

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK CLAIMED HOSPITAL-
BASED CONTINUING DAY
TREATMENT SERVICES THAT WERE
NOT IN COMPLIANCE WITH FEDERAL
AND STATE REQUIREMENTS**

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Gloria L. Jarmon
Deputy Inspector General

September 2013
A-02-11-01038

Office of Inspector General

<https://oig.hhs.gov>

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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) administers the Medicaid program.

Section 1905(a)(2)(A) of the Act authorizes outpatient hospital services. Federal regulations (42 CFR § 440.20) define outpatient hospital services as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients, by or under the direction of a physician, by an institution that is licensed or formally approved as a hospital.

The State elected to include Medicaid coverage of continuing day treatment (CDT) services, a form of outpatient hospital services, among its Licensed Outpatient Programs, which are administered by its Office of Mental Health (OMH). OMH's CDT program provides active treatment to Medicaid beneficiaries 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 beneficiary must have a designated mental illness diagnosis and a dysfunction due to a mental illness. CDT services are provided in hospital and nonhospital settings.

Pursuant to State requirements for Medicaid reimbursement of CDT services, a beneficiary's treatment plan must (1) be completed in a timely manner; (2) be signed and approved by both the beneficiary and the physician involved in the treatment; (3) include a diagnosis of a mental illness, treatment goals, objectives, and related services, a plan for the provision of additional services, and criteria for discharge planning; and (4) be reviewed every 3 months. Also, a beneficiary's progress notes must be recorded at least every 2 weeks by the clinical staff members who provided CDT services to the beneficiary and identify the particular services provided and the changes in goals, objectives, and services, as appropriate. In addition, CDT services must be adequately documented, including type, duration, and need for continuing services.

For the period April 1, 2009, through August 15, 2011, DOH claimed Medicaid reimbursement totaling approximately \$52 million (\$26 million Federal share) for CDT services provided by hospital-based providers.

OBJECTIVE

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

SUMMARY OF FINDINGS

DOH claimed Federal Medicaid reimbursement for CDT services provided by hospital-based providers that were not in accordance with Federal and State requirements. Of the 100 claims in our random sample, 57 claims complied with Federal and State requirements, but 43 claims did not.

Of the 43 noncompliant claims, 9 contained more than 1 deficiency:

- For 15 claims, progress notes were not properly recorded.
- For 14 claims, reimbursement standards were not met because the beneficiary did not receive either the required number of hours or services billed for the claim.
- For 10 claims, the treatment plan was not signed by either the beneficiary or the physician.
- For four claims, the need for continuing services was not determined.
- For three claims, progress notes were incomplete.
- For three claims, the treatment plan was incomplete.
- For two claims, the treatment plan was not completed timely.
- For two claims, CDT services were not documented.
- For one claim, the treatment plan was not reviewed timely.

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

On the basis of our sample results, we estimated that DOH improperly claimed at least \$8,281,766 in Federal Medicaid reimbursement during our April 1, 2009, through August 15, 2011, audit period.

RECOMMENDATIONS

We recommend that DOH:

- refund \$8,281,766 to the Federal Government,
- work with OMH to issue guidance to the hospital-based provider community regarding Federal and 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 Federal and State requirements.

DEPARTMENT OF HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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, if OMH found claims to have violated the State regulations we cited, those violations “would not have rendered the services non-reimbursable.” DOH also stated that we often based our disallowances on a “single alleged technical violation” of the regulations. For example, 17 of the 43 claims found to be nonreimbursable were for documentation errors in progress notes or a missing beneficiary signature.

After reviewing DOH’s comments, we maintain that our findings and recommendations are valid. Progress notes and beneficiary signatures are key components in the treatment of beneficiaries. Progress notes must be recorded at least every 2 weeks by the clinical staff member who provided CDT services to the beneficiary. Progress notes identify the particular services provided to the beneficiary and changes in the beneficiary’s goals, objectives, and services. These requirements were not met for 9 of the 17 claims that DOH referenced. Missing beneficiary signatures were related to beneficiaries’ individual treatment plans that outline their course of treatment. By signing a treatment plan, a beneficiary acknowledges participation in, and approval of, the goals and objectives of the plan. If a beneficiary cannot participate in treatment planning or approval of the treatment plan, reasons for the beneficiary’s nonparticipation must be documented in the case record. We did not find such documentation for 8 of the 17 claims.

