



New York State Office of the State Comptroller
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Division of State Government Accountability

Social Adult Day Services

Office for the Aging
Department of Health



Report 2014-S-31

December 2015

Executive Summary

Purpose

To determine whether State agencies, particularly the New York State Office for the Aging (NYSOFA) and the Department of Health (DOH), are effectively overseeing Social Adult Day Services (SADS) programs to ensure that providers comply with regulations related to client eligibility, service plans, staffing, training, and physical safety. The audit covers the period April 1, 2011 through March 26, 2015.

Background

SADS programs are structured, comprehensive programs that provide functionally impaired adults with services such as socialization, supervision and monitoring, personal care, and nutrition in a protective setting. Each participant should receive services in accordance with an individualized service plan, based on a personalized assessment. The programs may also provide support services, such as information, transportation, and caregiver assistance.

NYSOFA currently has oversight responsibility for 17 SADS programs that it directly funds through contracts. Certain other programs are funded at least partially through counties and are overseen at the local level by 59 county Area Agencies on Aging (AAAs). NYSOFA's regulations establish minimum standards for program eligibility, service plans, staffing, training, and physical safety. SADS is also a benefit available under the State's Medicaid Managed Long-Term Care (MLTC) model. DOH, as the Medicaid administrator, is responsible for supervising and overseeing Medicaid as a whole. However, it is not specifically required to oversee individual component services offered through MLTC plans, including SADS. Instead, DOH relies on MLTC plans themselves to oversee the programs at the local level. More than 15,000 New Yorkers receive Medicaid-funded SADS services each year.

In fiscal year 2014-15, NYSOFA provided \$1.1 million in funding to its 17 SADS contractors, while AAAs provided an additional \$4.5 million of direct funding to the SADS operating in their counties. According to DOH officials, for the two calendar years 2013 and 2014, SADS providers received over \$175 million in Medicaid funding for services delivered through MLTC plans.

Key Findings

- Because SADS programs are not currently licensed or registered by any one government agency, unless a program receives some form of direct government funding, program oversight is not guaranteed. Our research suggests a material number of unregulated providers operating in the State. Absent more comprehensive oversight by stakeholder agencies, their precise number, cost, and, most importantly, who is running them and the quality of their services are unknown.
- NYSOFA program regulations, which were originally designed over 20 years ago to define a base level of minimum requirements, lack specific measures needed to effectively evaluate program quality and performance in today's environment.
- In general, we found NYSOFA fulfills its responsibility to oversee compliance with regulations by the SADS providers that it funds, either directly or through the county AAAs. However, we identified opportunities for NYSOFA to further enhance its efforts, specifically in terms of the

frequency of on-site monitoring visits and its control over their tracking as well as better use of a standardized monitoring tool at the county level.

- DOH is not mandated by law to directly oversee SADS programs that provide services to Medicaid participants. Rather, officials assert that the MLTCs are responsible for overseeing the programs with which they contract. Even so, DOH has provided guidance and direction to the MLTCs, and is independently assessing the extent to which New York City-based programs comply with NYSOFA's regulations. Based on our own field visits, it appears such compliance may have improved in recent years, although problems continue to exist.

Key Recommendations

- Relevant stakeholder agencies should carefully consider the risks identified in this report in deciding whether a more comprehensive system of regulation, such as licensing, registration, or mandated inspection, is warranted as the SADS program moves forward.
- NYSOFA should consider updating program regulations and/or providing supplemental guidance that more specifically defines expectations for factors that directly impact program quality and performance.
- NYSOFA should take steps to improve existing oversight and monitoring programs, including conducting on-site monitoring of each of its direct SADS contractors at least annually, making provisions for unannounced site visits, and ensuring consistent evaluation of program compliance at the county level.
- Stakeholder agencies should work together to implement a comprehensive program to oversee Medicaid-funded SADS programs, which includes the oversight actions recently developed as well as procedures to verify the accuracy of the annual SADS self-assessment certifications.

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 2, 2015

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Office for the Aging
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Albany, NY 12223

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
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Dear Ms. Crossdale and Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Social Adult Day Services*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

Social Adult Day Services (SADS) are structured, comprehensive programs providing functionally impaired adults with services such as socialization, supervision and monitoring, personal care, and nutrition in a protective setting for any part of the day, but for less than a 24-hour period. The program may also provide support, such as transportation, information, and caregiver assistance. Each participant receives services in accordance with an individualized service plan that is developed based on a personalized assessment.

SADS are an important component of the community-based service delivery system that can help to delay or prevent the need for nursing home care and other more costly advanced-care services. SADS also provide vital assistance to older people with cognitive and/or physical impairments in a safe, nurturing, and stimulating environment. According to the New York State Office for the Aging (NYSOFA), research demonstrates that caregivers who experience stress and burden are more likely to “burn out” and place their loved ones in an institution, which can directly impact Medicaid spending. SADS can help to ease the burden of caregivers by providing them with time to continue to work or take care of other needs and address other priorities. At the same time, the program addresses the basic needs of the individual needing care.

