December 30, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers (A-02-08-01006)

Attached, for your information, is an advance copy of our final report on rehabilitative services claims submitted by community residence providers under the New York State Medicaid program. We will issue this report to New York State within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-08-01006.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

January 3, 2011

Report Number: A-02-08-01006

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Daines:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kevin W. Smith, Audit Manager, at (518) 437-9390, extension 232, or through email at Kevin.Smith@oig.hhs.gov. Please refer to report number A-02-08-01006 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW YORK'S MEDICAID REHABILITATIVE SERVICES CLAIMS SUBMITTED BY COMMUNITY RESIDENCE PROVIDERS

Daniel R. Levinson
Inspector General

January 2011
A-02-08-01006

Office of Inspector General

http://oig.hhs.gov

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New York State (the State), the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Medicaid Management administers the Medicaid program.

Section 1905(a)(13) of the Act authorizes optional rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

The State elected to include coverage of Medicaid rehabilitation services provided to recipients residing in community residences—group homes and apartments—under a program administered by its Office of Mental Health (OMH). Examples of rehabilitative services include training in and assistance with daily living skills, medication management, and socialization; substance abuse services; and parenting training.

State regulations governing rehabilitation services claimed by community residence rehabilitation providers are found at 14 New York Compilation of Codes, Rules, & Regulations part 593. These regulations require, in part, that: (1) an initial authorization for services must include a face-to-face assessment of the recipient; (2) the authorization must specify the maximum duration of services needed by the recipient; (3) the recipient's service plan must be reviewed and signed by a qualified mental health staff person; (4) each rehabilitative contact must be at least 15 minutes in duration; (5) at least four separate reimbursable rehabilitative services must be provided for a monthly claim or, for a semimonthly claim, at least two separate reimbursable rehabilitative services must be provided; and (6) reauthorization for services must be based on a summary of the recipient's 3-month service plan review or a review of the complete case record of the recipient.

OBJECTIVE

Our objective was to determine whether DOH claimed Federal Medicaid reimbursement for rehabilitation services provided by community residence rehabilitation providers in the State in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

DOH did not claim Federal Medicaid reimbursement for rehabilitation services submitted by community residence rehabilitation providers in the State in compliance with Federal and State requirements. Of the 100 claims in our random sample, 31 claims complied with Federal and State requirements, but 69 claims did not.

Of the 69 noncompliant claims, 6 contained more than 1 deficiency:

- For 61 claims, the physician's reauthorization for rehabilitation services was not based on a review of the recipient's service plan or case record.
- For six claims, the physician's initial authorization did not include a face-to-face assessment of the recipient.
- For four claims, each rehabilitation service was not at least 15 minutes in duration.
- For two claims, the physician's authorization did not specify the maximum duration of services needed by the recipient.
- For two claims, the recipient did not have at least four different reimbursable rehabilitative services provided for a monthly claim.
- For one claim, the service plan was not reviewed and signed by a qualified mental health staff person.

These deficiencies occurred because: (1) most of the physicians were not familiar with applicable State regulations and program requirements and (2) certain community residence rehabilitation providers did not comply with State regulations.

Based on our sample results, we estimate that the State improperly claimed $207,569,115 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2007, audit period.

RECOMMENDATIONS

We recommend that DOH:

- refund $207,569,115 to the Federal Government and
- work with OMH to implement guidance to physicians regarding State regulations on the authorization of community residence rehabilitation services.

DEPARTMENT OF HEALTH COMMENTS

In its comments on our draft report, DOH disagreed with our first recommendation (financial disallowance) and agreed with our second recommendation. DOH also disagreed with the legal basis of our findings and indicated that our findings are based solely on our application of State regulations.

DOH stated that our interpretation of the State's regulations was inappropriate, overly technical, and contrary to the meaning and intent of the regulations.

Further, in its response, DOH stated that, for 58 of the 61 sample claims for which the authorizing physician did not review the beneficiary's service plan or case record, the physician authorized the service "based upon an informed determination of the clinical need." Specifically, DOH cited physicians' responses to our questionnaires for 3 of the 61 sample claims we found to be in error. For one claim (sample 61), DOH noted that the physician based his reauthorization on his knowledge of the beneficiary and discussions with the beneficiary's case manager. For a second claim (sample 62), DOH noted that the physician indicated that he saw the beneficiary at least once a month in an outpatient program for medication management. Further, when signing reauthorizations, the physician indicated that he uses his knowledge of the beneficiary, the beneficiary's initial psychiatric evaluation, and communication with staff from the beneficiary's community residence rehabilitation services provider. For a third claim (sample 80), DOH noted that the physician stated that he is very familiar with the beneficiary and signs reauthorizations for the beneficiary's community residence rehabilitation services based on office visits with the beneficiary, his knowledge of the beneficiary, and discussions with the beneficiary's case management staff.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State's comments on our draft report, we maintain that our findings and recommendations are valid. The State's comments appear in their entirety as Appendix E.