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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) 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)(2)(A) of the Act authorizes outpatient hospital services. Federal regulations (42 CFR § 440.20) define outpatient hospital services as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients, by or under the direction of a physician, by an institution that is licensed or formally approved as a hospital.

Principles and standards for determining allowable costs incurred by State and local governments under Federal awards are established by 2 CFR part 225 (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). Pursuant to 2 CFR § 225, App. A, C.1.c, to be allowable, costs must be authorized or not prohibited by State or local laws and regulations.

Under the New York Medicaid State plan, DOH elected to include coverage of continuing day treatment (CDT) services, a form of outpatient hospital 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 CDT program, as well as standards for CDT care and treatment planning. Pursuant to these requirements, a beneficiary's treatment plan must (1) be completed in a timely manner; (2) be signed and approved by both the beneficiary and the physician involved in the treatment; (3) include a diagnosis of a designated mental illness, treatment goals, objectives, and related services, a plan for the provision of additional services, and criteria for discharge planning; and

¹ Although CDT 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.

(4) be reviewed every 3 months. Also, a beneficiary's progress notes must be recorded at least every 2 weeks by the clinical staff members who provided CDT services to the beneficiary and identify the particular services provided and the changes in goals, objectives, and services, as appropriate. In addition, CDT services must be adequately documented, including type, duration, and need for continuing services.

New York State's Continuing Day Treatment Program

OMH's CDT program provides Medicaid beneficiaries 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.² 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 beneficiary must have a diagnosis of a designated mental illness and a dysfunction due to a mental illness.³ CDT services are provided in both hospital and nonhospital settings.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered 614,496 CDT claim lines, totaling \$51,906,363 (\$25,951,634 Federal share), submitted by 58 hospital-based CDT providers for the period April 1, 2009, through August 15, 2011. (In this report, we refer to these lines as "claims.") Our audit population did not include CDT services provided by nonhospital providers, which we previously audited.⁴

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.

² 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 beneficiary's progress in achieving desired outcomes.

³ Designated mental illness diagnoses are *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnoses other than alcohol or drug disorders, developmental disabilities, organic brain syndromes, or social conditions. The DSM is the standard classification of mental disorders used by mental health professionals in the United States.

⁴ *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State* (A-02-09-01023, issued October 12, 2011).

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 31 hospital-based CDT providers' 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 CDT program;
- ran computer programming applications at the MMIS fiscal agent⁵ that identified a sampling frame of 614,496 CDT services claims, totaling \$51,906,363 (\$25,951,634 Federal share), submitted by 58 hospital-based CDT providers;
- selected a simple random sample of 100 claims from the sampling frame of 614,496 claims,⁶ and, for these 100 claims:
 - reviewed the corresponding hospital-based CDT provider's documentation supporting the claim and
 - interviewed officials at the corresponding hospital-based 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 614,496 claims.

Appendix A 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 objectives.

FINDINGS AND RECOMMENDATIONS

DOH claimed Federal Medicaid reimbursement for CDT services provided by hospital-based providers that were not in accordance with Federal and State requirements. Of the 100 claims in our random sample, 57 claims complied with Federal and State requirements, but 43 claims did

⁵ DOH has contracted with Computer Sciences Corporation to be its MMIS fiscal agent.

⁶ The 100 sample items were claims submitted by 31 hospital-based CDT providers.

not. Of the 43 claims, 9 contained more than 1 deficiency. The following table summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Summary of Deficiencies in Claims

Type of Deficiency	Number of Unallowable Claims⁷
Progress notes not properly recorded	15
Reimbursement standards not met	14
Treatment plan not signed	10
Need for continuing services not determined	4
Progress notes incomplete	3
Treatment plan incomplete	3
Treatment plan not completed timely	2
Services not documented	2
Treatment plan not reviewed timely	1

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

On the basis of our sample results, we estimated that DOH improperly claimed at least \$8,281,766 in Federal Medicaid reimbursement during our April 1, 2009, through August 15, 2011, audit period.