New York’s Elder Law authorizes NYSOFA to establish standards and regulations governing any SADS programs that it directly funds, as well as those funded through contracts with any of the 59 Area Agencies on Aging (AAAs) at the county level. In 1994, NYSOFA adopted regulations establishing minimum standards for eligibility, service plans, staffing, training, and physical safety.

In New York State, SADS is an available benefit under the Medicaid Managed Long-Term Care (MLTC) model. The Department of Health (DOH) is responsible for supervising and overseeing the Medicaid program, which includes a network of MLTC plans that administer services like SADS at the local level. As the Medicaid administrator, DOH has a stake in the proper oversight of SADS programs paid for with Medicaid funds.

In 2015, both houses of the State Legislature passed legislation requiring all persons or programs providing SADS to abide by NYSOFA’s rules and regulations. The legislation also requires NYSOFA to issue a report on the projected costs and benefits of establishing uniform standards and requirements for social adult day programs. At the time we concluded our fieldwork, this legislation had not been sent to the Governor for consideration.

According to DOH officials, for the two calendar years 2013 and 2014, SADS providers received over \$175 million for services delivered through MLTC plans. In fiscal year 2014-15, NYSOFA provided \$1.1 million total funding to 17 SADS contracts and AAAs provided an additional \$4.5 million to SADS operating within their counties.

Audit Findings and Recommendations

We found that because SADS programs are not currently licensed or registered by any one government agency, program oversight is not guaranteed, unless a program receives some form of direct government funding. Our research suggests a material number of unregulated providers operating in the State. Absent oversight by relevant stakeholder agencies, their precise number, cost, and, most importantly, who is running them and the quality of their services are all unknown.

In general, we found NYSOFA fulfills its responsibility to oversee compliance with the regulations by the SADS providers that it funds, either directly or through the county AAAs. We identified opportunities for NYSOFA to further enhance its efforts, specifically in terms of the frequency of on-site monitoring visits and its controls over their tracking as well as better use of a standardized monitoring tool at the county level. We also noted that program regulations, which were originally designed over 20 years ago to define a base level of minimum program requirements, are very broad in nature and lack specific measures that would be helpful in evaluating program quality and performance in today's environment.

DOH accurately points out that it is not mandated by law to directly oversee SADS programs that provide services to Medicaid participants. Rather, officials assert that the MLTC plans are responsible for overseeing the programs with which they contract. Even so, DOH has provided guidance and direction to the MLTC plans, and has independently assessed the extent to which New York City-based programs comply with NYSOFA's regulations. Based on our own field visits, it appears such compliance may have improved in recent years, although certain problems continue to exist, including participant service plans that are missing or outdated, staff health records that are not up-to-date, and fire drills that are not conducted as required.

Program Oversight Responsibility

As discussed in the Audit Scope and Methodology section of this report, we focused our audit primarily on assessing the nature and extent of program oversight exercised by the two State agencies, NYSOFA and DOH, which are primarily involved with the populations who receive many of the SADS program services in New York State: the elderly and Medicaid recipients. While the following sections of this report address the specific oversight efforts undertaken by each of these agencies, other conclusions about the overall regulatory structure of the program as a whole are also apparent.

Under the current regulatory framework, NYSOFA is the only agency with direct, mandated responsibilities that relate to establishing minimum program requirements and overseeing individual SADS programs. Although all programs are generally expected to comply with NYSOFA's regulations, especially if they receive NYSOFA funding, there is no requirement for programs – or the providers that operate them – to be licensed or registered by any government agency.

Although most of the SADS programs we identified serve Medicaid clients through DOH's network of MLTC plans, DOH does not have any direct mandate to oversee these programs or

their operators. Instead, DOH generally maintains that it is only responsible to oversee the MLTC plans themselves and not the individual services provided under their plans. DOH has provided guidance to both MLTC plans and the SADS programs they employ, including a recent requirement for programs to self-certify compliance with the NYSOFA regulations, but has no program of its own to directly monitor, inspect, or assess SADS providers or the quality of the services they deliver to the public.

In our opinion, the current SADS regulatory framework includes substantial gaps in program oversight that collectively present several risks:

- Absent any licensing or registration requirement, no agency has a complete accounting of all the SADS programs that are operating in New York State. Our research of similar services offered on the Internet, along with estimates provided by NYSOFA, place the count in the range of at least 500 programs.
- Currently, virtually anyone can become a SADS program provider and there is no required oversight of any programs that do not receive government funding.
- SADS programs that receive Medicaid funding are not directly overseen by stakeholder State agencies, leaving a substantial gap in SADS program oversight. This is in substantial contrast to most other Medicaid services, which are most often delivered by providers (e.g., doctors, hospitals, clinics, pharmacies, and ambulance services) that are each still otherwise directly overseen by an agency such as DOH in some manner outside the confines of the Medicaid program.

The number of SADS programs has rapidly expanded in recent years to the point where more than 15,000 older New Yorkers now receive services each year. Aside from the SADS funded by NYSOFA and DOH, there is currently no way to track the numbers of other SADS programs that may be operating in New York. It is not completely apparent which State agency, if any, is responsible for ensuring that these programs meet appropriate standards. This vagueness has the potential to put individuals at risk and creates an opportunity for unscrupulous providers to open substandard programs that may endanger the welfare of vulnerable seniors and lead to fraudulent Medicaid practices.

