

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

**July 2014
A-02-12-01011**

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

New York State claimed at least \$18 million in unallowable Medicaid reimbursement for nonhospital continuing day treatment services.

WHY WE DID THIS REVIEW

During a prior review of New York State's continuing day treatment (CDT) services, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. Subsequent to our audit period, the New York State Department of Health (State agency) revised its requirements for reimbursing these services from an hourly basis to a half- or full-day basis that requires a minimum amount of time and services be provided. On the basis of our prior review and the State agency's changes to its regulations, we decided to conduct additional reviews of CDT services.

The objective of this review was to determine whether the State agency's claims for Federal Medicaid reimbursement for CDT services provided by nonhospital providers complied with Federal and State requirements.

BACKGROUND

In New York State (the State), the State agency administers the Medicaid program. The State elected to include Medicaid coverage of CDT services, a form of clinic services, which are administered by its Office of Mental Health (OMH). 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. 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, a beneficiary must have a diagnosis of a designated mental illness and a dysfunction due to a mental illness. The 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 (4) be reviewed every 3 months. Also, the 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.

HOW WE CONDUCTED THIS REVIEW

During the period April 1, 2009, through August 17, 2011, the State agency claimed Federal Medicaid reimbursement totaling approximately \$143 million (\$71.5 million Federal share) for

1,811,039 claims for nonhospital CDT services. We reviewed a simple random sample of 100 of those claims.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for nonhospital CDT services claims that did not comply with Federal and State requirements. Of the 100 claims in our random sample, 66 claims complied with Federal and State requirements, but 34 claims did not.

The deficiencies occurred because (1) certain nonhospital CDT providers did not comply with Federal and State regulations and (2) the State agency 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 the State agency improperly claimed at least \$18,093,953 in Federal Medicaid reimbursement for nonhospital CDT services that did not meet Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$18,093,953 to the Federal Government,
- work with OMH to issue guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement for nonhospital CDT services, and
- work with OMH to improve OMH’s monitoring of the CDT program to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and did not indicate concurrence or nonconcurrence with our remaining recommendations. Specifically, State agency officials 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.” The State agency also disagreed with our determination that, for one sampled claim, progress notes were not prepared by a staff member who provided a service. Finally, the State agency disagreed with our determinations that certain sampled claims did not meet reimbursement standards.

After reviewing the State agency’s comments, we maintain that our findings and recommendations are valid. We maintain that the plain language of the State’s regulations provides clear requirements for Medicaid providers to be paid. Pursuant to 2 CFR part 225, *Cost Principles for State, Local, and Indian Tribal Governments* (Office of Management and Budget Circular A-87), to be allowable under Federal awards, costs must “[b]e authorized or not

prohibited under State or local laws or regulations.” Therefore, we may conduct an audit to determine whether Federal payments have been made in violation of State law and regulations and recommend disallowances of Federal funding on the findings of such an audit.

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INTRODUCTION

WHY WE DID THIS REVIEW

During a prior review of New York State’s continuing day treatment (CDT) services, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement.¹ Subsequent to our audit period, the New York State Department of Health (State agency) revised its requirements for reimbursing these services from an hourly basis to a half- or full-day basis that requires a minimum amount of time and services be provided. On the basis of our prior review and the State agency’s changes to its regulations, we decided to conduct additional reviews of CDT services.²

OBJECTIVE

The objective of this review was to determine whether the State agency’s claims for Federal Medicaid reimbursement for CDT services provided by nonhospital providers complied with Federal and State requirements.

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.

New York’s Medicaid Continuing Day Treatment Services Program

In New York State (the State), the State agency administers the Medicaid program. The State elected to include Medicaid coverage of CDT services, a form of clinic services, which are administered by its Office of Mental Health (OMH).³ 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

¹ *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State* (A-02-09-01023, issued October 12, 2011).

² We separately audited CDT services provided by hospital-based providers (*New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements* (A-02-11-01038, issued September 5, 2013)).

³ Although CDT services are administered by OMH, providers submit claims for payment through the State agency.

exploration and development of strengths and interests.⁴ 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.⁵ CDT services are provided in both hospital and nonhospital settings.

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. Clinic services are defined 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 [beneficiaries]" (42 CFR § 440.90). Whereas these regulations broadly define Federal requirements for what clinic services are eligible for Federal reimbursement, States may impose more specific standards for what services are eligible for Medicaid reimbursement.

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.

The State agency requires that 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 (4) be reviewed every 3 months. Also, the 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 details on Federal and State requirements related to CDT services, see Appendix A.

⁴ 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.

⁵ 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.

HOW WE CONDUCTED THIS REVIEW

During the period April 1, 2009, through August 17, 2011, the State agency claimed Federal Medicaid reimbursement totaling approximately \$143 million (\$71.5 million Federal share) for 1,811,039 claims for nonhospital CDT services. We reviewed a simple random sample of 100 of those claims. Specifically, we reviewed provider documentation to determine whether CDT services were provided in accordance with Federal and State requirements.