The plain language of the State's regulations (repealed after our audit period) provided that a physician's reauthorization be based on a review of the beneficiary's service plan or entire case record. These requirements addressed two subject areas—medical necessity and coordination of care—that are not wholly technical.

Regarding the claims for which DOH indicated that the physician authorized the community residence rehabilitation service "based upon an informed determination of the clinical need," we note that, in most cases, the physician was not familiar with the beneficiary in a community residence setting. For example, for one claim (sample 13), the physician stated that she knew the beneficiary from a chemical addiction program and was not sure if the beneficiary was even receiving community residence rehabilitation services. For another claim (sample 6), the physician stated that he signed an initial authorization without a face-to-face assessment for a beneficiary whom he had not seen in at least 5 years, when the beneficiary was incarcerated.

Regarding the three sample claims cited in DOH's response, we maintain that none of the authorizing physicians reviewed the beneficiary's service plan or case record before authorizing community residence rehabilitation services. For the first claim (sample 61), the physician told us that he did not review the beneficiary's case record before reauthorizing services. For the second claim (sample 62), the physician indicated that he did not review any of the community residence rehabilitation provider's records—including the beneficiary's service plan and case record—before reauthorizing services. For the third claim (sample 80), the physician told us during an interview that he does not review a summary of the quarterly service plan review, the actual service plan review, or the complete case record before signing a reauthorization form.

TABLE OF CONTENTS

Page

APPENDIXES

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New York State (the State), the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Medicaid Management administers the Medicaid program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

Federal and State Requirements Related to Community Residence Rehabilitation Services

Section 1905(a)(13) of the Act and 42 CFR § 440.130(d) authorize optional rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

Title 14, part 593 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) establishes standards for Medicaid reimbursement of community residence rehabilitation services, as well as standards for service planning and review that community residence rehabilitation providers must follow.[1] These regulations state, in part, that: (1) an initial authorization for services must include a face-to-face assessment of the recipient; (2) the authorization must specify the maximum duration of services needed by the recipient; (3) the recipient's service plan must be reviewed and signed by a qualified mental health staff person; (4) each rehabilitative contact must be at least 15 minutes in duration; (5) at least four separate reimbursable rehabilitative services must be provided for a monthly claim or, for a semimonthly claim, at least two separate reimbursable rehabilitative services must be provided; and (6) reauthorization for services must be based on a review of a summary of the recipient's 3-month service plan review or a review of the complete case record of the recipient.

[1] In February 2010, after our audit period, the State's Office of Mental Health (OMH) revised some of its requirements for Medicaid reimbursement of community resident rehabilitation services. Among its changes to the program, the State repealed 14 NYCRR § 593.6(g) and revised 14 NYCRR § 593.4(b) to allow reauthorizations for services to be signed by a physician, physician assistant, or nurse practitioner in psychiatry.

The State elected to include Medicaid coverage of rehabilitation services provided to recipients in community residences under a program administered by OMH.[2]

New York State's Community Residence Rehabilitation Services Program

OMH's community residence rehabilitation services program (the program) provides Medicaid rehabilitation services to adults with mental illness and children and adolescents with serious emotional disturbances who reside in State- and non-State-operated community residences, i.e., group homes and apartments. Rehabilitation services for these recipients include training and assistance with daily living skills, medication management, and socialization; substance abuse services; and parenting training.

Program eligibility is determined by a physician or other licensed practitioner of the healing arts. Physicians' authorizations are valid for up to 6 months for recipients in congregate homes (group homes) and up to 12 months for recipients in apartments. For recipients in community residences, providers develop service plans, provide services, monitor recipient progress, and periodically review the status of recipients. Providers maintain records documenting service authorizations, service plans and reviews, and progress notes. Medicaid reimbursement is based on monthly or semimonthly rates.[3]

Appendix A contains the specific Federal and State requirements related to community residence rehabilitation services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether DOH claimed Federal Medicaid reimbursement for rehabilitation services provided by community residence rehabilitation providers in the State in accordance with Federal and State requirements.

Scope

Our review covered 319,571 rehabilitation services claim lines, totaling $695,556,591 ($348,278,906 Federal share), submitted by 137 community residence rehabilitation providers in the State for the period January 1, 2004, through December 31, 2007. (In this report, we refer to these lines as "claims.")

[2] Although the program is administered by OMH, community residence rehabilitation providers submit claims for payment through the MMIS. DOH then seeks Federal reimbursement for these claims through the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

[3] During our audit period, the average monthly rate paid to community residence rehabilitation providers serving adults was $2,087 and the average monthly rate paid to community residence rehabilitation providers serving children was $7,084.