Similar programs that provide direct care services to vulnerable populations generally mandate compliance with safety requirements and require provider certification prior to operation. Examples include day care programs for children, which are overseen by the Office of Children and Family Services, and the Office of Mental Health's Assertive Community Treatment program for the severely mentally ill. While the State has not yet acted to establish equally comprehensive oversight for SADS programs, such requirements inform our consideration of potential risk in the absence of similar regulations. State agencies that are charged with oversight of SADS programs should consider these risks in deciding whether a more comprehensive system of regulation, such as licensing, registration, or mandated inspection, is warranted as the SADS program moves forward.

Agency Oversight Efforts

New York State Office for the Aging

Program Guidance

In 1994, NYSOFA adopted regulations establishing minimum standards for the SADS programs that it directly funds as well as those funded through contracts with AAAs at the county level. These regulations have not been updated in more than 20 years. We found the standards address many of the important aspects of the SADS program, including eligibility, service plans, staffing, training, and physical safety. The regulations are broad in nature and in some cases lack detailed measures that would be helpful in evaluating program quality and performance.

For example, the regulations require that programs have “sufficient space to accommodate program activities and services,” and that each program director be a “qualified individual with appropriate educational qualifications and work experience.” No additional guidance currently exists to define the subjective terms “sufficient,” “qualified,” and “appropriate.”

Considering the recent and rapid growth in SADS programs, this is an opportune time for NYSOFA to consider whether experience has provided any guidance as to the level of specificity that is appropriate for factors that directly impact program quality and performance.

Program Compliance

NYSOFA’s policy is to review all of the SADS programs it funds to ensure they comply with the regulations, which establish minimum standards for SADS program elements. NYSOFA instituted the following criteria for monitoring to ensure programs are meeting these requirements:

- Every three years, NYSOFA will conduct an on-site monitoring visit at each of the 17 direct SADS contractors;
- Annually, the AAAs will conduct on-site monitoring of all programs in their areas, and a specific SADS compliance component must be included on at least a three-year cycle; and
- Annually, NYSOFA will monitor and evaluate the results of all AAAs’ on-site monitoring and reports.

NYSOFA’s own on-site monitoring is scheduled based upon risk, considering factors such as history of non-compliance, change in program leadership, and complaints. In addition, NYSOFA has developed a comprehensive Monitoring Tool to assess SADS programs’ compliance with requirements. NYSOFA recommends – but does not require – that AAAs use the Monitoring Tool in their monitoring visits. The annual evaluation of AAA monitoring reports provides NYSOFA with assurance that all AAA reviews are completed timely and all issues are properly addressed. During the course of our audit, we identified areas where improvements can be made in NYSOFA’s monitoring process, and its procedure for tracking on-site visits, to more effectively and efficiently oversee compliance with SADS regulations.

Due to the inherent vulnerability of the SADS program population, lapses in oversight could allow situations to develop that might inhibit participants' achievement of service plan goals or even negatively impact their health and safety. Since NYSOFA already requires AAAs to visit each program at least annually, we question whether the current requirement to monitor the SADS program compliance component on a three-year cycle is adequate to identify non-compliance and to mitigate risk in a timely manner. We discussed these concerns with NYSOFA officials, who agreed there is a need for more frequent monitoring and now plan to require that AAAs include the SADS program compliance component as part of each annual on-site evaluation. For even greater oversight, we recommend that NYSOFA also perform on-site reviews of its own directly contracted programs on an annual basis instead of every three years. NYSOFA officials concurred with our recommendation.

We determined that although NYSOFA performs a risk assessment to prioritize its on-site visits, it has not met its desired monitoring schedule for SADS contractors. Over the three-year period ended October 24, 2014, NYSOFA made physical, on-site visits to only 11 of its 17 contractors. NYSOFA officials indicated that, where their own on-site visits are overdue, they use the most recent SADS program compliance component of AAAs' on-site evaluations in substitution. Our review of summary reports indicates that five of the six contractors did have AAA visits that addressed SADS during the period, but one did not. After our audit was completed, NYSOFA officials told us their staff have now completed monitoring visits to each of these six programs.

NYSOFA developed its comprehensive Monitoring Tool specifically to assess SADS compliance with program requirements. The Monitoring Tool incorporates all elements of the regulations, including a breakdown of data based on participants' initial assessment, current statistics, and discharge information, thereby allowing greater precision in data analysis and program assessment. Although NYSOFA doesn't require that AAAs use its Monitoring Tool for assessing compliance, we found that about two thirds of AAAs do anyway.

Other AAAs use less comprehensive methods, including modified versions of the Monitoring Tool or various monitoring checklists that are different and, in some cases, less detailed. For example, the Monitoring Tool provides an extensive array of questions geared toward assessment of personal care and training issues, while one of the AAA assessments we reviewed did not address personal care issues at all and had only a very limited set of questions related to staff training. As a result, it appears that AAAs are not evaluating all SADS programs consistently. Consequently, NYSOFA has less assurance that effective reviews have been completed or that SADS providers are meeting minimum standards.