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.

Appendix B contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for nonhospital CDT services claims that did not comply with Federal and State requirements. Of the 100 claims in our random sample, 66 claims complied with Federal and State requirements, but 34 claims did not. Of these 34 unallowable claims, 10 contained more than 1 deficiency. The table below summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table: Summary of Deficiencies in Sampled Claims

Deficiency	Number of Unallowable Claims^a
Progress notes not properly recorded	16
Reimbursement standards not met	13
Treatment plan incomplete	6
Treatment plan not signed	5
Treatment plan not completed timely	3
Need for continuing services not determined	2
Treatment plan not reviewed timely	2

^a The total exceeds 34 because 10 claims contained more than 1 deficiency.

The deficiencies occurred because (1) certain nonhospital CDT providers did not comply with Federal and State regulations and (2) the State agency 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 the State agency improperly claimed at least

\$18,093,953 in Federal Medicaid reimbursement for nonhospital CDT services that did not meet Federal and State requirements.

PROGRESS NOTES NOT PROPERLY RECORDED

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. Further, progress notes for each beneficiary should identify the particular services provided and the changes in goals, objectives, and services, as appropriate (14 New York Compilation of Codes, Rules, & Regulations (NYCRR) § 587.16(f)).

For 16 of the 100 claims in our sample, progress notes were not properly recorded by the nonhospital CDT provider. Specifically, for 14 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. For the remaining two claims, progress notes did not identify either the particular services provided or the change in goals, objectives, and services.

REIMBURSEMENT STANDARDS NOT MET

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

For 13 of the 100 claims in our sample, the nonhospital provider did not meet the applicable reimbursement standards for a half- or full-day claim. Specifically, for nine full-day claims, the providers' documentation did not support either a minimum visit of 4 hours or three medically necessary services.⁶ For four half-day claims, the providers' documentation did not support either a minimum visit of 2 hours or one medically necessary service.

TREATMENT PLAN INCOMPLETE

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 the program; and (4) criteria for discharge planning (14 NYCRR § 587.16(e)).

For 6 of the 100 claims in our sample, the treatment plan lacked 1 of the required elements. Specifically, for six claims, the nonhospital CDT providers did not include a plan for the provision of additional services to support the beneficiary outside the program.

⁶ For four of the nine full-day claims, the nonhospital 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.

TREATMENT PLAN NOT SIGNED

A beneficiary's treatment plan, as well as a periodic review of the plan, should include the beneficiary's signature to document the beneficiary's participation in treatment planning and approving the plan.⁷

For 5 of the 100 claims in our sample, the treatment plan was not signed by the beneficiary, and the case record did not include the reasons (if any) for the beneficiary's nonparticipation in the treatment planning and approval.

TREATMENT PLAN NOT COMPLETED TIMELY

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 (14 NYCRR § 588.7(k)).

For 3 of the 100 claims in our sample, the treatment plan was not completed within the required time limit. For two of the claims, the treatment plan was not completed until after the 12th visit (one after the 17th visit and the other after the 18th visit). For the remaining claim, the treatment plan was not prepared until 35 days after admission.

NEED FOR CONTINUING SERVICES NOT DETERMINED

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 (14 NYCRR §§ 588.7(l) and (m)).

For 2 of the 100 claims in our sample, the associated service date fell beyond the 156th visit for the calendar year. For both claims, determination of the continued need for CDT services was not completed by the treating clinician or documented in the case record.

TREATMENT PLAN NOT REVIEWED TIMELY

A beneficiary's treatment plan must be reviewed every 3 months (14 NYCRR § 588.7(k)).

For 2 of the 100 claims in our sample, the treatment plan was not reviewed every 3 months. Specifically, for both claims, treatment plan reviews were not completed until approximately 3 months after their due date.⁸

⁷ 14 NYCRR § 587.16(c). 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.

⁸ For one claim, the beneficiary's treatment plan review was due on September 4, 2009; however, a review was not completed until December 1, 2009. For the second claim, the beneficiary's treatment plan review was due on July 23, 2009; however, a review was not completed until October 23, 2009.

CONCLUSION

These deficiencies occurred because (1) certain nonhospital CDT providers did not comply with Federal and State regulations and (2) the State agency 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 the State agency improperly claimed at least \$18,093,953 in Federal Medicaid reimbursement for nonhospital CDT services that did not meet Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$18,093,953 to the Federal Government,
- work with OMH to issue guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement for nonhospital CDT services, and
- work with OMH to improve OMH’s monitoring of the CDT program to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and did not indicate concurrence or nonconcurrence with our remaining recommendations. Specifically, State agency officials 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.”

The State agency also disagreed with our determination that, for one sampled claim, progress notes were not prepared by a staff member who provided a service. Specifically, State agency officials stated that, for the sampled claim (#73), a progress note clearly demonstrated that “the treatment provider was actively engaged” with the beneficiary during the 2-week period that included the sampled service date.