PROGRESS NOTES NOT PROPERLY RECORDED

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

For 15 of the 100 claims in our sample, progress notes were not properly recorded by the hospital-based CDT provider. Specifically, for seven claims, progress notes were not recorded at least every 2 weeks.⁸ For the remaining eight claims, progress notes were not recorded by a clinical staff member who actually provided a CDT service during the 2-week period that included our service date.

⁷ The total exceeds 43 because 9 claims contained more than 1 error.

⁸ One provider associated with three claims recorded progress notes on a monthly basis rather than every 2 weeks. The remaining four claims did not have progress notes for the 2-week period that included our service date.

REIMBURSEMENT STANDARDS NOT MET

Pursuant to 14 NYCRR § 588.7(d), CDT visits are reimbursed on either a full- or half-day basis. To be eligible for reimbursement for a full-day visit, the hospital-based CDT provider must document a minimum visit of 4 hours and three or more medically necessary services. To be eligible for reimbursement for a half-day visit, the hospital-based CDT provider must document a minimum visit of 2 hours and one or more medically necessary services.

For 14 of the 100 claims in our sample, the hospital-based CDT provider did not meet the applicable reimbursement standards for a half- or full-day claim. Specifically, for 10 full-day claims, the provider's documentation did not support either a minimum visit of 4 hours or 3 medically necessary services.⁹ For four half-day claims, the provider's documentation did not support either a minimum visit of 2 hours or one medically necessary service.

TREATMENT PLAN NOT SIGNED

Pursuant to 14 NYCRR §§ 587.16, a beneficiary's treatment plan, and a periodic review of the plan, should include the signature of the physician involved in the treatment. A beneficiary's participation in treatment planning and approval of the plan should be documented by the beneficiary's signature. If a beneficiary cannot participate in treatment planning or approval of the treatment plan, reasons for the beneficiary's nonparticipation must be documented in the case record (14 NYCRR § 587.16(c)).

For 10 of the 100 claims in our sample, the applicable treatment plan was not signed by either the beneficiary or the physician involved in the treatment. Specifically, for eight claims, the beneficiary's participation in treatment planning and approval of the applicable treatment plans were not documented by the beneficiary's signature, and the reasons (if any) for nonparticipation by the beneficiary were not documented in the case record. For two other claims, the applicable treatment plan, or the applicable periodic review of the treatment plan, did not include the signature of the physician involved in the treatment.

NEED FOR CONTINUING SERVICES NOT DETERMINED

Pursuant to 14 NYCRR §§ 588.7, a beneficiary's need for CDT services beyond 156 visits per year should be determined no later than the 156th visit during such year. The determination should include an estimate of the number of visits beyond 156 required for the beneficiary within the remaining year. The required determination should be completed by the treating clinician and documented in the case record.

⁹For 3 of the 10 full-day claims, the hospital-based CDT provider documented services eligible for reimbursement at the half-day rate. Therefore, we disallowed the difference between the full- and half-day rates for these claims.

For 4 of the 100 claims in our sample, our service date fell beyond the 156th visit for the calendar year. For all four claims, determination of the need for CDT services was not completed by the treating clinician or documented in the case record.¹⁰

PROGRESS NOTES INCOMPLETE

Pursuant to 14 NYCRR § 587.16(f), progress notes for each beneficiary should identify the particular services provided and the changes in goals, objectives, and services, as appropriate.

For 3 of the 100 claims in our sample, progress notes did not identify the particular services provided.¹¹

TREATMENT PLAN INCOMPLETE

Pursuant to 14 NYCRR § 587.16(e), a beneficiary's treatment plan should include (1) the beneficiary's designated mental illness diagnosis; (2) the beneficiary's treatment goals, objectives, and related services; (3) a plan for the provision of additional services to support the beneficiary outside of the program; and (4) criteria for discharge planning.