NYSOFA officials agreed that consistent use of the Monitoring Tool – or at least its data elements – would better ensure that AAAs are monitoring SADS programs' compliance with all of the minimum requirements as described in the regulations. They indicated they would issue guidance requiring all AAAs to either use the Monitoring Tool for evaluating the SADS program compliance component during their future on-site visits or modify their own local monitoring tools to ensure that the same data is collected.

New York State Department of Health

As the administrator of the State's Medicaid program, DOH is responsible for program guidance and oversight of the services provided to recipients. Throughout our audit, DOH officials acknowledged their duty to oversee MLTC plans, but indicated DOH does not have any responsibility for directly overseeing SADS programs. Instead, they maintained that it is the duty of the MLTCs to monitor and oversee their own service vendors.

Program Guidance

Even though DOH is not mandated by law or regulation to oversee individual SADS programs, it appears that officials recognize that the agency has some level of responsibility in this area. Our review found that DOH has made some attempts to place controls on the MLTC plans and, in some cases, the individual programs that provide SADS services. These actions range from commissioning a consultant study of program compliance by MLTC SADS providers in New York City to issuing limited program guidance to MLTCs. DOH officials acknowledged that many of these actions were taken in response to news reports alleging widespread fraud in the program.

In 2011, DOH proposed an amendment to New York's Medicaid program (Section 1115) that would mandate enrollment in an MLTC for certain Medicaid recipients, including those receiving both Medicare and Medicaid and requiring community-based long-term care for more than 120 days. On August 31, 2012 the U.S. Department of Health and Human Services approved the amendment, thereby making MLTC enrollment mandatory effective September 2012. DOH is a stakeholder in SADS – both indirectly as overseer of MLTC plans, which deliver program services, and directly as the administrator of the State's Medicaid program, which is accountable for oversight of Medicaid dollars.

In terms of SADS oversight, we found DOH was not fully prepared for the transition mandated by Medicaid reform, despite providing input into the reform and having more than a year to establish monitoring processes to ensure SADS compliance with the regulations. Although DOH proposed the amendment in 2011, it did not issue any SADS guidance until the second quarter of 2013. In the meantime, media reports began to surface detailing fraudulent practices by some of the start-up SADS that had begun proliferating in response to the Medicaid redesign and were by then operating with little regulation and oversight. Specifically, the reports alleged that SADS providers were luring non-eligible individuals to enroll in their programs with the promise of cash payments and free meals, while at the same time billing Medicaid for the broad range of program services (including socialization, supervision, personal care, and nutritional guidance) that were not actually needed or being provided.

On April 26, 2013, in response to several negative articles published weeks earlier in the *New York Times*, DOH issued a one-page directive stating that MLTCs should reassess members receiving SADS care as a plan benefit. Further, the directive stated that "In order to ensure the health and safety of members, MLTC plans may choose to conduct site visits...prior to entering into a contract and on a periodic basis thereafter to monitor performance." About two weeks later, on May 8, 2013, DOH issued a Q&A document as clarification to the guidance. Together, these directives required MLTCs to:

- Immediately reassess any current enrollees who were receiving SADS;
- Review enrollees' plans of care to determine if SADS is an appropriate service;
- Have a formal process for credentialing providers on a periodic basis (both initially and not less than every three years thereafter) and for monitoring provider performance;
- Only enter into contracts with providers that have demonstrated the capacity to perform contracted services; and
- Ensure all SADS providers meet the standards and requirements of NYSOFA's regulations.

In May 2015, DOH issued additional guidance that now requires SADS programs to participate in a self-monitoring and self-certification process. New programs are required to complete an electronic certification form prior to contracting with an MLTC plan, and existing programs that receive MLTC funding must recertify their compliance. We believe this self-certification is a step in the right direction. However, DOH currently has no plan to ensure that the SADS providers are accurately reporting monitoring and certification data.

The MLTC plans we interviewed indicated they have not had substantive input from DOH other than receiving the guidance memos. However, one MLTC plan did tell us that DOH had forwarded complaints received, and another stated DOH had asked for a listing of their provider network and any site visits they have conducted.

Program Compliance

As part of our audit, we conducted a series of interviews with MLTC plan representatives as well as field visits to SADS providers. Our tests found overall compliance with most areas of the regulations, but we did find some providers that are not always complying with minimum requirements and areas where improvements are needed. Even so, it appears that MLTC plans have improved their oversight of SADS as a result of the guidance. Many MLTC plans told us they now conduct upfront assessments of SADS providers before contracting with them, but don't consistently monitor programs thereafter. While some assess SADS annually, others assess every three years, and some assess only in response to complaints.

NYSOFA's regulations require SADS programs to meet minimum standards in several areas:

- **Participant Eligibility:** Individuals must have functional impairments with needs that can be met and managed by the program.
- **Service Plans:** Services should be provided for each participant in accordance with an individualized service plan that has been developed by staff and reviewed at least annually.
- **Physical Safety:** Sufficient space needs to be provided to accommodate program activities and services; facility/equipment must be properly maintained to prevent hazards to personal safety.
- **Staffing:** An adequate number of qualified staff must be on hand at all times and providers must regularly assess and document their health status.
- **Training:** Appropriate training is provided to staff and documented.