During our audit, we did not review the overall internal control structure of DOH, OMH, or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We conducted fieldwork at OMH's offices in Albany, New York; at the MMIS fiscal agent in Rensselaer, New York; at 57 community residence rehabilitation providers throughout the State; and at physician offices throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with OMH officials to gain an understanding of the program;
- ran computer programming applications at the MMIS fiscal agent that identified a sampling frame of 319,571 rehabilitation services claims, totaling $695,556,591 ($348,278,906 Federal share), made by 137 community residence rehabilitation providers;
- selected a simple random sample of 100 claims from the sampling frame of 319,571 claims,[4] and for these 100 claims, we:
    - reviewed the corresponding community residence rehabilitation provider's supporting documentation,
    - reviewed the professional credentials of the community residence rehabilitation provider staff person who reviewed and signed the recipient's service plan,
    - interviewed community residence rehabilitation provider officials to determine the provider's policies and procedures for obtaining authorizations for rehabilitation services, and
    - interviewed the physician, if available, who authorized rehabilitation services to determine the physician's knowledge of program requirements; and
- estimated the unallowable Federal Medicaid reimbursement paid in the population of 319,571 claims.

[4] The 100 sampled claims comprised 83 different authorizing or reauthorizing physicians (i.e., some physicians authorized or reauthorized two or more claims). For various reasons (e.g., relocation), we were able to interview only 72 of the 83 physicians (representing 88 claims).

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

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

DOH did not claim Federal Medicaid reimbursement for rehabilitation services submitted by community residence rehabilitation providers in the State in compliance with Federal and State requirements. Of the 100 claims in our random sample, 31 claims complied with Federal and State requirements, but 69 claims did not. Of the 69 claims, 6 contained more than 1 deficiency. The table below summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[5]
Physicians reauthorized services without review of service plan or case record	61
No face-to-face assessment	6
Services not at least 15 minutes in duration	4
Maximum duration of services not specified	2
Monthly claim not supported by required number of services	2
Service plan not reviewed and signed by a qualified staff person	1

These deficiencies occurred because: (1) most of the physicians were not familiar with applicable State regulations and program requirements and (2) certain community residence rehabilitation providers did not comply with State regulations.

Based on our sample results, we estimate that DOH improperly claimed $207,569,115 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2007, audit period.

[5] The total exceeds 69 because 6 claims contained more than 1 error.

PHYSICIANS REAUTHORIZED SERVICES WITHOUT REVIEW OF SERVICE PLAN OR CASE RECORD

Pursuant to 14 NYCRR § 593.6(b), the physician's authorizations must be renewed every 6 months for recipients in congregate residences and every 12 months for recipients in apartments. A summary of the service plan review prepared immediately preceding the expiration date of the physician's authorization, signed by a qualified mental health staff person, must be submitted to the physician before the physician reauthorizes rehabilitation services for the individual (14 NYCRR § 593.6(g)). The physician may reauthorize the services based on the summary of the service plan review or, if necessary, may request the complete case record of the individual. The service plan review is developed by qualified staff at the program and identifies the recipient's service goals and objectives, the services to be provided, proposed time periods, and efforts to coordinate services with other providers. For 61 of the 100 claims in our sample, the physician reauthorized the rehabilitation services without reviewing the summary of the service plan review or the complete case record.

For 45 of the 61 claims, the community residence rehabilitation provider did not submit any documentation (e.g., service plan reviews, assessments, summaries of service plan reviews) to the physician who reauthorized rehabilitation services.[6] For the remaining 16 claims, the community residence rehabilitation providers furnished this documentation; however, the physicians stated in interviews that they did not review the documentation before reauthorizing rehabilitation services.[7]

NO FACE-TO-FACE ASSESSMENT

Pursuant to 14 NYCRR § 593.6(a)(1), the physician's initial authorization must "be based upon appropriate clinical information and assessment of the individual ... [and] must include a face-to-face assessment" of the recipient. For 6 of the 100 claims in our sample, the assessments on which physicians had based initial authorizations did not include face-to-face assessments of the recipients.

SERVICES NOT AT LEAST 15 MINUTES IN DURATION

Pursuant to 14 NYCRR § 593.7(b)(3), reimbursement for the provision of rehabilitation services for recipients in community residences is based on monthly and semimonthly rates. These rates are paid based on a minimum number of face-to-face contacts between an eligible resident and a staff person. Only one face-to-face contact can be counted each day, and it must be at least 15 minutes in duration. For 4 of the 100 claims in our sample, community residence

[6] Community residence provider officials stated they did not provide service plan reviews or case records to physicians. In interviews, all of the physicians associated with these claims (except seven who could not be located) confirmed this information.

