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

Washington, D.C. 20201

October 7, 2011

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

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State (A-02-09-01023)

Attached, for your information, is an advance copy of our final report on Medicaid claims submitted by continuing day treatment providers in New York State. We will issue this report to New York State Department of Health within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-09-01023.

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

October 12, 2011

Report Number: A-02-09-01023

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

Dear Dr. Shah:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State*. 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-02-09-01023 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS SUBMITTED BY CONTINUING DAY TREATMENT PROVIDERS IN NEW YORK STATE

Daniel R. Levinson
Inspector General

October 2011
A-02-09-01023

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)(9) of the Act authorizes "clinic services" furnished by or under the direction of a physician. Federal regulations (42 CFR § 440.90) define clinic services as "… preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to [recipients]."

The State elected to include Medicaid coverage of day treatment services, a form of clinic services, among its Licensed Outpatient Programs, which are administered by its Office of Mental Health (OMH). OMH's continuing day treatment (CDT) program provides active treatment to Medicaid recipients designed to maintain or enhance current levels of functioning and skills, to maintain community living, and to develop self-awareness and self-esteem through the exploration and development of strengths and interests. CDT services include assessment and treatment planning, discharge planning, medication therapy, case management, psychiatric rehabilitation, and activity therapy, among others. To be eligible for the CDT program, the recipient must have a designated mental illness diagnosis and a dysfunction due to mental illness. CDT services are provided in hospital and nonhospital settings.

Pursuant to State requirements for Medicaid reimbursement of CDT services, a recipient's treatment plan must: (1) be completed in a timely manner, (2) be signed and approved by the recipient, (3) include criteria for discharge planning, and (4) be reviewed every 3 months. In addition, CDT services must be adequately documented (including type and duration of services) and provided in accordance with the recipient's treatment plan.

OBJECTIVE

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

SUMMARY OF FINDINGS

DOH did not claim Federal Medicaid reimbursement for CDT services provided by nonhospital providers in the State in accordance with State requirements. Of the 100 claims in our random sample, all claims complied with Federal requirements and 43 claims complied with Federal and State requirements, but 57 claims did not comply with State requirements.

Of the 57 noncompliant claims, 10 contained more than 1 deficiency:

- For 43 claims, the type of service was not documented.
- For eight claims, progress notes were not properly recorded.
- For seven claims, the duration of the recipient's contact with staff was not indicated.
- For three claims, the treatment plan was not completed in a timely manner.
- For three claims, the treatment plan was incomplete.
- For two claims, service hours were improperly calculated.
- For one claim, the recipient's participation in treatment planning was not documented.
- For one claim, the treatment plan was not reviewed in a timely manner.
- For one claim, CDT services were not provided.

These deficiencies occurred because: (1) certain nonhospital CDT providers did not comply with State regulations and (2) DOH did not ensure that OMH adequately monitored the CDT program for compliance with certain State requirements.

Based on our sample results, we estimate that DOH improperly claimed $84,366,929 in Federal Medicaid reimbursement during our January 1, 2005, through December 31, 2008, audit period.

RECOMMENDATIONS

We recommend that DOH:

- refund $84,366,929 to the Federal Government,
- work with OMH to issue guidance to the provider community regarding State requirements for claiming Medicaid reimbursement for CDT services, and
- work with OMH to improve OMH's monitoring of the CDT program to ensure compliance with State requirements.

DEPARTMENT OF HEALTH COMMENTS

In written comments on our draft report, DOH disagreed with our first recommendation (financial disallowance) and did not indicate concurrence or nonconcurrence with our remaining recommendations. Specifically, DOH stated that we based our findings entirely on State regulations and that we should afford DOH the discretion to interpret its own regulations. DOH stated that, if OMH found a provider's claims to not be in compliance with the State regulations we cited, it "would not have rendered the services non-reimbursable under the same regulations applied by OIG."

DOH also stated that, for the 43 sampled claims for which the provider did not document that at least 1 Medicaid reimbursable CDT service was delivered on the sampled service date, providers furnished us with a schedule of the group services provided to each client for each day the client attended the CDT program. DOH stated that these schedules documented the "frequency and the types of services planned for the individual." Providers furnished us with progress notes that recorded clients' "general attendance and progress in group therapies." DOH further stated that, in audits of 2 providers associated with 15 of the 43 sampled claims, the New York State Office of Medicaid Inspector General (OMIG) concluded that the 2 providers maintained sufficient documentation to support that they had provided Medicaid-eligible services.

