included a physician order or request signed before treatment began.

Approximately 22 percent of documented nursing and therapy services were not included in plans of care

Services documented in beneficiaries' treatment records were not always included in their plans of care. Approximately 22 percent of nursing and therapy services received on service days were not included in beneficiaries' most recent plans of care (before the service date) and, therefore, may not have been consistent with their treatment goals. Table 4 shows the extent to which different types of services were not included in beneficiaries' plans of care on service days.

Table 4: Documented Services Not Included in Plans of Care

Service Type	Percentage
All nursing and therapy services	**22%**
Nursing services	27%
Physical therapy	14%
Occupational therapy	11%

Source: OIG analysis of adult day health medical review results, 2010.

RECOMMENDATIONS

In 2007, Medicaid beneficiaries who attended adult day health programs received a variety of nursing, rehabilitation, therapeutic, and nonhealth services and activities. Meals and/or snacks were the only documented services on 34 percent of service days. In addition, documentation in beneficiary records often included no indication that physical and occupational therapy services were rendered by staff who received supervision required under State law or regulation. In some cases, physician orders or requests were signed after the start of treatment or beneficiaries received services that were not included in their plans of care. Our findings indicate the need for (1) explicit requirements regarding the provision of health services in Medicaid adult day health centers and (2) enforcement of current therapy supervision requirements.

Therefore, we recommend that CMS:

Specify what services are required for Medicaid reimbursement of adult day health services

CMS should clearly delineate what services must be provided in adult day health centers for providers to receive Medicaid reimbursement. State requirements do not always explicitly require that a health service be provided on each service day reimbursed by Medicaid. Additionally, CMS does not have any standard definition or guidance as to what constitutes a health service. Clear delineation as to what services are required for Medicaid reimbursement of adult day health services will ensure that CMS pays for the services necessary to deliver quality care to beneficiaries who attend adult day health programs.

Direct States to enforce supervision requirements for staff who provide therapy services in Medicaid adult day health centers

CMS should encourage States to ensure that staff who provide therapy services in adult day health centers are operating within the scope of practice under State law and regulation. State physical and occupational therapy licensing requirements specify qualifications and supervision arrangements for therapy services. CMS should work with States to ensure that adult day health centers are aware of, and are in compliance with, these requirements. CMS could require States to conduct program reviews to assess adult day health providers' compliance with supervision requirements.

Take appropriate action to address adult day health centers that did not respond to repeated data requests

Thirty-one adult day health centers did not respond to requests for records representing 37 service days.[41] In addition, one center indicated that the beneficiary listed on the Medicaid claim never attended the facility. We forwarded information regarding these centers to CMS under separate cover.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all of our recommendations in its written comments on our draft report. In response to our first recommendation, CMS stated that it will continue to work with States, either through the State Plan Amendment review process or by providing technical assistance, to educate States on the proper authorities by which services in an adult day health setting may be covered under Medicaid.

In response to our second recommendation, CMS stated that it will work with States, through the State Plan Amendment review process, to ensure that each State plan includes assurances that services are provided in accordance with Federal regulations. CMS also stated that the findings of this report will be shared with CMS staff responsible for conducting financial management reviews. These reviews verify that States claimed Federal financial participation only for services provided in accordance with the State plan and Federal regulations.

In response to our third recommendation, CMS stated that it will follow up with the appropriate States to discuss whether they have policies and procedures in place that require Medicaid providers to allow State Medicaid agencies access to data and records that can be used to support appropriate reimbursement for services rendered.

We made changes, as appropriate, to the report based on CMS's technical comments. For the full text of CMS's comments, see Appendix B.

[41] We requested records from 303 health centers for the 400 sampled service days.