We conducted phone surveys of ten MLTC plans over the three-month period September through November 2014 to assess DOH and MLTC program compliance oversight activities, both before and after contracting with SADS providers. We selected the ten MLTC plans with the largest number of participants. Officials at each of these MLTC plans assured us that, in compliance with DOH's 2013 memos, they follow NYSOFA guidelines to ensure SADS abide by minimum standards prior to contracting with them. However, they also reported that periodic reassessment recommended in the memos is ambiguous and, as a result, is not consistently conducted. For example, one of the MLTC plans we interviewed stated it would only review its contractors in response to a complaint.

We also conducted announced site visits to 14 SADS facilities, 11 of which are Medicaid funded and operate under the auspices of MLTC plans. Three of the 14 providers were located in the New York City area, while the other 11 operated in various areas upstate. At each location, we tested samples of participant files and employee records to determine compliance with minimum standards. The results of our tests indicate general compliance with standards; however, certain exceptions were noted, which we have referred to DOH for follow-up:

- **Participant Eligibility:** We reviewed all of the participant files at each location we visited and found no problems with participant eligibility. In total, we reviewed records for 460 participants, 377 of whom were enrolled in MLTCs. Based on our review of each person's initial assessment of functional impairment, as well as other documentation including medical statements and caregiver testimony, we determined all were eligible for the program.
- **Training:** At the 14 sites we visited, we examined training files for all employees and volunteers, which totaled 84 individuals, 65 of whom worked at MLTC providers. We reviewed each record to ensure the following criteria had been met:
 - Personal Care Training was provided;
 - At least 6 hours of annual training was provided;
 - At least 20 hours of New Hire Training was provided; and
 - Volunteers are trained.

In each case, we found evidence that paid employees met the minimum training requirements. However, one facility did not provide the required initial Personal Care Training, nor did it have a program to train volunteers. This facility did not have any volunteer staffing at the time of our visit.

- **Staffing:** We also examined records for each of the applicable personnel at the 14 sites as they relate to the following other criteria:
 - Health records are current;
 - Data on staff-to-participant ratios is appropriately recorded;
 - Director qualifications are met; and
 - The policy/procedure manual is up-to-date.

We found five instances at two locations where employee health records were not current.

No other problems were noted.

- **Service Plans.** We selected a sample of service plans for three participants, one new participant and two established participants, chosen at random at each of the 14 sites we visited (42 in total) and evaluated them against the following four criteria:
 - There is a service plan in the participant’s file;
 - The service plan includes a section on personal care needs;
 - A log is maintained to periodically note the participant’s conduct; and
 - The service plan was updated within the last year. (This criterion does not apply to the new participants’ files as they have not been enrolled long enough to be updated; therefore, for this criterion only 28 participant files were sampled, two at each location.)

We found three instances at two programs where service plans had not been updated in the past year.

- **Physical Safety.** At the 14 facilities in our sample, we reviewed 10 separate safety criteria, as follows:
 - Fire drills are conducted annually;
 - The local fire department is notified of SADS;
 - An update letter is sent annually to the local fire department;
 - Fire extinguishers are in place;
 - Participants’ emergency contact information is contained in their files;
 - Patients’ rights are conspicuously posted;
 - There are no walkway obstacles;
 - The bathrooms have handrails;
 - Exits are clearly marked; and
 - The kitchen area is clean and safety precautions are taken.

In total, we found issues at four of the 14 locations. At one location, fire drills and the annual notification to the local fire department were both overdue. At a second location, the required fire drills were not performed. A third location had never formally notified the local fire department about the program’s existence and a fourth had not updated its notification.

In the fall of 2013, DOH engaged a consultant – Island Peer Review Organization, Inc. (IPRO) – to perform a one-time study of compliance by MLTC SADS programs operating in the New York City area. DOH did not provide us with the results of this review until December 2014, after our own field visits were completed. We analyzed the reported results and, although IPRO’s program coverage and methodology differed from ours in some respects,¹ there is evidence that program compliance has improved when compared with our own more recent field visits.

¹ According to its report, IPRO conducted 173 announced on-site monitoring reviews of SADS programs in the New York City area. IPRO’s methodology included reviewing relevant regulations and guidelines, as well as the review tools used by NYSOFA and the New York City Department for the Aging. IPRO then developed and pilot-tested its own monitoring tools, which included 22 main indicators that comprised 111 distinct compliance criteria.

I PRO reported 90 percent or greater compliance for 52 (46.8%) of the 111 criteria it tested, but less than 50 percent compliance for 18 (16.2%) other program aspects, including:

- **Participant Eligibility:** 87 percent of providers were able to demonstrate that program participants met eligibility requirements; however, only 59 percent had evidence that this eligibility assessment had occurred before participants were admitted to the program.
- **Service Plans:** Records reviewed showed 92 percent of providers had written participant service plans that complied with standards. However, only 74 percent had evidence the plans were developed within 30 days of admission as required, and only 58 percent had sufficient evidence about who participated in developing the initial service plans.
- **Required Services:** The vast majority of entities met minimum standards for three of the four required service components: Socialization (100%), Supervision and Monitoring (99%), and Activities of Daily Living Assistance (86%). For the fourth required service, Nutrition, although all sites demonstrated that meals were provided, only 43 percent could show that their menus had been reviewed by an appropriately credentialed professional. Further, half of the programs had insufficient documentation about individual participants' dietary needs.