[7] The physicians indicated that they authorized rehabilitation services based on their knowledge of the recipients through other programs (e.g., continuing day treatment or clinic) and not based on their review of the recipients' community residence service plan reviews or case records.

rehabilitation providers could not document that rehabilitation services lasted at least 15 minutes.[8]

MAXIMUM DURATION OF SERVICES NOT SPECIFIED

Pursuant to 14 NYCRR § 593.6(a)(2), the physician's authorization for rehabilitation services must specify the maximum duration of the authorization to receive the services. For 2 of the 100 claims in our sample, the physicians' authorizations did not specify the maximum duration of services needed by the recipients.

MONTHLY CLAIM NOT SUPPORTED BY REQUIRED NUMBER OF SERVICES

Pursuant to 14 NYCRR § 593.7(b)(1), a recipient in a community residence must have been provided at least four different rehabilitation services for the community residence rehabilitation provider to be eligible for a monthly claim. For 2 of the 100 claims in our sample, the recipient had not been provided at least four different reimbursable rehabilitative services for a monthly claim.

SERVICE PLAN NOT REVIEWED AND SIGNED BY A QUALIFIED STAFF PERSON

Pursuant to 14 NYCRR § 593.6(d), the recipient's service plan must be reviewed and signed by a qualified mental health staff person. For 1 of the 100 claims in our sample, the service plan was not reviewed and signed.

CAUSES OF UNALLOWABLE CLAIMS

We identified two main causes of the unallowable claims: (1) most of the physicians were not familiar with applicable State regulations[9] and program requirements and (2) certain community residence rehabilitation providers did not comply with State regulations.

Physicians Not Familiar With State Regulations

Forms used by physicians to authorize rehabilitation services for recipients in community residences vary slightly throughout the State.[10] However, each form requires the physician to declare that the authorization or reauthorization for rehabilitation services is based on a review of the recipient's assessments and a determination that the recipient would benefit from services defined in 14 NYCRR § 593. However, 67 of the 72 physicians we interviewed (93 percent) stated that they were not familiar with these regulations. Most of the physicians stated that they

[8] For the remaining 96 sample claims, community residence rehabilitation providers documented the duration of rehabilitation services in their records.

[9] In February 2010, subsequent to our audit period, OMH revised its requirements for Medicaid reimbursement of community resident rehabilitation services. See footnote 1.

[10] Community residence rehabilitation providers generally provide physicians with forms modeled after a DOH prototype. See Appendix C for the DOH prototype authorization form.

did not practice in a community residence rehabilitation program setting and were familiar with the recipient for whom they authorized rehabilitation services only through a different program, such as an outpatient mental health continuing day treatment or clinic program.[11]

For 61 of the claims determined to be in error, the physician's reauthorization for services was not based on a review of the summary of a recipient's 3-month service plan review (or the actual service plan review) or a review of the complete case record, as required. The service plan identifies the recipient's service goals and objectives, the services to be provided, proposed time periods, and efforts to coordinate services with other providers. We interviewed the 46 physicians who signed 54 of the 61 authorizations to determine the basis used for signing the authorization.[12] All 46 stated that they signed authorizations based on their general knowledge of the recipient from other programs the recipient attended and not their own knowledge of the community residence rehabilitation services program. Two physicians stated that they believed the authorizations they signed were for recipients' participation in a continuing day treatment program—not the community residence rehabilitation services program.

Community Residence Rehabilitation Providers Did Not Comply With State Regulations

Contrary to State regulations, 30 of the community residence rehabilitation providers associated with 45 of the 61 sample claims determined to be in error did not provide any documentation to the recipient's physician for use in determining the reauthorization of rehabilitation services. In addition, some providers did not ensure that physicians performed face-to-face assessments of recipients before authorizing rehabilitative services. Finally, other providers did not comply with State regulations concerning the length and number of rehabilitative services required for Medicaid reimbursement.

ESTIMATION OF THE UNALLOWABLE AMOUNT

Of the 100 community residence rehabilitation services claims sampled, 69 were not made in accordance with Federal and State requirements. Based on our sample results, we estimate that the State improperly claimed $207,569,115 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2007, audit period. The details of our sample results and estimates are shown in Appendix D.

[11] Most beneficiaries who reside in community residences attend outpatient mental health continuing day treatment or clinic treatment programs during the day. The providers who operate these outpatient mental health programs are also eligible for Medicaid reimbursement for their services. Generally, community residence rehabilitation services programs do not have a physician on staff or under contract. Therefore, they usually send reauthorizations for rehabilitation services to the physicians at the day treatment or clinic programs.