For 3 of the 100 claims in our sample, the applicable treatment plan lacked 1 or more of the required elements. All three claims lacked discharge criteria, one claim lacked the beneficiary's designated mental illness diagnosis, and one claim lacked both the beneficiary's treatment goals, objectives, and related services and a plan for the provision of additional services to support the beneficiary outside of the program.

TREATMENT PLAN NOT COMPLETED TIMELY

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

For 2 of the 100 claims in our sample, the beneficiary's treatment plan was not completed within the required time limit. For both claims, the beneficiary's treatment plan was completed within 30 days of admission but after the beneficiary's 12th visit. For one claim, the treatment plan was completed after the beneficiary's 23rd visit. For the other claim, the treatment plan was completed after the beneficiary's 19th visit.

¹⁰ The four claims in error were submitted by two providers. Officials from both providers stated that they were aware of the requirement. One provider had a procedure in place to comply with the requirement, but the procedure was not followed. The other provider had no procedures to comply with the requirement.

¹¹ For example, one claim's 2-week note only addressed an individual session focusing on the beneficiary's plan to attend security guard training.

SERVICES NOT DOCUMENTED

Pursuant to 42 CFR § 433.32, services claimed for Federal Medicaid reimbursement must be documented. Pursuant to 18 NYCRR § 504.3(e), by enrolling in the State's Medicaid program, a provider agrees to submit claims for payment only for services actually provided to Medicaid beneficiaries.

For 2 of the 100 claims in our sample, the provider was unable to document that any services were provided to the beneficiary on our service date.

TREATMENT PLAN NOT REVIEWED TIMELY

Pursuant to 14 NYCRR § 588.7(k), a beneficiary's treatment plan must be reviewed every 3 months.

For 1 of the 100 claims in our sample, the beneficiary's treatment plan was not reviewed every 3 months. Specifically, a treatment plan review was due on June 12, 2009; however, the review was not completed until nearly 1 month later, on July 9, 2009.

CAUSES OF UNALLOWABLE CLAIMS

Certain Providers Did Not Comply With Federal and State Requirements

Of the 31 hospital-based CDT providers included in our sample review, 9 did not properly record progress notes related to the CDT services billed to Medicaid. These 9 providers submitted 15 of the 43 claims determined to be in error, including 1 that submitted 4 claims determined to be in error. In addition, 9 of the 31 hospital-based CDT providers did not comply with Federal and State requirements concerning the documentation of hours and services to meet the minimum reimbursement standards. These 9 providers submitted 14 of the 43 claims determined to be in error. Three of these nine providers submitted more than one claim determined to be in error. Finally, 6 of the 31 hospital-based CDT providers did not obtain the required signatures on treatment plans. These 6 providers submitted 10 of the 43 claims in error, including one that submitted 5 claims determined to be in error.

Inadequate Monitoring by Office of Mental Health

DOH did not ensure that OMH adequately monitored hospital-based CDT providers for compliance with certain Federal and State requirements. Although OMH conducted periodic onsite monitoring visits at providers to review case records for compliance with applicable Federal and State requirements, OMH's monitoring program did not ensure that providers complied with Federal and State requirements.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 CDT services claims made by hospital-based providers, 43 were not made in accordance with Federal and State requirements. On the basis of our sample results, we

estimated that DOH improperly claimed at least \$8,281,766 in Federal Medicaid reimbursement during our April 1, 2009, through August 15, 2011, audit period. The details of our sample results and estimates are shown in Appendix B.

RECOMMENDATIONS

We recommend that DOH:

- refund \$8,281,766 to the Federal Government,
- work with OMH to issue guidance to the hospital-based provider community regarding Federal and 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 Federal and State requirements.