I PRO also indicated that it referred three SADS programs to DOH for additional follow-up based on what it described as unusual communications with the SADS staff prior to, or during, the on-site monitoring visit, or due to their suspicion of potential fraud or unethical practices. DOH officials confirmed that three programs from I PRO's sample were referred to the Office of the Medicaid Inspector General (OMIG) for investigation. However, due to confidentiality issues surrounding ongoing investigations, OMIG officials declined to discuss the nature of these specific cases or the frequency of similar problems in the industry.

Corrective Actions

Although we repeatedly asked DOH about corrective actions they had taken in response to the I PRO report, it was not until May 26, 2015, at the end of the audit and in response to a preliminary audit report, that DOH officials asserted they had taken steps to address the I PRO findings. In addition to the self-certification process previously discussed, DOH told us they have increased training for MLTC plans and SADS, and they also make additional referrals to OMIG when warranted. However, officials provided no details supporting these efforts, nor any examples of how they have been employed. Officials also indicated that they have taken other actions to oversee the SADS program, a list of which follows. Because of the extensive and excessive delay, not only were we unable to verify these assertions, but we also question to what extent they were done primarily in response to our audit scrutiny.

- DOH officials indicated they now maintain a Technical Assistance Hotline available for plan enrollees, their family members, and providers to assist in any issues or concerns related to the provision of care.
- DOH officials also told us that all complaints are tracked and monitored for trends on a monthly basis by DOH plan managers. Plan managers follow up on consistent complaints and may audit MLTC plan records, issue statements of deficiency, and, when warranted,

require corrective plans.

- DOH also indicated that staff monitor and review plan network submissions and encounter data on a quarterly basis to ensure that appropriate services, including SADS, are available and utilized by enrollees.
- DOH officials told us they are increasing their oversight capability by adding additional staff, and have taken steps to ensure MLTCs are providing proper oversight of the entities with which they contract.

These actions, if implemented, will likely improve oversight of the Medicaid-funded SADS.

Recommendations

1. Relevant stakeholder agencies should carefully consider the risks identified in this report in deciding whether a more comprehensive system of regulation, such as licensing, registration, or mandated inspection, is warranted as the SADS program moves forward.
2. NYSOFA should consider updating program regulations and/or providing supplemental guidance that more specifically defines expectations for factors that directly impact program quality and performance.
3. NYSOFA should take steps to improve existing oversight and monitoring programs, including:
 - Conducting on-site monitoring of each of its direct SADS contractors at least annually and making provisions for unannounced site visits.
 - Ensuring consistent evaluation of program compliance at the county level by requiring all AAAs to utilize the standardized SADS monitoring tool as part of their annual on-site evaluations.
4. Stakeholder agencies should work together to implement a comprehensive program to oversee Medicaid-funded SADS programs, which includes the oversight actions recently developed as well as procedures to verify the accuracy of the annual SADS self-assessment certifications.

Audit Scope and Methodology

The objective of our audit was to determine whether DOH and NYSOFA are effectively overseeing SADS to ensure providers are complying with regulations related to client eligibility, service plans, staffing, training, as well as physical environment. The audit covers the period April 1, 2011 through March 26, 2015.

To accomplish our audit objective, and to assess the related internal controls, we reviewed on-site reports and documentation that NYSOFA used as support. In addition, we interviewed staff and officials from DOH and NYSOFA, as well as selected MLTC plans and SADS programs, to understand their activities and monitoring systems. We conducted interviews of representatives from a sample of ten of the largest MLTC plans in terms of customers served to determine the

nature and extent of DOH oversight as well as their own oversight activities. We conducted on-site visits of 14 SADS facilities that were either NYSOFA, AAA, or MLTC contractors. Each was selected primarily based upon location, to ensure coverage of programs operating both inside and outside of the New York City area.

During the on-site visits, we reviewed each participant's file for evidence of eligibility and other service factors. Our reviews totaled 460 participants, 377 of whom were enrolled in MLTC programs. We also selected three service plans at random at each facility to determine whether they had been updated and if the participants remained eligible for SADS. We also reviewed the staffing and training for each employee at the SADS we visited. Finally, we toured each facility to look for obvious safety issues and reviewed fire safety procedures.