In addition, DOH stated that it disputes our findings related to 8 other types of documentation deficiencies related to 26 sampled claims. For one sampled claim (claim number 17), DOH stated that we indicated that the progress note was written by someone who did not actually provide a service during the relevant 2-week period. However, DOH stated that the client's therapist wrote the progress note and that our workpapers supported the therapist's "active involvement in providing services" during the 2-week period, as the therapist made several outreach telephone calls.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The schedules provided to us indicated <u>planned</u> CDT services. These schedules did not document that services were actually performed and, in many cases, did not include the date (month or year) of the planned services. In one case, the schedule, although dated, was prepared 1 year before the date of the sampled service. In addition, the biweekly progress notes indicating "general attendance" were often just a summation of the prior 2 weeks without any specific information regarding a particular day, including our sampled date of service. Regarding the two OMIG audits cited by DOH, we discussed OMIG's methodology and conclusions with OMIG officials. We maintain that our results regarding the two providers are valid.

Regarding claim number 17, we note that the beneficiary received CDT services on only 2 days during the 2-week period. Based on documentation provided, the therapist who signed the progress note did not provide a Medicaid-reimbursable service to the beneficiary on the 2 days the client attended the CDT program or at any other time during the 2-week period covered by the progress note.

DOH's comments appear in their entirety as Appendix D.

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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 Continuing Day Treatment Services

Section 1905(a)(9) of the Act authorizes "clinic services" furnished by or under the direction of a physician. Federal regulations (42 CFR § 440.90) define clinic services as "… preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to [recipients]." Whereas these regulations broadly define Federal requirements for what clinic services are eligible for Federal reimbursement, States may impose more specific standards (e.g., through Medicaid State plans, State regulations) for what services are eligible for Medicaid reimbursement.

Under the New York Medicaid State plan, DOH elects to include coverage of day treatment services, a form of clinic services, among the State's Licensed Outpatient Programs, which are administered by its Office of Mental Health (OMH).[1]

Title 14 §§ 587-588 and Title 18 § 505.25 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) establish requirements for Medicaid reimbursement for the continuing day treatment (CDT) program, as well as standards for CDT care and treatment planning.[2] Pursuant to these requirements, a recipient's treatment plan must: (1) be completed in a timely manner, (2) be signed and approved by the recipient, (3) include criteria for discharge planning,

[1] Although day treatment services are administered by OMH, 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.

[2] In April 2009, after our audit period, the State revised its requirements for Medicaid reimbursement of CDT services, as well as its standards for CDT care and treatment planning.

and (4) be reviewed every 3 months. In addition, CDT services must be adequately documented (including type and duration of services) and provided in accordance with the recipient's treatment plan.

New York State's Continuing Day Treatment Program

OMH's CDT program provides Medicaid recipients active treatment designed to maintain or enhance current levels of functioning and skills, to maintain community living, and to develop self-awareness and self-esteem through the exploration and development of strengths and interests.[3] CDT services include assessment and treatment planning, discharge planning, medication therapy, case management, psychiatric rehabilitation, and activity therapy, among others. To be eligible for the CDT program, the recipient must have a designated mental illness diagnosis and a dysfunction due to mental illness.[4] CDT services are provided in both hospital and nonhospital settings.

Appendix A contains the specific Federal and State regulations related to CDT services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered 4,864,775 CDT claim lines, totaling $385,114,484 ($192,556,880 Federal share), submitted by 95 nonhospital CDT providers in the State for the period January 1, 2005, through December 31, 2008. (In this report, we refer to these lines as "claims.")

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 DOH's and OMH's offices in Albany, New York; at the MMIS fiscal agent in Rensselaer, New York; and at 45 nonhospital CDT providers' offices throughout the State.

[3] A primary function of the CDT program is to provide individually tailored treatment services that address substantial skill deficits in specific life areas that interrupt an individual's ability to maintain community living. The configuration, frequency, intensity, and duration of services correspond to the Medicaid recipient's progress in achieving desired outcomes.

