Human Resources Administration
Department of Social Services

Robert Doar
Commissioner

James G. Sheehan
Chief Integrity Officer/
Executive Deputy
Commissioner

250 Church Street
New York, NY 10013

212 274 5600

April 17, 2013

Dear Administrator:

I am the Chief Integrity Officer for the New York City Human Resources Administration, the agency responsible for administering the Medicaid program in New York City. In this position, I am responsible for assessing whether Medicaid claims, certifications, and submissions are accurate; and for identifying and investigating certain criminal, civil, and other violations of the laws governing Medicaid.

As part of my role, I believe in educating providers about particular Medicaid compliance risks. Please read the attached letter, which represents a sample letter that I sent to the medical directors of New York City skilled nursing facilities and/or nursing homes. This letter outlines four significant Medicaid program integrity concerns that we have identified as the result of our work.

Please contact me at the address above if you have any questions.

Sincerely,

James G. Sheehan
sheehanj@hra.nyc.gov

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Executive Deputy Commissioner

250 Church Street
New York, NY 10013

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Dr. John Doe
Medical Director
Residential Health Care Facility
1 Madison Avenue
New York, NY, 10000

Dear Doctor:

I am the Chief Integrity Officer for the New York City Human Resources Administration. In this position, I am responsible for assessing whether Medicaid claims, certifications, and submissions are accurate; and for identifying and investigating certain criminal, civil, and other violations of the laws governing Medicaid. The Human Resources Administration is the New York City agency responsible for administering the Medicaid program in New York City.

As a New York physician, you have undertaken responsibility as the Medical Director of a New York City skilled nursing facility and/or nursing home administrator. I want to share with you four significant Medicaid program integrity concerns that we have identified as the result of our work.

Issue 1: Physician certification of "permanent placement" for patients admitted to a residential health care facility.

My staff has recently conducted reviews of certain Residential Health Care Facility (RHCF) patients who were certified by the treating physician as "admitted for permanent placement." In certain cases, we have found:

- Patients who were certified for "permanent placement" immediately prior to or after discharge from the RHCF;
- Patients who were certified for "permanent placement" inconsistent with the hospital discharge plan; and
- Patients who were certified for "permanent placement" because the managed care plan requested the certification in order to avoid responsibility for payment for the RHCF stay.

The concept of "permanent placement" means that the patient "is not expected to return home based upon medical documentation affirming the individual's need for permanent placement." (DOH Medicaid Update, April 2005). The effect of the physician certification of the medical necessity for a "permanent placement" is significant for both the patient and the Medicaid program. For the patient, it means upon his or her return to the community, (s)he is no longer able to access community-based health care

services via the managed care plan because (s)he is disenrolled from his or her original health plan. For the Medicaid program, it means the cost of the nursing home stay is borne by the State, rather than the Managed Care plan—which has responsibility to pay for a stay if the patient is expected to return to the community.

The Department of Health reinforced the duty to assure accurate determinations regarding "permanent placement" last month in its March 2013 Medicaid Update at page 4:

"MCOs are required to notify the RHCF and the enrollee, by phone and in writing, of any decision to discontinue coverage of the RHCF stay and must work with the RHCF to identify the appropriate next level of care. . . where the enrollee's status is non-permanent, if the RHCF or the enrollee disagrees with the MCO decision, the RHCF should not seek to disenroll the individual from Medicaid managed care on the basis that the individual's status has changed to a permanent stay, nor should the RHCF seek payment from FFS Medicaid, as the MCO is responsible for the non-permanent stay as long as it is medically necessary. RHCFs should request retroactive disenrollment of an individual only when such an action is appropriate to a change in the enrollee's status, and the enrollee is no longer expected to return home in a community setting."

The decision as a treating physician to certify the patient as a "permanent placement" can expose the treating physician to potential liability under the False Claims Acts of the City, State, and Federal governments if the decision is made without a good faith, factual basis. When a physician certifies a "permanent placement," that physician needs to assure the patient's record and condition support the certification, including the enrollee plan of care. This agency relies upon the physician's good faith medical judgment, based on appropriate review, to disenroll the patient.