We conducted our 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 objective. With the exception of the limitation discussed in the following paragraph, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

DOH officials were substantially less than cooperative in providing our auditors information necessary to conduct our examination. Their actions ranged from excessive delays in providing information to outright refusals. Government auditing standards require us to report actions that impede our audit as scope impairments so that readers may consider these factors in evaluating the issues discussed in our report. Some examples of the significant constraints placed on our audit are as follows:

- We asked DOH for over a year to provide us with data on the amount of Medicaid funding spent on SADS services. DOH refused to provide the requested amounts until July 2015, when officials gave us an "estimate" of the amounts paid in 2013 and 2014.
- Early in our audit, we learned that DOH engaged a consultant – Island Peer Review Organization, Inc. or IPRO – in 2013 to perform a one-time study of compliance by MLTC SADS programs operating in the New York City area. IPRO reportedly delivered a draft of its report to DOH in July 2014. We made several requests for a copy of this report, but DOH officials repeatedly indicated they were reviewing and discussing the report to determine if any modifications were necessary and refused to share it with us until it was finalized in December 2014, nearly five months after our initial request.
- Throughout our review, DOH management also refused to respond to our inquiries about their planned actions to address any identified aspects of the program, or specific SADS sites, which IPRO had found were not fully complying with the regulations. Not until May 26, 2015, after our fieldwork was completed, did we receive a response from DOH that stated in part, "The department has taken steps to address findings in the IPRO report." Because of this extensive delay, we were unable to verify any of the planned actions that DOH asserted it is pursuing.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

A draft copy of this report was provided to NYSOFA and DOH officials for their review and comment. Their comments were considered in preparing this report and are attached in their entirety at the end. Officials indicated the steps they are taking to implement the report's recommendations.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Director of NYSOFA and the Commissioner of DOH shall each report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Agency Comments - Office for the Aging



Office for
the Aging

ANDREW M. CUOMO
Governor

CORINDA CROSSDALE
Director

GREG OLSEN
Executive Deputy Director

November 6, 2015

Hon. Thomas P DiNapoli, Comptroller
Office of the State Comptroller
110 State Street
Albany, NY 12236

Attn: Division of Government Accountability, 11th Floor

Re: Audit 2014-S-31

Dear Comptroller DiNappoli:

NYSOFA is in receipt of the draft report of the Office of the State Comptroller's (OSC) audit of NYSOFA's Social Adult Day Services Program (SADS). After reviewing the recommendations contained in the your draft report, we have compiled our comments in an attachment to this letter.

NYSOFA thanks the Comptroller for the work on this audit, particularly on identifying risks to some of the most vulnerable older New Yorkers.

Sincerely,

Corinda Crossdale

**New York State Office for the Aging
Comments on the
Office of the State Comptroller's
Draft Audit Report 2014-S-31
Social Adult Day Services**

The following is the New York State Office for the Aging's (NYSOFA) comments on the Office of the State Comptroller's (OSC) Draft Audit Report 2014-S-31 entitled "Social Adult Day Services."

General Comments:

NYSOFA appreciates OSC's recognition that the Office is fulfilling its oversight and monitoring responsibilities for Social Adult Day Services (SADS) programs that are either funded directly by the Office or by the Area Agencies on Aging (AAAs) as indicated on page 6 of the report. NYSOFA has taken additional actions including:

1. Increasing the frequency of on-site monitoring. In calendar year 2014, NYSOFA implemented an annual monitoring cycle rather than a three year cycle. NYSOFA is also incorporating unscheduled monitoring visits as part of the SADS monitoring plan.
2. Evaluating current regulations to determine whether they need to be updated.
3. Issuing a Program Instruction requiring all AAAs to utilize the data elements of the monitoring tool developed by NYSOFA.

After reviewing the recommendations contained in the OSC preliminary report, NYSOFA offers the following comments:

Recommendation #1

Relevant Stakeholder agencies should carefully consider the risks identified in this report in deciding whether a more comprehensive system of regulation, such as licensing, registration or mandated inspection is warranted as the SADS program moves forward.

Response: NYSOFA will continue to partner with the Department of Health (DOH) and the Office of the Medicaid Inspector General (OMIG) to evaluate risk mitigation strategies offered by OSC. Over the past two years NYSOFA has provided funding, technical assistance and guidance to a specialized not-for-profit to provide consistent and standardized training on regulatory compliance to SADS and Managed Long-Term Care (MLTC) providers. NYSOFA will continue these efforts and will continue to build capacity based on training evaluations.

Recommendation #2

NYSOFA should consider updating program regulations and/or providing supplemental guidance that more specifically defines expectations for factors that directly impact program quality and performance.

Response: In July of 2015, NYSOFA issued 15-PI-12 which set minimum requirements and procedures for monitoring SADS programs. NYSOFA updated and enhanced its program monitoring guide, monitoring tool, and has mandated that all AAAs annually monitor SADS programs. Additionally, NYSOFA has required the AAAs to use the data elements of the NYSOFA monitoring tool. NYSOFA is also evaluating current regulations to determine whether they need to be updated.

Recommendation #3

NYSOFA should take steps to improve existing oversight and monitoring programs including:

- Conducting on-site monitoring of each of its direct SADS contractors at least annually and making provisions for unannounced visits.
- Ensuring consistent evaluation of program compliance at the county level by requiring all AAAs to utilize the standardized SADS monitoring tool as part of the annual on-site evaluations.

Response: In 2014 NYSOFA implemented an annual monitoring plan for all direct funded SADS programs. Further, in 2015, NYSOFA extended the requirement for annual SADS monitoring to all the AAAs by issuing a Program Instruction which included a standardized SADS monitoring tool and other monitoring and evaluation tools.

Recommendation #4

Stakeholder Agencies should work together to implement a comprehensive program to oversee Medicaid funded SADS programs, which includes the oversight actions recently developed as well as procedures to verify the accuracy of the annual SADS self-assessment certifications.