APPENDIX ~ A

Table 1: Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of service days on which beneficiaries received a documented health service	300 service days	60.3%	54.7%–65.7%
Average number of services documented each service day	300 service days	9.4	8.2–10.7
Average number of health services documented each service day with at least one health service	181 service days	11.5	9.9–13.0
Percentage of service days on which nursing services were documented	300 service days	59.0%	53.3%–64.5%
Percentage of service days on which a meal was documented	300 service days	45.3%	39.8%–51.0%
Percentage of service days on which a snack was documented	300 service days	35.0%	29.8%–40.6%
Percentage of service days on which occupational therapy was documented	300 service days	28.7%	23.8%–34.1%
Percentage of service days on which physical therapy was documented	300 service days	28.7%	23.8%–34.1%
Percentage of service days on which assistance with activities of daily living (ADL) were documented	300 service days	26.7%	21.9%–32.0%
Percentage of service days on which social work services were documented	300 service days	19.3%	15.2%–24.2%
Percentage of service days on which recreational and/or social activities were documented	300 service days	17.7%	13.7%–22.4%
Percentage of service days on which vital signs checks were documented	300 service days	28.3%	23.5%–33.7%

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Table 1: Confidence Intervals (Continued)

Estimate description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of service days on which pain assessments were documented	300 service days	22.0%	17.7%–27.1%
Percentage of service days on which blood sugar checks were documented	300 service days	13.3%	9.9%–17.7%
Percentage of service days on which medication administration was documented	300 service days	11.7%	8.5%–15.8%
Percentage of service days on which monitoring of food intake was documented	300 service days	10.7%	7.6%–14.7%
Percentage of service days on which nursing care was documented with at least one other service	300 service days	49.3%	43.7%–55.0%
Percentage of service days on which beneficiaries received physical and/or occupational therapy services, but no nursing services	300 service days	1.0%	0.3%–3.1%
Percentage of service days on which only nursing services were documented	300 service days	9.7%	6.8%–13.6%
Percentage of nursing services that were skilled	1,364 services	47.5%	44.6%–50.4%
Percentage of nursing services that were nonskilled	1,364 services	51.8%	48.9%–54.6%
Percentage of service days on which therapy was documented	300 service days	32.3%	27.3%–37.9%
Percentage of service days on which occupational therapy was documented	300 service days	28.7%	23.8%–34.1%

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Table 1: Confidence Intervals (Continued)

Estimate description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of service days on which physical therapy was documented	300 service days	28.7%	23.8%–34.1%
Percentage of service days on which beneficiaries received both physical and occupational therapy	300 service days	25.0%	20.4%–30.2%
Percentage of documented physical therapy services that were maintenance services	360 services	88.1%	80.5%–92.9%
Percentage of documented occupational therapy services that were maintenance services	341 services	79.2%	69.0%–86.7%
Percentage of documented physical therapy services that were restorative/rehabilitative services	360 services	10.0%	5.6%–17.3%
Percentage of documented occupational therapy services that were restorative/rehabilitative services	341 services	17.0%	10.2%–27.0%
Percentage of service days on which beneficiaries received no documented health services	300 service days	39.7%	34.3%–45.3%
Percentage of service days on which meals and/or snacks were the only documented services	300 service days	34.0%	28.8%–39.6%
Of service days with no documented health service, percentage on which only meals and/or snacks were documented	119 service days	85.7%	78.2%–90.9%
Of service days with no documented health service, percentage on which only recreational/social activities were documented	119 service days	5.9%	2.8%–11.9%

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Table 1: Confidence Intervals (Continued)

Estimate description	Sample Size	Point Estimate	95-Percent Confidence Interval
Of service days with no documented health service, percentage on which no services were documented	119 service days	3.4%	1.3%–8.6%
Of service days with no documented health service, percentage on which only meals and/or snacks and recreational activities were documented	119 service days	0.8%	0.1%–5.8%
Of service days with no documented health service, percentage on which only meals and/or snacks and assistance with ADLs were documented	119 service days	0.8%	0.1%–5.8%
Of service days with no documented health service, percentage on which only recreational/social activities and assistance with ADLs were documented	119 service days	0.8%	0.1%–5.8%
Of service days with no documented health service, percentage on which only social work services were documented	119 service days	0.8%	0.1%–5.8%
Of service days with no documented health service, percentage on which only meals and/or snacks and undetermined services were documented	119 service days	0.8%	0.1%–5.8%
Of service days with no documented health service, percentage on which only “other,” nonspecific, services were documented	119 service days	0.8%	0.1%–5.8%
Percentage of service days on which beneficiaries received no documented services	300 service days	1.3%	0.5%–3.5%
Of documented physical therapy services, percentage that were provided by staff who lacked required supervision	360 services	43.2%	33.9%–53.0%
Of documented physical therapy services, percentage that did not include documentation of necessary supervision	341 services	53.6%	41.5%–65.3%
Of documented occupational therapy services, percentage that did not include documentation of necessary supervision	341 services	32.3%	22.5%–43.8%