[12] We did not interview the physicians who authorized services for 7 of the 61 unallowable claims because the physicians could not be located. However, provider officials stated they did not provide the service plan or case record to the physicians for these seven claims.

RECOMMENDATIONS

We recommend that DOH:

- refund $207,569,115 to the Federal Government and

- work with OMH to implement guidance to physicians regarding State regulations on the authorization of community residence rehabilitation services.

DEPARTMENT OF HEALTH COMMENTS

In its comments on our draft report, DOH disagreed with our first recommendation (financial disallowance) and agreed with our second recommendation. DOH also disagreed with the legal basis of our findings and indicated that our findings are based solely on our application of State regulations.

DOH stated that our interpretation of the State's regulations was inappropriate, overly technical, and contrary to the meaning and intent of the regulations.

Further, DOH stated that, for 58 of the 61 sample claims for which the authorizing physician did not review the beneficiary's service plan or case record, the physician authorized the service "based upon an informed determination of the clinical need." Specifically, DOH cited physicians' responses to our questionnaires for 3 of the 61 sample claims we found to be in error. For one claim (sample 61), DOH noted that the physician based his reauthorization on his knowledge of the beneficiary and discussions with the beneficiary's case manager. For a second claim (sample 62), DOH noted that the physician indicated that he saw the beneficiary at least once a month in an outpatient program for medication management. Further, when signing reauthorizations, the physician indicated that he uses his knowledge of the beneficiary, the beneficiary's initial psychiatric evaluation, and communication with staff from the beneficiary's community residence rehabilitation services provider. For a third claim (sample 80), DOH noted that the physician stated that he is very familiar with the beneficiary and signs reauthorizations for the beneficiary's community residence rehabilitation services based on office visits with the beneficiary, his knowledge of the beneficiary, and discussions with the beneficiary's case management staff.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State's comments on our draft report, we maintain that our findings and recommendations are valid. The State's comments appear in their entirety as Appendix E.

The plain language of the State's regulations (repealed after our audit period) provided that a physician's reauthorization be based on a review of the beneficiary's service plan or entire case record. These requirements addressed two subject areas—medical necessity and coordination of care—that are not wholly technical.

Regarding the claims for which DOH indicated that the physician authorized the community residence rehabilitation service "based upon an informed determination of the clinical need," we note that, in most cases, the physician was not familiar with the beneficiary in a community residence setting. For example, for one claim (sample 13), the physician stated that she knew the beneficiary from a chemical addiction program and was not sure if the beneficiary was even receiving community residence rehabilitation services. For another claim (sample 6), the physician stated that he signed an initial authorization without a face-to-face assessment for a beneficiary whom he had not seen in at least 5 years, when the beneficiary was incarcerated.

Regarding the three sample claims cited in DOH's response, we maintain that none of the authorizing physicians reviewed the beneficiary's service plan or case record before authorizing community residence rehabilitation services. For the first claim (sample 61), the physician told us that he did not review the beneficiary's case record before reauthorizing services.[13] For the second claim (sample 62), the physician indicated that he did not review any of the community residence rehabilitation provider's records—including the beneficiary's service plan and case record—before reauthorizing services. For the third claim (sample 80), the physician told us during an interview that he does not review a summary of the quarterly service plan review, the actual service plan review, or the complete case record before signing a reauthorization form.

[13] In addition, the beneficiary's community residence rehabilitation provider did not send the physician any clinical documentation. Rather, the provider only sent the physician an authorization form.

APPENDIXES

APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO COMMUNITY RESIDENCE REHABILITATION SERVICES

- Section 1902(a)(27) of the Social Security Act specifies that a "State plan for medical assistance must—… provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request."

- Section 1905(a)(13) of the Social Security Act authorizes optional "... 'rehabilitative services,' including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

- Rehabilitative services, as defined in the Federal regulations (42 CFR § 440.130(d)), "include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

- Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A of Circular A-87 says that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

- At the service plan review immediately preceding the expiration date of the physician's authorization, a summary of the review, signed by the Qualified Mental Health Staff person, must be submitted to the physician to obtain a new authorization of rehabilitation services for the individual. The physician may authorize the services based on the summary of the 3-month review or, if necessary, may request the complete case record of the individual (14 New York Compilation of Codes, Rules, & Regulations (NYCRR) § 593.6(g)).

- The initial authorization for services must include a face-to-face assessment of the recipient (14 NYCRR § 593.6(a)(1)).

- Only one contact can be counted each day and the contact must be at least 15 minutes in duration (14 NYCRR § 593.7(b)(3)).

- A contact takes place when an eligible resident of a program and a staff person of an approved provider of community residence rehabilitation services have face-to-face contact (14 NYCRR § 593.7(b)).