[4] Designated mental illness diagnoses are diagnoses other than alcohol or drug disorders, developmental disabilities, organic brain syndromes, or social conditions.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines;
- held discussions with OMH officials to gain an understanding of the CDT program;
- ran computer programming applications at the MMIS fiscal agent that identified a sampling frame of 5,104,839 CDT services claims, totaling $402,221,643 ($201,109,884 Federal share), made by 101 nonhospital CDT providers;
- eliminated from the sampling frame all claims submitted by 6 nonhospital CDT providers identified in New York State Office of the Medicaid Inspector General (OMIG) audit reports covering our audit period;[5]
- determined that our revised sampling frame contained 4,864,775 claims, totaling $385,114,484 ($192,556,880 Federal share), made by 95 nonhospital CDT providers;
- selected a simple random sample of 100 claims from the sampling frame of 4,864,775 claims,[6] and for these 100 claims, we:
    - reviewed the corresponding nonhospital CDT provider's documentation supporting the claim and
    - interviewed officials at the corresponding nonhospital CDT provider to gain an understanding of the provider's policies for documenting and claiming CDT services; and
- estimated the unallowable Federal Medicaid reimbursement paid in the population of 4,864,775 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.

[5] OMIG audit numbers 08-2718, 07-4280, 07-4278, 07-3607, 07-3530, and 06-7638.

[6] The 100 sample items were claims submitted by a total of 45 nonhospital CDT providers.

FINDINGS AND RECOMMENDATIONS

DOH did not claim Federal Medicaid reimbursement for CDT services provided by nonhospital providers in the State in accordance with State requirements. Of the 100 claims in our random sample, all claims complied with Federal requirements and 43 claims complied with Federal and State requirements, but 57 claims did not comply with State requirements. Of the 57 claims, 10 contained more than 1 deficiency. The table 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[7]
Type of services not documented	43
Progress notes not properly recorded	8
Duration of recipient's contact with staff not indicated	7
Treatment plan not completed in a timely manner	3
Treatment plan incomplete	3
Service hours improperly calculated	2
Recipient participation in treatment planning not documented	1
Treatment plan not reviewed in a timely manner	1
Services not provided	1

These deficiencies occurred because: (1) certain nonhospital CDT providers did not comply with State regulations and (2) DOH did not ensure that OMH adequately monitored the CDT program for compliance with certain State requirements.

Based on our sample results, we estimated that DOH improperly claimed $84,366,929 in Federal Medicaid reimbursement during our January 1, 2005, through December 31, 2008, audit period.

TYPE OF SERVICES NOT DOCUMENTED

Pursuant to 14 NYCRR § 587.18(b)(7), a recipient's case record shall be available to all outpatient program staff who are participating in the recipient's treatment and shall include the date(s) of all onsite and offsite face-to-face contacts with the recipient, the type of service(s) provided, and the duration of the contact(s). Pursuant to 18 NYCRR § 505.25(e)(5), every claim for Medicaid-eligible services shall be for a documented, definable medical service that includes a face-to-face professional exchange between provider and recipient in accordance with goals stated in the recipient's treatment plan. Pursuant to 18 NYCRR § 505.25 (h)(1)(ii), State reimbursement shall be available when documentation shows that at least one Medicaid reimbursable service has been delivered for each billable occasion of service.

[7] The total exceeds 57 because 10 claims contained more than 1 error.

For 43 of the 100 claims in our sample, the nonhospital CDT provider could not document that at least 1 Medicaid reimbursable CDT service was delivered on the date of the sampled service. Specifically, for these claims, providers could document only the duration of the visit (i.e., sign-in sheets) but not the type of CDT service provided.

PROGRESS NOTES NOT PROPERLY RECORDED

Pursuant to 14 NYCRR § 587.16(f)(2), progress notes for each recipient shall be recorded at least every 2 weeks by the clinical staff members who provided CDT services to the recipient.

For 8 of the 100 claims in our sample, progress notes were maintained by the nonhospital CDT provider; however, the progress notes were not recorded by a clinical staff member who actually provided a CDT service during the 2-week period that included our sampled service.

DURATION OF RECIPIENT'S CONTACT WITH STAFF NOT INDICATED

Pursuant to 14 NYCRR § 587.18(b)(7), a recipient's case record shall be available to all outpatient program staff who are participating in the recipient's treatment and shall include the date(s) of all onsite and offsite face-to-face contacts with the recipient, the type of service(s) provided, and the duration of the contact(s).

For 7 of the 100 claims in our sample, the corresponding case record did not indicate the duration of the recipient's contact with outpatient program staff.