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Table 1: Confidence Intervals (Continued)

Estimate description	Sample Size	Point Estimate	95-Percent Confidence Interval
Of documented physical therapy services, percentage that were directly performed by qualified staff	360 services	28.6%	19.3%–40.2%
Of documented occupational therapy services, percentage that were directly performed by qualified staff	341 services	32.6%	23.1%–43.7%
Of documented occupational therapy services, percentage that were performed by staff who required supervision and for which appropriate documentation of supervision is available in beneficiary and/or facility records	341 services	15.8%	10.0%–24.2%
Of physical therapy services, percentage that have missing/inadequate description of provider qualifications	360 services	11.9%	5.6%–23.8%
Of occupational therapy services, percentage that have missing/inadequate description of provider qualifications	341 services	12.9%	6.9%–22.9%
Of physical therapy services, percentage that list illegible provider qualifications	360 services	5.8%	1.9%–16.6%
Of occupational therapy services, percentage that list illegible provider qualifications	341 services	5.6%	2.1%–14.2%
Of documented occupational therapy services, percentage that were provided by staff performing beyond the scope of their State licenses	341 services	0.9%	0.2%–3.8%
Of service days, percentage that included timely assessments	300 service days	89.7%	85.7%–92.7%
Of service days, percentage that included assessments completed after treatment began	300 service days	8.3%	5.7%–12.1%
Of service days, percentage for which no assessment was included in records	300 service days	1.3%	0.5%–3.5%
Of service days, percentage for which assessment did not appear to be completed by the appropriate staff or for the correct admission date	300 service days	0.7%	0.2%–2.6%

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Table 1: Confidence Intervals (Continued)

Statistic	Sample Size	Point Estimate	95-Percent Confidence Interval
Of service days, percentage that did not include a dated or timely physician order	300 service days	21.3%	17.0%–26.4%
Of service days, percentage with a physician order signed after treatment began, but within 2 months	300 service days	11.0%	7.9%–15.1%
Of service days, percentage with a physician order signed after 2 months but within 1 year	300 service days	5.7%	3.5%–8.9%
Of service days, percentage with a physician order signed more than 1 year after treatment began	300 service days	1.0%	0.3%–3.1%
Of service days, percentage with an unsigned order	300 service days	1.0%	0.3%–3.1%
Of service days, percentage with no physician order	300 service days	1.3%	0.5%–3.5%
Of service days, percentage with a timely physician order	300 service days	78.7%	73.6%–83.0%
Of nursing and therapy services, percentage that were not included in the most recent plan of care	2,065 services	21.9%	18.2%–26.0%
Of nursing services, percentage that were not included in the most recent plan of care	1,364 services	26.8%	22.2%–32.1%
Of physical therapy services, percentage that were not included in the most recent plan of care	360 services	13.6%	8.7%–20.6%
Of occupational therapy services, percentage that were not included in the most recent plan of care	341 services	10.8%	5.7%–19.8%

Source: Office of Inspector General analysis of adult day health medical review results, 2010.

APPENDIX ~ B

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 1 6 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Adult Day Health Services" (OEI-09-07-00500)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on this draft report. In this draft report, the OIG: (1) examined the types of services reimbursed by Medicaid in an adult day health setting; (2) determined whether nursing and therapy services were provided or supervised by qualified staff; and (3) examined whether beneficiary records contained the required documentation.