- The physician's authorization must specify the maximum duration of the authorization to receive services (14 NYCRR § 593.6(a)(2)).

- A recipient must have been provided at least four different community rehabilitative services (at least four separate face-to-face contacts) for a monthly claim or at least two different community rehabilitation services (at least two separate face-to-face contacts) for a semimonthly claim (14 NYCRR § 593.7(b)(1) & (2)).

- The service plan must be reviewed and signed by a Qualified Mental Health Staff person (14 NYCRR § 593.6(d)).

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was community residence rehabilitation services claim lines (claims) submitted by 137 providers in the State during our January 1, 2004, through December 31, 2007, audit period that were claimed for Federal Medicaid reimbursement by the New York State Department of Health.

SAMPLING FRAME

The sampling frame was a computer file containing 319,571 detailed paid claims for community residence rehabilitation services submitted by 137 providers in the State during our audit period. The total Medicaid reimbursement for the 319,571 claims was $695,556,591 ($348,278,906 Federal share). The Medicaid claims were extracted from the claims' files maintained at the Medicaid Management Information System fiscal agent.

SAMPLING UNIT

The sampling unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

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

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the 319,571 detailed claims. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

ESTIMATION METHODOLOGY

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

APPENDIX C: PROTOTYPE OF PHYSICIAN AUTHORIZATION FORM

AUTHORIZATION FOR
RESTORATIVE SERVICES OF
COMMUNITY RESIDENCES

☐ Initial Authorization

☐ Semi-Annual Authorization

☐ Annual Authorization

CLIENT'S NAME: _____

CLIENT'S MEDICAID NUMBER: _____

ICD.9 DIAGNOSIS: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that _____ would benefit from the provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR.
(client's name)

This determination is in effect for the period _____ to _____, at which time there will be an evaluation for continued stay.

_____ / _____ / _____
Mo. Day Yr.

_____
Name (Please Print)

_____
Licensure #

_____
Signature

☐ Check here if client is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinator Program) and enter primary care physician name and managed care provider identification number.

_____
Physician

_____
Managed Care Provider ID #

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
319,571	$348,278,906	100	$111,134	69	$77,355

Estimated Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$247,204,499
Lower Limit	$207,569,115
Upper Limit	$286,839,882

APPENDIX E: DEPARTMENT OF HEALTH COMMENTS

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

August 23, 2010

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No. A-02-08-01006

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-08-01006 on "Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: Robert W. Reed
Donna Frescatore
James Sheehan
Michael F. Hogan, Ph.D.
Diane Christensen
Dennis Wendell
Stephen Abbott
James Russo
Irene Myron
Ronald Farrell
Mary Elwell
Lynn Oliver

New York State Department of Health's Comments on the Department of Health and Human Services Office of Inspector General's Draft Audit Report A-02-08-01006 on "Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-08-01006 on "Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers."

Recommendation #1:

The State should refund $207,569,115 to the Federal Government.

Response #1:

The Department and the New York State Office of Mental Health (OMH) strongly disagree with the recommendation for the State to refund $207,569,115 to the Federal government on the basis that OIG's underlying audit methodology is flawed. Further, the New York State Office of the Medicaid Inspector General (OMIG) has concerns with the standards and methodology applied during the OIG review. The OMIG has conducted similar rehabilitation service audits of OMH providers, and as part of these audits, has considered additional documentation seemingly not considered by the OIG in the audit at hand. In the OMIG's opinion, the OIG's consideration of this additional documentation would not only be consistent with OMIG's approach but would also be a more accurate reflection of provider compliance with the billing requirements. This could also have a significant impact on potential findings. The OMIG is requesting a meeting with the OIG to discuss both agencies' audit approaches and the possible impact on the OIG's findings and recommendations.

The New York State Community Residence Rehabilitation Program provides vital rehabilitative services to individuals who are seriously impaired as a result of mental illness. OIG conducted this audit of the program and recommends a punitive disallowance of $207,569,115 based upon findings of alleged technical violations of New York State program regulations. This recommendation results from OIG's review of a sample of 100 claims out of a universe of 319,571 claims, and is made despite the fact that there is no finding or allegation that the services provided were not medically-necessary, were not in fact provided or were provided to individuals who were not Medicaid-eligible. Indeed, preliminary State analyses of the OIG audit workpapers reveals that the auditors were, in fact, aware that the services in question were provided, documented and medically-necessary, and that they were indeed authorized or reauthorized by a physician.