TREATMENT PLAN NOT COMPLETED IN A TIMELY MANNER

Pursuant to 14 NYCRR § 588.7(d), a recipient's treatment plan shall be completed before the recipient's 12th visit after admission or within 30 days of admission, whichever occurs first.

For 3 of the 100 claims in our sample, the recipient's treatment plan was not completed before the recipient's 12th visit after admission or within 30 days of admission.

TREATMENT PLAN INCOMPLETE

Pursuant to 14 NYCRR § 587.16(e), a recipient's treatment plan shall include criteria for discharge planning.

For 3 of the 100 claims in our sample, the treatment plan did not contain criteria for discharge planning.

SERVICE HOURS IMPROPERLY CALCULATED

Pursuant to 14 NYCRR § 588.5(h), service hours shall be determined by rounding to the nearest full hour once the minimum billable period has occurred.[8]

For 2 of the 100 claims in our sample, service hours were not properly calculated once the minimum billable period had occurred. Specifically, one claim was rounded up by 45 minutes (from 2 hours and 15 minutes to 3 hours) and a second claim was rounded up by a full hour (from 3 hours to 4 hours).

RECIPIENT PARTICIPATION IN TREATMENT PLANNING NOT DOCUMENTED

Pursuant to 14 NYCRR § 587.16(c), recipient participation in treatment planning and approval of the plan shall be documented by the recipient's signature. If a recipient cannot participate in treatment planning and/or approval of the treatment plan, reasons for the recipient's nonparticipation shall be documented in the case record.

For 1 of the 100 claims in our sample, the treatment plan did not contain the recipient's signature, and the case record did not document reasons for the recipient's nonparticipation.

TREATMENT PLAN NOT REVIEWED IN A TIMELY MANNER

Pursuant to 14 NYCRR § 588.7(d), a recipient's treatment plan shall be reviewed every 3 months.

For 1 of the 100 claims in our sample, the recipient's treatment plan was not reviewed every 3 months. Specifically, nearly 5 months passed between the preparation of the recipient's treatment plan and the date a psychiatrist reviewed the plan.

SERVICES NOT PROVIDED

Pursuant to 14 NYCRR § 588.5(c), reimbursement shall be made only for services identified and provided in accordance with the recipient's treatment plan.

For 1 of the 100 claims in our sample, reimbursement was made for CDT services that were not provided. Specifically, the recipient's chart indicated that, on the date of the sampled claim, the recipient worked at a store operated by the nonhospital CDT provider for the total duration of her visit to the facility and did not receive CDT services that day. Provider officials confirmed that the recipient did not receive CDT services on the date of the sampled claim.

[8] In April 2009, after our audit period, the State revised its requirements for Medicaid reimbursement of CDT services, as well as standards for CDT care and treatment planning. For example, only the actual time that a recipient is in attendance at the CDT program is counted toward the CDT service (i.e., time is not rounded).

CAUSES OF UNALLOWABLE CLAIMS

Certain Providers Did Not Comply With State Regulations

Of the 45 nonhospital CDT providers included in our review, 20 did not document the type of CDT services billed to Medicaid. These 20 providers submitted 43 of the 57 sample items determined to be in error. In addition, other nonhospital CDT providers did not comply with State regulations concerning the documentation of recipients' clinical progress and/or contact with outpatient program staff.

Inadequate Monitoring by Office of Mental Health

DOH did not ensure that OMH adequately monitored nonhospital CDT providers for compliance with certain State requirements. Although OMH conducts periodic onsite monitoring visits at providers to review case records for compliance with applicable State regulations, OMH's monitoring program did not ensure that providers complied with State requirements.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 CDT services claims sampled, 57 were not made in accordance with State requirements. Based on our sample results, we estimated that DOH improperly claimed $84,366,929 in Federal Medicaid reimbursement during our January 1, 2005, through December 31, 2008, audit period. The details of our sample results and estimates are shown in Appendix C.

RECOMMENDATIONS

We recommend that DOH:

- refund $84,366,929 to the Federal Government,
- work with OMH to issue guidance to the provider community regarding State requirements for claiming Medicaid reimbursement for CDT services, and
- work with OMH to improve OMH's monitoring of the CDT program to ensure compliance with State requirements.

DEPARTMENT OF HEALTH COMMENTS

In written comments on our draft report, DOH disagreed with our first recommendation (financial disallowance) and did not indicate concurrence or nonconcurrence with our remaining recommendations. Specifically, DOH stated that we based our findings entirely on State regulations and that we should afford DOH the discretion to interpret its own regulations. DOH stated that, if OMH found a provider's claims to not be in compliance with the State regulations we cited, it "would not have rendered the services non-reimbursable under the same regulations applied by OIG."