DEPARTMENT OF HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DOH disagreed with our first recommendation (financial disallowance). DOH did not indicate concurrence or nonconcurrence with our remaining recommendations and instead described actions that OMH had taken.¹²

DOH stated that we based our findings entirely on State regulations and, if OMH found claims to have violated the regulations we cited, those violations “would not have rendered the services non-reimbursable.” DOH also stated that we often based our disallowances on a “single alleged technical violation” of the regulations. For example, 17 of the 43 claims found to be nonreimbursable were for documentation errors in progress notes or a missing beneficiary signature.¹³

After reviewing DOH’s comments, we maintain that our findings and recommendations are valid. According to 14 NYCRR § 588.1, 14 NYCRR part 588 “establishes standards for reimbursement under the medical assistance program of outpatient programs for adults with a diagnosis of mental illness and children with a diagnosis of emotional disturbance certified by the Office of Mental Health.” Our findings are based on the reimbursement standards applicable to CDT services in 14 NYCRR part 588. Further, our findings are not technical violations of the reimbursement standards. Progress notes and beneficiary signatures are key components in the treatment of beneficiaries. Progress notes must be recorded at least every 2 weeks by the clinical

¹² Specifically, DOH did not indicate whether it agreed to work with OMH to issue guidance to the hospital-based provider community regarding Federal and State requirements for claiming Medicaid reimbursement for CDT services. Rather, DOH described steps that OMH took in 2004 and 2009 to provide guidance to the provider community. Regarding our recommendation that it work with OMH to improve monitoring of the CDT program, DOH described OMH’s monitoring process and OMH’s process for closing noncompliant providers.

¹³ DOH indicated that the State has hired an independent consulting firm to review the cases we disallowed and expects to “find supporting documentation” that we overlooked.

staff member who provided CDT services to the beneficiary. Progress notes identify the particular services provided to the beneficiary and the changes in the beneficiary's goals, objectives, and services. These requirements were not met for 9 of the 17 claims that DOH referenced. Missing beneficiary signatures were related to beneficiaries' individual treatment plans that outline their course of treatment. By signing a treatment plan, a beneficiary acknowledges participation in, and approval of, the goals and objectives of the plan. If a beneficiary cannot participate in treatment planning or approval of the treatment plan, reasons for the beneficiary's nonparticipation must be documented in the case record. We did not find such documentation for 8 of the 17 claims.

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

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was hospital-based continuing day treatment (CDT) services claim lines (claims) submitted by 58 providers in New York State (the State) during our April 1, 2009, through August 15, 2011, audit period that the State claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a computer file containing 614,496 detailed claims for CDT services submitted by 58 hospital-based providers during our audit period. The total Medicaid reimbursement for the 614,496 claims was \$51,906,363 (\$25,951,634 Federal share). The Medicaid claims were extracted from the claims' files maintained at the State's Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample 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 consecutively numbered the 614,496 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 B: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
614,496	\$25,951,634	100	\$4,192	43	\$1,788

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

Point estimate	\$10,988,602
Lower limit	8,281,766
Upper limit	13,695,437

APPENDIX C: DEPARTMENT OF HEALTH COMMENTS



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

Sue Kelly
Executive Deputy Commissioner

June 24, 2013

Mr. 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-02-11-01038

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-11-01038 entitled, "New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance with Federal and State Requirements."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Nazarko", written over a horizontal line.

Michael J. Nazarko
Deputy Commissioner
for Administration

enclosure

cc: Nirav R. Shah, M.D., M.P.H.
Jason A. Helgerson
James C. Cox
Michael J. Nazarko
Robert W. LoCicero, Esq.
Diane Christensen
Dennis Wendell
Stephen F. LaCasse
Ronald Farrell
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**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-11-01038 entitled,
New York Claimed Hospital-Based Continuing
Day Treatment Services That Were Not in
Compliance with Federal and State Requirements**

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-02-11-01038 entitled, "New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements."

Recommendation #1

The Department should refund \$ 8,281,766 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 \$8,281,766 to the Federal Government on the basis that OIG's underlying audit methodology is flawed.

This recommendation results from OIG's review of a sample of 100 claims out of 614,496. Of the 100 claims sampled, OIG found 43 claims to be non-reimbursable, despite the fact that: there is no finding that these services were not medically necessary; that for all claims the physician who signed the treatment plan was involved in the treatment of that patient; and, that reimbursement was made only for those "services identified and provided in accordance with an individual treatment plan." For all but two claims OIG found that there was "evidence that services were rendered for the claim."