Under Medicaid law, certain Adult Day Health Services (ADHS) fall within the statutory definition of "medical assistance" which is set forth at section 1905(a) of the Social Security Act (the Act). Based on the statutory authority provided in sections 1915(c) and 1915(i) of the Act, ADHS are generally furnished 4 or more hours per day on a regularly scheduled basis for one or more days per week, in a non-institutional, community-based setting, encompassing both health and social services. Following Federal guidance, States define what services can be included in ADHS and set the provider qualifications under these authorities.

With respect to section 1905(a) of Act, ADHS are not included as a specific coverable Medicaid State plan service. However, there are services provided by ADHS that may be covered under the CMS approved State plan. In such situations, Medicaid may pay for those services under the appropriate benefit (e.g., personal care, physical therapy, occupational therapies and nursing services) furnished by the ADHS center. However, Medicaid cannot pay for activities not included in those recognized benefits (e.g. meals and recreation). All State plan services must be provided in accordance with the respective regulations. Qualifications for providers of State plan services must at a minimum meet the qualification set forth in Federal regulations.

This OIG study focused on beneficiary and facility records for services delivered in an ADHS setting during the last six months of 2007 and reimbursed under the State plan. The review was focused on 12 States that, as of December 31, 2007, provided a State plan nursing- and therapy-focused adult day health benefit. The OIG draft report finds that (1) beneficiaries received at least one health service on 60 percent of service days with nursing services being the services most commonly documented; (2) forty-three percent of documented therapy services were provided by staff who lacked required

supervision; and (3) documentation included timely assessments, but in some cases lacked appropriate physician orders or was inconsistent with plans of care.

We acknowledge and appreciate the OIG's efforts in undertaking this study and believe the findings will be helpful as we implement the OIG's recommendations.

OIG Recommendation

Specify what services are required for Medicaid reimbursement of adult day health services.

CMS Response

We concur. CMS will continue to work with States either through the State Plan Amendment review process or by providing technical assistance, to educate States on the proper authorities in which services provided in an ADHS setting may be covered under the Medicaid program. Specifically, CMS will make States aware of the following options:

a. 1915(c) Medicaid Home and Community-Based Services - Adult Day Health Care services are specifically referenced in section 1915(c)(4)(B) of the Act as an allowable benefit.

b. 1915(i) Home and Community-Based State Plan Services - Allows States, at their option, to provide home and community-based services under the Medicaid State plan.

c. Recognized 1905(a) Services under the State Plan – CMS recognizes ADHS centers may be providing coverable State plan services such as physical therapy, occupational therapy, nursing, and personal care. Medicaid may pay for such services as long as they meet the applicable Federal requirements set forth in Title 42 of the Code of Federal Regulations. However, Medicaid cannot pay for activities furnished by such a center that are not included in the recognized benefits (e.g., meals and recreation).

OIG Recommendation

Encourage States to enforce supervision requirements for staff who provide therapy services in Medicaid adult day health centers.

CMS Response

We concur. CMS will work with States through the State Plan Amendment review process to ensure each State plan includes an assurance that services are provided in accordance with Federal regulations. Additionally, the findings of this report will be shared with CMS staff responsible for conducting financial management reviews. The purpose of these reviews is to verify States only claimed Federal financial participation for services provided in accordance with the State plan and Federal regulations.

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OIG Recommendation

Take appropriate action to address adult day health centers that did not respond to repeated data requests.

CMS Response

We concur. CMS will follow-up with the appropriate States to discuss if they have policy and procedures in place requiring Medicaid providers to allow State Medicaid agencies access to data and records that can be used to support appropriate reimbursement for Medicaid services rendered.

We appreciate the work of the OIG in this report and look forward to continuing to work with the OIG on this and other issues.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Camille Harper served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the San Francisco regional office who contributed to the report include Loul Alvarez, Veronica Gonzalez, and Abby Lopez; central office staff who contributed include Sandy Khoury, Lyn Killman, and Robert Gibbons.

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