DOH also stated that, for the 43 sampled claims for which the provider did not document that at least 1 Medicaid reimbursable CDT service was delivered on the sampled service date, providers furnished us with a schedule of the group services provided to each client for each day the client attended the CDT program. DOH stated that these schedules documented the "frequency and the types of services planned for the individual." Providers furnished us with progress notes that recorded clients' "general attendance and progress in group therapies." DOH further stated that, in audits of 2 providers associated with 15 of the 43 sampled claims, OMIG concluded that the 2 providers maintained sufficient documentation to support that they had provided Medicaid-eligible services.

In addition, DOH stated that it disputes our findings related to 8 other types of documentation deficiencies related to 26 sampled claims. For one sampled claim (claim number 17), DOH stated that we indicated that the progress note was written by someone who did not actually provide a service during the relevant 2-week period. However, DOH stated that the client's therapist wrote the progress note and that our workpapers supported the therapist's "active involvement in providing services" during the 2-week period, as the therapist made several outreach telephone calls.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The schedules provided to us indicated planned CDT services. These schedules did not document that services were actually performed and, in many cases, did not include the date (month or year) of the planned services. In one case, the schedule, although dated, was prepared 1 year before the date of the sampled service. In addition, the biweekly progress notes indicating "general attendance" were often just a summation of the prior 2 weeks without any specific information regarding a particular day, including our sampled date of service. Regarding the two OMIG audits cited by DOH, we discussed OMIG's methodology and conclusions with OMIG officials. We maintain that our results regarding the two providers are valid.

Regarding claim number 17, we note that the beneficiary received CDT services on only 2 days during the 2-week period. Based on documentation provided, the therapist who signed the progress note did not provide a Medicaid-reimbursable service to the beneficiary on the 2 days the client attended the CDT program or at any other time during the 2-week period covered by the progress note.

DOH's comments appear in their entirety as Appendix D.

APPENDIXES

APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO CONTINUING DAY TREATMENT SERVICES

- Section 1902(a)(27) of the Social Security Act (the 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)(9) of the Act authorizes "clinic services" furnished by or under the direction of a physician.

- Federal regulations at 42 CFR § 440.180(b) specify that "Home or community-based services may include the following services, as they are defined by the agency and approved by CMS: …(8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinical services (whether or not furnished in a facility) for individuals with chronic mental illness …."

- Federal regulations at 42 CFR § 440.90 specify that "Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) Services furnished at the clinic by or under the direction of a physician or dentist."

- Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR part 225) 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 those principles says that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

- Title 18 § 505.25(e)(5) of the New York Compilation of Codes, Rules, & Regulations (NYCRR) specifies that for "Services coverable under the Medical Assistance Program …. (5) All reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client, or collateral, in accordance with goals stated in the treatment plan."

- 18 NYCRR § 505.25 (h)(1-2) states:

> Reimbursement. (1) State reimbursement shall be available for expenditures made in accordance with the provisions of this section and when the following conditions are met: (i) documentation by a physician that treatment is appropriate and necessary; (ii) documentation that at least one Medicaid reimbursable service has been delivered for each billable occasion of service; (iii) services are provided by staff designated as appropriate by regulations of the Office of Mental Health; (iv) except for crisis services, the location of service is documented in the recipient's record and off-site service is justified; and (v) utilization review policies and procedures, acceptable to the Office of Mental Health, are operative. (2) State reimbursement shall be available, at fees approved by the New York State Director of the Budget ….

- 14 NYCRR § 587.10 specifies that only allowable services are included in the hours billed to Medicaid.

- 14 NYCRR § 587.16(c) specifies that "Recipient participation in treatment planning by an adult and approval of the plan shall be documented by the recipient's signature. Reasons for non-participation and/or approval by the recipient shall be documented in the case record."

- 14 NYCRR § 587.16(e)(1-5) specifies that "The treatment plan shall include, but need not be limited to, the following: (1) the signature of the physician involved in the treatment; (2) the recipient's designated mental illness diagnosis; (3) the recipient's treatment goals, objectives and related services; (4) plan for the provision of additional services to support the recipient outside of the program; and (5) criteria for discharge planning."

- 14 NYCRR § 587.16(f) specifies that "Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient."