The OIG's recommended disallowance is not based upon any alleged violations of Federal Medicaid laws, rules or regulations. Rather, the recommendation is based solely upon alleged violations of New York State program regulations. The OIG auditors, however, never consulted with either OMH or Department Medicaid officials in interpreting these regulations. This flawed auditing practice resulted in an OIG interpretation that is at odds with the way in which the State interprets and enforces these provisions. Further, the auditors were selective in their reliance upon these regulations. While they chose to enforce certain requirements, they also chose to ignore the enforcement provisions contained therein. The result is that the OIG has recommended a disallowance of a magnitude that threatens the viability of the State's entire program for providing much-needed services to a seriously disabled population, for alleged infractions having nothing to do with the quality or appropriateness of care, recipient eligibility or provider fraud or abuse.

Although OIG's stated audit objective was to determine whether the State claimed Medicaid reimbursement for rehabilitation services in accordance with Federal and State requirements, each of the findings and the recommended disallowance are based solely upon OIG's application of the New York State regulations. Accordingly, the report and recommendations should not be afforded the deference ordinarily given to agencies when interpreting and enforcing their own regulations. Rather, deference should be given to the State in interpreting, applying and enforcing its own regulations.

The OIG audit is seriously flawed in a number of respects:

I. The auditors ignored the appropriateness of remedies other than disallowance for alleged regulatory violations. OIG has taken the position that any violation of State program regulations, regardless of whether substantive or technical, renders the services provided non-reimbursable. This approach ignores the variety of regulatory enforcement mechanisms utilized by the State, and called for in the regulation in question, including requiring providers to submit corrective action plans, increasing the frequency of program inspections, and ultimately the imposition of fines, or license limitation or revocation.

II. OIG applied an inappropriate and overly technical interpretation of New York State's program regulations that is contrary to the meaning and intent of those regulations.

III. OIG ignored documentation in the charts reviewed of the need for services, and of the authorizing physicians' knowledge of the patients for whom services were being authorized.

These OIG audit flaws are more thoroughly addressed below.

I. <u>The auditors ignored the appropriateness of remedies other than disallowance for alleged regulatory violations.</u>

OIG determined that the providers in question had violated State requirements. However, as detailed below, the large majority of such findings are based upon an overly literal reading

of the regulations, resulting in an interpretation and application of the requirements that was never intended by the State. Even had the conduct of these providers been violative of the regulations, the mechanism provided by the regulations for addressing violations would not have resulted in the payment for these services being disallowed, under the terms of the same regulation that the OIG is purporting to enforce.

OMH maintains various means of monitoring and enforcing provider compliance with program standards. Among these are requiring that providers submit a plan of correction addressing program deficiencies, increasing the frequency of program inspections, the imposition of fines and the limitation, suspension or revocation of a provider's license. Section 593.8 of the regulation in question, Enforcement of Service Planning and Reimbursement Standards, makes this explicit for the program. This section specifically provides that where OMH determines that a provider of service is not exercising due diligence in complying with the State regulatory requirements pertaining to this program, OMH will give notice of the deficiency to the provider, and may also either request that the provider prepare a plan of correction, or OMH may provide technical assistance. If the provider fails to prepare an acceptable plan of correction within a reasonable time, or if it refuses to permit OMH to provide technical assistance or effectively implement a plan of correction, then it will be determined to be in violation of the program regulations. Such a determination, as well as a failure to comply with the terms of the provider's operating certificate or with the provisions of any applicable statute, rule or regulation, subjects the provider to a possible revocation, suspension or limitation of the provider's operating certificate, or the imposition of a fine. It is only when a provider of service seeks reimbursement in excess of that provided for in Section 593.7, which sets out the program reimbursement standards, that OMH would make a referral to the Department for the recovery of an overpayment.

Thus, the OIG has issued a recommended disallowance based entirely upon State regulations. In so doing, however, it has chosen to ignore provisions of the regulation it is purporting to enforce. As is detailed below, the OIG then compounds this error by misinterpreting and misapplying these regulations, resulting in a determination of violations based upon behaviors that the State would have found to be compliant.

II. OIG applied an inappropriate and overly technical interpretation of New York State's program regulations that is contrary to the meaning and intent of those regulations.

The draft OIG audit report relies on an overly technical interpretation of State regulations. OIG recommends a disallowance of $207,569,115 based upon a review of a sample of 100 claims from a universe of 319,571 claims. Of the 100 claims sampled, OIG found that 69 claims were so flawed as to render such claims non-reimbursable. Of those 69 "noncompliant" claims, 61 were found to violate the State's requirement for service reauthorization, which states that at the service plan review immediately preceding the expiration date of the physician's authorization, a summary of the review must be submitted to the physician, and that the physician may authorize the services based upon the summary of the three month review or, if necessary, may request the complete case record of the individual. For 45 of the 61, OIG states that the provider did not submit the review

summary to the physician. For the remaining 16 claims, OIG states that such summaries were provided, but the physician did not base his or her reauthorization upon them.