Your RHCF may request you to move someone to permanent placement because its negotiated managed care rate may be much lower than the fee-for-service rate it can receive for a permanent placement patient. If either the RHCF or a managed care plan requested you certify a patient for "permanent placement" when you believe the certification is not appropriate, you should decline to do so. If either the RHCF or the plan persists or insists after your declination, I would appreciate hearing from you personally about the plan and the conversation.

We will continue our reviews with our Medicaid colleagues of "permanent placement" certifications, and will take appropriate enforcement actions where we find that the evidence in the record does not support the certification.

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Issue 2: Discharging Medicaid patients without assuring the patient has access to Medicaid community-based health care services.

One of the most significant responsibilities for an RHCF and a patient's professional treatment team is assuring that, upon discharge, the patient has a discharge plan which includes arrangements for appropriated home based services needed for safe discharge, and access to community-based providers. This discharge planning responsibility for RHCFs has recently been the subject of critical reports from the federal Office of Inspector General describing the failure of certain facilities to provide these services. HRA has recently heard from patients and their families where their access to community-based providers has not been addressed in discharge planning. See, for example, HHS/OIG/OEI Report 02-09-00201 (February 2013) "Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements." As a result of the failure of the discharge planning, the patient can lack access to any community based care.

Where a patient has been previously identified as permanently placed in an RHCF, and in certain other circumstances, the RHCF and the treating physician provides or arranges for the provision of all services through the facility. When the patient is discharged, the patient's Medicaid eligibility must be modified so that (s)he is once again able to access medical services in a community setting. The RHCF is required to complete the MAP-259F, 'Discharge Notice' to the Medical Assistance Program's Nursing Home Eligibility Division. For a copy of this form and details on how to submit it, please access the Medicaid Authorized Resource Center (MARC) at www.nyc.gov/marc.

Issue 3: Physicians and facility contractors who order or provide unnecessary services in the RHCF setting

In early March 2013, the United States Attorney's Office for the Southern District of New York filed a detailed and extensive False Claims Act complaint in a case brought by a whistleblower against a multi-specialty physician group called Park Avenue Associates. The whistleblower's original complaint also names physicians, Mitchell Kaplan, Daniel Sussman and Antony Mendola. The full complaint is enclosed and is also available on the HRA program integrity website at www.nyc.gov/welfarefraudnyc. It is worth reviewing in detail, as it identifies specific physicians and facilities, including some here in New York City, and describes the precise conduct in the RHCF context which is alleged to violate the False Claims Act.

The United States Attorney's complaint charges that for more than 10 years, Park Avenue Associates has provided medically unnecessary services, and services not documented in the medical record, to nursing home patients. The complaint focuses on

psychiatric services allegedly rendered to patients with severe dementia. The complaint states that the defendants entered into contracts with facilities to provide these services.

If you are a treating physician under the Medicare and Medicaid programs, you have the responsibility to order and provide only medically necessary services. A physician who orders medically unnecessary services, or who signs certificates or plans of care without knowledge of the patient's actual need for the services may be liable not only under the federal, state, and City False Claims Acts, but also under federal and state criminal statutes. For example, Texas physician Ben Harris Echols "signed plans of care for Medicare beneficiaries who were not under his care and about whose conditions he had no knowledge." He was recently convicted and sentenced to 63 months in federal prison.

"In many instances, Echols signed plans of care even though other doctors were listed as the attending physician on the documents," according to the Department of Justice press release dated March 14, 2013.

Fourth issue: The Affordable Care Act requires that all skilled nursing facilities have an effective compliance program in place beginning March 23, 2013.

Section 6102 of the Affordable Care Act requires that by March 23, 2013, every RHCF have a "compliance and ethics" program "reasonably designed, implemented, and enforced so that it will be generally effective in preventing and detecting criminal, civil, and administrative violations . . . and in promoting quality of care." These federal compliance requirements are in addition to the New York State Medicaid Inspector General's requirements to all New York RHCF providers that they have, and certify annually to having, an effective compliance program. (*See* 18 NYCRR 521 and the Office of Medicaid Inspector General website at http://omig.state.ny.us/). You and your professional colleagues should be familiar with and follow the compliance program for your RHCF as mandated by each of these requirements.

Please contact me at the address above if you have any questions.

Sincerely,

James G. Sheehan
sheehanj@hra.nyc.gov