- 14 NYCRR § 587.18(b)(7) specifies that "The case record shall be available to all staff of the outpatient program who are participating in the treatment of the recipient and shall include the following information; … (7) record and date of all on-site and off-site face to face contacts with the recipient, the type of service provided and the duration on contact."

- 14 NYCRR § 588.5(c) specifies that "Reimbursement shall only be made for services identified and provided in accordance with an individual treatment plan or psychiatric rehabilitation service plan as defined in paragraphs 587.4(c)(27) and (16) of this Title."

- 14 NYCRR § 588.5(h) specifies that "Service hours shall be determined by rounding to the nearest full hour once the minimum billable period has occurred, except for

pre-admission visits and crisis visits to a partial hospitalization program which shall be minimum of one hour."

- 14 NYCRR § 588.7(d) specifies that "The treatment plan required pursuant to section 587.16 of this Title shall be completed prior to the twelfth visit after admission or within 30 days of admission, whichever occurs first. Review of the treatment plan shall be every three months."

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was continuing day treatment (CDT) services claim lines (claims) submitted by 95 providers in New York State (the State) during our January 1, 2005, through December 31, 2008, audit period that were claimed for Federal Medicaid reimbursement by the State Department of Health.

SAMPLING FRAME

The sampling frame was a computer file containing 4,864,775 detailed claim lines for CDT services submitted by 95 nonhospital-based providers in the State during our audit period. The total Medicaid reimbursement for the 4,864,775 claims was $385,114,484 ($192,556,880 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 4,864,775 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: 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)
4,864,775	$192,556,880	100	$3,950	57	$2,078

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

Point Estimate	$101,093,916
Lower Limit	$84,366,929
Upper Limit	$117,820,903

APPENDIX D: NEW YORK STATE DEPARTMENT OF HEALTH COMMENTS

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

July 27, 2011

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-02-09-01023

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-02-09-01023 on "Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State."

Thank you for the opportunity to comment.

Sincerely,

Stephen Abbott

for Robert W. Reed
Deputy Commissioner
for Administration

Enclosure

cc: Jason Helgerson
James C. Cox
Michael Hogan, Ph.D.
Diane Christensen
Ken Lawrence
Dennis Wendell
Stephen Abbott
Irene Myron
Ronald Farrell

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-02-09-01023 on "Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State"

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-02-09-01023 on "Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State."

OVERVIEW

OIG reviewed a sample of 100 claims from the nearly 4.9 million claims reimbursed over the four-year audit period, and found 57 of the claims non-reimbursable despite there being no finding that the corresponding services were not medically necessary. OIG extrapolated the $3,950 in total federal share (FS) reimbursements associated with these 57 claims against the $192,556,880 in total claim reimbursements (FS) to derive the $84,366,929 recommended refund amount.

The Department and the New York State Office of Mental Health (OMH) strongly disagree with the recommendation for the State to refund $84,366,929 to the Federal Government on the basis that OIG's underlying audit methodology is flawed. OIG issued its recommended disallowance based entirely upon State regulations. However, the type of violations alleged by OIG, even had they been violative of the regulatory provisions cited, would not have rendered the services non-reimbursable under the same regulations applied by OIG. Further, OIG misapplied these State regulations, resulting in determinations of violations in some cases based upon documentation which the New York State Office of the Medicaid Inspector General (OMIG) found to be compliant.

The State has hired an independent consultant, Behavioral and Organizational Consulting Associates (BOCA), to review each case disallowed by OIG, and to obtain supporting documentation to refute the disallowed claims which will be provided to OIG as soon as available.

Recommendation #1:

The Department of Health should refund $84,366,929 to the Federal Government.

Response #1:

The Department and OMH strongly disagree with the recommendation for the State to refund $84,366,929 to the Federal Government on the basis that OIG's underlying audit methodology is flawed. The type of violations alleged by OIG, even had they been violative of the regulatory

provisions cited, would not have rendered the services non-reimbursable under the same regulations applied by OIG. Rather, they would have resulted in alternative enforcement actions by the State, as specifically provided for in the regulations. It is only when a provider of service does not meet the State's reimbursement rules and regulations that OMH would make a referral to the Department for the recovery of an overpayment.