OIG instead often based its disallowances on a single alleged technical violation of the regulations. For example, in 17 of the 43 claims found to be non-reimbursable, the reason cited by OIG was for either documentation errors in progress notes or missing beneficiary signatures. For these 17 claims OIG found all of the other 22 elements out of the 23 reviewed to be in compliance. As will be explained later, cases such as the 17 just cited will be reviewed to identify any documentation that may have been missed by OIG.

The auditors ignored the appropriateness of remedies other than disallowance for alleged regulatory violations.

The type of violations alleged by the OIG, even had they been violative of the regulatory provisions cited, would not have rendered the services non-reimbursable under the same regulations being applied by the OIG. Rather, they would have resulted in alternative enforcement actions by the State, which are specifically provided for in the regulations in question.

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 587.22 of the regulation in question, "Enforcement standards and procedures", makes this explicit. 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. 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.

Initial Review by the State

Given the totality and quality of the documentation, it continues to be the State's position that the providers are in compliance with the regulations. By disallowing these claims, the OIG is applying a new regulatory standard. OIG cannot retroactively apply a new standard that contradicts long standing industry practice. As federal and state law clearly demonstrates, administrative language will not be construed as having a retroactive effect unless the language clearly dictates a result. *See Bowen v. Georgetown University Hospital*, 109 S.Ct. 468, 471 (1988) "An administrative agency's power to promulgate regulations is limited to the authority delegated by Congress. As a general matter, statutory grants of rulemaking authority will not be understood to encompass the power to promulgate retroactive rules unless that power is conveyed by express terms." *See also, Childs v. Childs*, 69 A.D.2d 406, 420 (2d Dept's 1979), "If retroactive application of a decision would produce chaotic or inequitable results, it should be applied prospectively only." This is a situation where a retroactive change in policy creates an extreme hardship for the continuing day treatment providers and the State.

Independent Consultant's Review

The State has hired an independent company, Behavioral and Organizational Consulting Associates, Inc. (BOCA) which is a consulting firm that has conducted evaluations, inspections and reviews in behavioral health care since 1988, to review the cases that were audited by the OIG. Its staff has direct clinical background with psychiatrically impaired populations, enabling BOCA to conduct inspections and reviews related to the quality of mental health treatment programs as well as regulatory based reviews. We expect BOCA's review of the disallowed cases will find supporting documentation that was overlooked by OIG, to refute many of these disallowed claims.

Recommendation #2:

Work with OMH to issue guidance to the hospital-based provider community regarding Federal and State requirements for claiming Medicaid reimbursement for CDT services.

Response #2:

OMH has distributed guidance to continuing day treatment providers regarding reimbursement and Medicaid. In January 2004, OMH disseminated a guideline entitled "Medicaid Requirements for OMH Licensed Outpatient Programs." In January of 2009, OMH disseminated another document to providers entitled "Continuing Day Treatment Programs, New Reimbursement Methodology." Additionally, OMH has distributed guidance materials to continuing day treatment (CDT) providers that focus on the topics of medical necessity, person-centered planning and related documentation.

Recommendation #3

Work with OMH to improve OMH's monitoring of the CDT program to ensure compliance with Federal and State requirements.

Response #3

During the time period covered by the audit (4/1/09 through 8/15/11), OMH licensing staff conducted 94 recertification surveys at 88 licensed CDT programs. 38 of those CDT programs have now closed. There are currently 53 open licensed CDTs. Each of these visits was conducted by trained staff from the licensing unit of the OMH Field Office in the region where the program was located. Survey visits were conducted on site and included observation, interviews with program staff, administrators and recipients, in addition to a review of program policies and procedures and a review of open and closed records.

Surveys were conducted utilizing the 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 (MOR) sent to the program and a satisfactory Plan of Corrective Action (POCA) was 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, which was followed during the audit period, seeks, wherever possible, to promote improvement in the quality of services provided and in a program's compliance with applicable regulations. The implementation of POCAs is monitored and additional visits are conducted when needed. In addition, technical assistance is often offered to improve program performance in specific areas. 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.

Comments:

The recommended disallowance is based upon a misapplication of State regulations. The majority of the OIG's findings are based on alleged violations of the State's program regulations, which would not have rendered the services non-reimbursable. 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.