As noted in the draft OIG audit report, the services in question are provided under the Medicaid rehabilitation option which authorizes states to furnish rehabilitative services recommended by a physician, nurse or other licensed practitioner of the healing arts within their scope of practice under State law. One of the major ways in which Federal requirements for rehabilitative services differ from those pertaining to other Medicaid services is that such services can be recommended by licensed practitioners other than physicians. This reflects the fact that the focus of rehabilitative services is primarily the restoration of function, rather than the medical treatment of illness.

The services in question are provided to individuals residing in community residences for persons with serious mental illness. OMH, in designing program standards for this service, wanted to ensure that there was physician involvement in the determination of the need for services, and in periodic reauthorizations. The program standards, however, permit service planning and service plan reviews to be conducted by "qualified mental health staff." Accordingly, the program design did not ensure that the physicians reauthorizing these services would be familiar with the status or progress of the individual receiving them.

The intent of the requirement that the program supply the physician with a summary of the service plan review, and the language stating that the physician may authorize additional services based upon that review, was to ensure that physicians not otherwise familiar with the individual would be provided with sufficient information to make an informed clinical judgment. The requirement was not intended to require that a physician who was fully familiar with the clinical presentation of the individual as a result of being actively engaged in providing treatment to him or her be given a document summarizing information already known to the physician. Similarly, it was not intended to require that the physician base his or her recommendation on that summary, rather than his or her own informed clinical judgment.

III. OIG ignored documentation in the charts reviewed of the need for services, and of the authorizing physicians' knowledge of the patients for whom services were being authorized.

The OIG auditors ignored documentation of the authorizing physicians' knowledge of the patients for whom services were being authorized. The auditors' own workpapers reflect the absurdity resulting from their interpretation of the regulations in question. Despite having ample documentation that the physicians providing the service reauthorizations in question were familiar with the clinical status and needs of the individuals as a result of the physicians' own personal knowledge, the OIG repeatedly disallowed services based upon its reading of a regulation intended to ensure that such reauthorizations be provided by informed physicians because those physicians did not base the reauthorization on a summary prepared by others.

In a questionnaire used by the OIG auditors, the physicians were asked whether they reauthorized services based upon a review of the summary of the three-month service plan

review, the actual service plan review or the complete case record, and to explain. In case after case, when the "no" box was marked, the explanation given was that the physician was personally familiar with the patient. For the sake of brevity, not all of these examples are recited in this document, although examples include the following:

- "Dr. [redacted] saw [redacted] for a psychiatric assessment and medication management at the Middletown Mental Health Center clinic. Dr. [redacted] based his reauthorization on knowledge of [redacted] and discussions with case manager…" (Sample 61)

- "Dr. [redacted] sees [redacted] once a month or more often if needed in an outpatient program for medication management. When signing a reauthorization Dr. [redacted] uses his knowledge of the patient, initial psych evaluation and communications with staff from Catholic Charities Syracuse." (Sample 62)

- "Dr. [redacted] stated that he signs the reauthorization form based on his office visits with the patient, knowledge of the patient, and discussions with staff (Clear View case manager and CDPC social worker). He added that he is very familiar with this patient's history, based on regular contact with the patient (he has seen this patient for years)." (Sample 80)

The above excerpts represent three examples of the cases that were determined by the OIG auditors to be noncompliant with the State's requirements, despite it being clear that the service reauthorization was made by physicians based upon an informed determination of clinical need. State review of the OIG's audit workpapers showed that of the 61 cases found by the OIG to be noncompliant with this requirement, at least 58 reflected reauthorizations based upon actual knowledge of the patient's case by the physician. This honoring of form over substance, and the recommendation of a disallowance of this magnitude based upon such a stilted misinterpretation and misapplication of the State's regulations, is unwarranted and excessive. Further, while it was impossible for the State to determine from the auditors' notes whether the remaining three cases were also based upon such physicians' knowledge, the State will be reviewing all of the charts reviewed by OIG and reserves the right to raise additional concerns and to introduce additional information as the process proceeds.

Recommendation #2:

The Department should work with OMH to implement guidance to physicians regarding State regulations on the authorization of community residence rehabilitation services.

Response #2:

The Department will work with OMH to disseminate any necessary guidance to physicians regarding authorizations of community residence rehabilitative services, although it is relevant to note that OMH has repealed the specific section of the regulation in question (i.e., NYCRR 593.6 (g) and has adopted amended regulations that reflect the intent of OMH regarding medical assistance payments for community rehabilitation services, including physician authorizations and reauthorizations. An explanation of the intent of the repealed section of the regulation, as

well as a copy of the amended regulations, was previously provided to the OIG auditors during their review.