OMH maintains various means of monitoring and enforcing provider compliance with program standards. These include requiring providers to submit a plan of correction addressing program deficiencies that have been identified by OMH; increasing the frequency of program inspections; the imposition of fines; and the limitation, and suspension or revocation of the provider's license. Title 14 § 587.22 of the New York Compilation of Codes, Rules, & Regulations (NYCCRR) makes this explicit by specifically providing that where OMH determines a provider of service is not exercising due diligence in complying with State regulatory requirements pertaining to the program, OMH will issue 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 period or 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 possible revocation, suspension or limitation of its operating certificate, or the imposition of a fine.

OIG based its recommended refund amount entirely upon State regulations. In so doing, however, it chose to ignore provisions of the regulation it is purporting to enforce. Furthermore, because OIG's findings are based solely on its own application of State regulations, rather than on any underlying Federal laws or regulations, the discretion ordinarily afforded the federal Department of Health and Human Services to interpret the laws and regulations with which it is charged with enforcing does not apply. Rather, discretion should be afforded to the State's interpretation of its own regulations[1].

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[1]Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc. 467 U.S. 837, 104 S. Ct. 2778. 81L. Ed. 2d 694 (Agency determinations and statutory interpretations, made in relation to areas in which the agency has particular expertise, are to be affirmed unless "unreasonable."): Arif v. New York City Taxi and Limousine Com'n. 3 A.D. 3d 345, 770 N.Y.S. 2d 344 (1st Dep't 2004), leave to appeal granted, 2 N.Y. 3d 705, 780 N.Y.S. 2d 311, 812 N.E.2d 1261 (2004) and appeal withdrawn, N.Y. 3d 669, 784 N.Y.S.2d 7. 817 N.E.2d 825 (2004) ("Where such a rational basis exists, an administrative agency's construction and interpretation of its own regulations and of the statute under which it functions are entitled to great deference.") "It is well settled that the construction given statutes and regulations by the agency responsible for their administration, if not irrational or unreasonable, should be upheld. " Matter of Mounting & Finishing Co. v. McGoldrick, 294 N.Y. 104, 108, 60 N.E.2d 825, 827; Matter of Colgate-Palmolive-Peet Co. v. Joseph, 308 N.Y. 333, 338, 125 n.E.2d 857, 859; Udall v. Tallman, 380 U.S. 1, 16-18, 85 S.Ct. 792, 13 L.Ed.2d 616; Power Reactor Co. v. International Union of Electricians, 367 U.S. 396, 408, 81 S.Ct. 1529, 6 L.Ed.2d 924.) *see also* :Mounting & Finishing Co. case (294 N.Y., at p. 108, 60 N.E.2d at p. 827), 'statutory construction is the function of the courts 'but where the question is one of specific application of a broad statutory term in a proceeding in which the agency administering the statute must determine it initially, the reviewing viewing court's function is limited' (National Labor Relations Board v. Hearst Publications, 322 U.S. 111, 131, 64 S.Ct. 851, 860, 88 L.Ed. 1170).

For 43 of the 57 disallowed claims, OIG alleges that the type of service reimbursed was not documented. However, preliminary State analysis of OIG's audit workpapers reveals that the auditors were furnished a schedule of the group services that were provided to each client for each day the client attended the continuing day treatment (CDT) program. These schedules document the frequency and the types of services planned for the individual. Progress notes also recorded the client's general attendance and progress in group therapies. Included in the OIG workpapers are copies of daily attendance sheets which show that the client was present at the CDT program on the date for which reimbursement was claimed.

Of the 43 disallowed claims noted, 10 were submitted by the New York Psychotherapy and Counseling Center and 5 by the New Horizon Counseling Center. The OMIG, New York State's Medicaid regulatory enforcement body, routinely conducts similar CDT program audits of mental health providers. During two of these reviews, OMIG reviewed 50 claims from New York Psychotherapy and Counseling Center and 45 claims from New Horizon Counseling Center, covering 3 of the 4 years of the OIG review period. OMIG auditors reviewed all available documentation to support the Medicaid claims including sign-in/sign-out sheets, client schedules with day and time specification, progress notes and group notes. While OMIG cited the providers for some technical violations, of these 95 claims, OMIG concluded that there was sufficient documentation to support that a Medicaid-eligible service had been provided for 100 percent of the billings. This contrasts sharply with the conclusions drawn by the OIG auditors which disallowed every claim sampled for these two providers for a lack of such documentation, accounting for over 25 percent of the total OIG recommended audit recovery amount, or approximately $22 million. It appears OIG disallowed the claim unless there was a group attendance sheet to demonstrate client participation on the day of service to support a Medicaid claim. Unlike OIG, OMIG reviewed all of the documentation available from each provider and, based upon the totality of it, determined that Medicaid services were provided for each of the claims reviewed. Had OIG applied the appropriate protocol to the claims which it reviewed, it also would have ascertained that adequate documentation exists and that reimbursable services had been furnished. OMIG staff are available to meet with OIG.