Response: NYSOFA will continue to work with OMIG and DOH to support activities related to reviewing and monitoring the self-assessment Certification process.

Agency Comments - Department of Health



Department of Health

ANDREW M. CUOMO
Governor

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

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

November 4, 2015

Mr. John Buyce, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236-0001

Dear Mr. Buyce:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2014-S-31 entitled, "Social Adult Day Services."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
Dennis Rosen
Robert Loftus
James Cataldo
Ronald Farrell
Brian Kiernan
JoAnn Veith
Elizabeth Misa
Ralph Bielefeldt
Marcy Natale
Diane Christensen
Lori Conway
OHIP Audit SM

**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2014-S-31 entitled,
Social Adult Day Services**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2014-S-31 entitled, "Social Adult Day Services."

General Comments:

As noted by the Comptroller in the summary of Key Findings, "DOH has provided guidance and direction to the MLTCs." These actions have been effective, as demonstrated by OSC's finding on page 12 of the audit that 100 percent of the 460 individuals reviewed were found eligible for the program.

The OSC is correct in its assertion that the Department does not have any direct mandate to regulate Social Adult Day Care (SADC) programs or their operators, but is responsible for the oversight of Managed Long Term Care (MLTC) plans and covered benefits for qualified enrollees. SADC has been a covered benefit within MLTC since the inception of the program, and the transition to mandatory MLTC enrollment for individuals receiving long term care services did not change the threshold for authorization that MLTC plans use in reviewing need for this benefit. The Department has issued guidance clarifying Medicaid recipients' eligibility for mandatory enrollment in MLTC. In addition, the Department amended its MLTC contract provisions in 2012 to require all SADCs under contract with a MLTC plan to adhere to the New York State Office for the Aging (NYSOFA) SADC regulations under Title 9 New York Codes, Rules, and Regulations (NYCRR) §6654.20.

In May 2015, in conjunction with NYSOFA and the Office of the Medicaid Inspector General (OMIG), the Department established a new Certification process for all SADC entities that contract with MLTC plans. SADC operators that contract with MLTC plans are now required to attest to meeting the standards and requirements set forth in Title 9 NYCRR §6654.20.

The Department maintains a Technical Assistance Hotline for MLTC plan enrollees, their family members and providers. All complaints received by the Hotline are tracked and monitored for any trends on a monthly basis by Department plan managers. Plan managers examine complaint trends, and may audit MLTC plan records, issue Statements of Deficiency and require Plans of Correction, if warranted. Department staff also monitor and review plan network submissions and encounter data on a quarterly basis to ensure that appropriate services, including SADC services, are available and utilized by enrollees.

The Department is compelled to point out some language in the audit report that misrepresents the benefit of SADC. Specifically, the OSC referred to SADC as "DOH funded" and "MLTC SADS programs." SADC programs are not directly funded by the Department or Medicaid or directly provided by MLTC plans—SADC is a covered benefit for qualified enrollees.

Background

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the OMIG, for 2009 through 2013, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. For 2011 through 2013, the administration's

Medicaid enforcement efforts recovered over \$1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,330,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1

Relevant stakeholder agencies should carefully consider the risks identified in this report in deciding whether a more comprehensive system of regulation, such as licensing, registration, or mandated inspection, is warranted as the SADS program moves forward.

Response #1

The Department intends to continue to work with NYSOFA and OMIG to evaluate and mitigate the risks identified in the OSC's audit report. The Department will continue to partner with NYSOFA and OMIG to ensure compliance with existing requirements and educate plans and providers through webinars, Frequently Asked Questions and policy documents.

Recommendation #2

NYSOFA should consider updating program regulations and/or providing supplemental guidance that more specifically defines expectations for factors that directly impact program quality and performance.

Recommendation #3

NYSOFA should take steps to improve existing oversight and monitoring programs, including:

- Conducting on-site monitoring of each of its direct SADS contractors at least annually and making provisions for unannounced site visits.
- Ensuring consistent evaluation of program compliance at the county level by requiring all AAAs to utilize the standardized SADS monitoring tool as part of their annual on-site evaluations.

Response #2 and #3

The Department defers to NYSOFA for comment.

Recommendation #4

Stakeholder agencies should work together to implement a comprehensive program to oversee Medicaid-funded SADS programs, which includes the oversight actions recently developed as well as procedures to verify the accuracy of the annual SADS self-assessment certifications.

Response #4

The Department has created a distinct surveillance and audit unit within the Office of Health Insurance Program's Division of Long Term Care, responsible for ongoing oversight of MLTC plans through on-site and desk audits. Surveillance efforts review compliance with the Department's MLTC contract standards, relevant statutes, regulations and policies, as well as oversight of all contractors—including SADC entities. In addition, the Department's MLTC plan managers ensure members receive only appropriate services, and may issue Statements of Deficiency and require corrective actions, if warranted. Oversight capacity has been increased by the addition of surveillance staff and MLTC plan network submissions will continue to be reviewed on a quarterly basis.

The Department will continue to work with OMIG and NYSOFA to review and monitor the self-assessment Certification process to oversee the submissions and accuracy of the SADC Certifications.