Besides alleging that the type of service was insufficiently documented in 43 of the cases reviewed, OIG also alleges 8 other types of documentation deficiencies relative to 26 of the disallowed claims (10 claims contain more than one deficiency), which the State disputes. For example, for case #17, OIG indicates that the progress note was written by someone who did not actually provide a service during the relevant two-week period. However, review of the case record verifies that the client's therapist wrote the progress note, and there is documentation in the OIG workpapers supporting the therapist's active involvement in providing services during the period as she made several outreach calls. The progress notes record the client's participation in groups, skills development activities and social functioning. Under psychotherapy notes, the client's therapist indicates, *"client is exploring taking pre-GED classes at The Downtown Learning Center. Worker will follow up with client to ensure enrollment in classes."* It is clear that the treatment provider was actively engaged with the client during the two-week period prior to her writing the progress note, and therefore the resultant billing should not have been disallowed.

The State has hired an independent company, Behavioral and Organizational Consulting Associates (BOCA), to review each case disallowed by the OIG. BOCA is a consulting firm that

has conducted evaluations, inspections and reviews in behavioral health care since 1988. Its staff has direct clinical background with psychiatrically impaired populations, enabling BOCA to conduct regulatory based reviews as well as inspections and reviews related to the quality of mental health treatment programs. The State expects BOCA to obtain further supporting documentation to refute the disallowed claims, which it will provide to OIG as soon as available.

Recommendation #2:

The Department of Health should work with OMH to issue guidance to the provider community regarding State requirements for claiming Medicaid reimbursement for CDT services.

Response #2:

The Department continually works with OMH on all matters related to Medicaid reimbursement and claiming instructions, including CDT services' reimbursement. The Department will work with OMH and publish any needed clarifications regarding State requirements for claiming Medicaid reimbursement for CDT services in its Medicaid Update monthly provider publication. It is additionally relevant to note that OMH has distributed guidance to CDT providers regarding claiming Medicaid reimbursement including, "Medicaid Requirements for OMH Licensed Outpatient Programs" (January 2004), "Continuing Day Treatment Programs, New Reimbursement Methodology" (January 2009), as well as other guidance documents focusing on the topics of medical necessity, person-centered planning and related topics.

Recommendation #3:

The Department of Health should work with OMH to improve OMH's monitoring of the CDT program to ensure compliance with State requirements.

Response #3:

While OMH maintains primary responsibility under State law for overseeing compliance against State rules promulgated under Mental Hygiene law, the Department will continue to work with OMH on relevant compliance procedures in order to ensure compliance with State requirements. OMH's existing monitoring program helps ensure provider compliance with State requirements. Over the four-year audit period, OMH licensing staff conducted 285 recertification surveys at 170 licensed CDT programs, including 71 surveys at the 48 CDT programs covered by the OIG audit. Each was conducted by trained staff from the licensing unit of the OMH Field Office in the Region where the program is located. Survey visits were conducted on-site and included observation; interviews with program staff, administrators and recipients; and the review of program policies and procedures as well as open and closed records.

The surveys utilized OMH's Tiered Certification standards for outpatient programs. The programs were evaluated on specific outcome-oriented performance indicators within five compliance categories. Each citation for inadequate performance on an indicator was identified in a Monitoring Outcome Report sent to the program, with a satisfactory Plan of Corrective

Action required to be implemented. The length of the program operating certificate was related to performance on the standards, with additional weight given to key indicators.

The OMH monitoring process seeks, wherever possible, to promote improvement in the quality of services as well as program compliance with applicable regulations. Implementation of the Plan of Corrective Action is monitored, with additional visits conducted as needed. Further, technical assistance is often provided to improve program performance in specific areas, and programs with limited duration licenses, resulting from numerous or significant citations, are re-surveyed on a more frequent basis. When it is determined that a provider has repeatedly failed to take necessary corrective actions or operates in such manner as to potentially adversely affect the health or well being of recipients, the program can face suspension or revocation of the operating certificate, imposition of a fine or other sanctions.