In addition, the State agency disagreed with our determination that certain sampled claims did not meet reimbursement standards. State agency officials indicated that their preliminary analysis of our workpapers revealed that providers supplied us with schedules of group services that beneficiaries were scheduled to attend each day they visited the CDT provider. State agency officials stated that these schedules document the frequency and types of services planned for each beneficiary.

The State agency’s comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We maintain that the plain language of the State's regulations provides clear requirements for Medicaid providers to be paid. Pursuant to 2 CFR part 225, *Cost Principles for State, Local, and Indian Tribal Governments* (Office of Management and Budget Circular A-87), to be allowable under Federal awards, costs must "[b]e authorized or not prohibited under State or local laws or regulations." Therefore, we may conduct an audit to determine whether Federal payments have been made in violation of State law and regulations and recommend disallowances of Federal funding on the findings of such an audit.

For claim #73, there was no documentation that the clinical staff member who wrote the progress note actually provided a CDT service during the 2-week period that encompassed our sampled service date. The State agency explained that "M.D." (the beneficiary's counselor) wrote the progress note; however, we found no documentation that "M.D." provided a CDT service during the 2-week period.

State agency officials were correct when they stated that the schedules provided to us for certain claims documented the frequency and types of CDT services planned for each beneficiary. However, these schedules did not document that the services were actually provided. We used a combination of group sign-in/sign-out sheets, daily attendance logs, and/or other documentation to determine whether claims met reimbursement standards.

APPENDIX A: 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.

2 CFR pt. 225 (Office of Management and Budget Circular A-87) establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. App. A, C.1.c. provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

42 CFR § 440.90 defines 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 [beneficiaries].”

14 NYCRR § 587.16(c) states that a beneficiary’s treatment plan and a periodic review of the plan should include the signature of the beneficiary documenting participation in treatment planning and approval 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.

14 NYCRR § 587.16(e) states that 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.

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

14 NYCRR § 587.16(f)(2) states that 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.

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

14 NYCRR § 588.7(k) states that 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. The regulation further states that a beneficiary’s treatment plan must be reviewed every 3 months.

14 NYCRR § 588.7(l) and (m) state that 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.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 1,811,039 CDT claim lines, totaling \$142,914,444 (\$71,452,179 Federal share), submitted by 70 nonhospital CDT providers for the period April 1, 2009, through August 17, 2011. (In this report, we refer to these lines as claims.) Our audit population did not include CDT services provided by hospital-based providers, which we audited separately.⁹

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information file for our audit period, but we did not assess the completeness of the file.

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

We conducted fieldwork at the State agency's and OMH's offices in Albany, New York; at the Medicaid Managed Information System (MMIS) fiscal agent¹⁰ in Rensselaer, New York; and at 38 nonhospital CDT providers' offices throughout the State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency and 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 1,811,039 CDT services claims, totaling \$142,914,444 (\$71,452,179 Federal share), submitted by 70 nonhospital CDT providers;
- selected a simple random sample of 100 claims from the sampling frame of 1,811,039 claims,¹¹ and, for each of the 100 claims:

⁹ *New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements* (A-02-11-01038, issued September 5, 2013).

¹⁰ The State agency uses the MMIS, a computerized payment and information reporting system, to process and pay Medicaid claims and has contracted with Computer Sciences Corporation to be its MMIS fiscal agent.

¹¹ The 100 sampled items were claims submitted by 38 nonhospital CDT providers.

- reviewed the corresponding nonhospital CDT provider's documentation supporting the claim and
- interviewed officials at the corresponding nonhospital CDT providers to gain an understanding of the provider's policies for documenting and claiming CDT services;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 1,811,039 claims; and
- discussed our findings with State agency and OMH officials.

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.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population was nonhospital CDT services claim lines (claims) submitted by 70 providers in the State during our April 1, 2009, through August 17, 2011, audit period that the State agency claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a computer file containing 1,811,039 detailed claims for CDT services submitted by 70 nonhospital providers during our audit period. The total Medicaid reimbursement for the 1,811,039 claims was \$142,914,444 (\$71,452,179 Federal share). The Medicaid claims were extracted from the claims' files maintained at the State's MMIS fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with the unallowable claims at the lower limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
1,811,039	\$71,452,179	100	\$3,934	34	\$1,365

Estimated Unallowable Costs

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$24,722,131
Lower limit	18,093,953
Upper limit	31,350,310

APPENDIX E: STATE AGENCY COMMENTS



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

Sue Kelly
Executive Deputy Commissioner

May 1, 2014

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Ref. No. A-02-12-01011

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General Draft Audit Report #A-02-12-01011 entitled, "New York Claimed Nonhospital-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".

Michael J. Nazarko
Deputy Commissioner
for Administration

Enclosure

cc: Jason A. Helgeson
James C. Cox
Diane Christensen
Lori Conway
Robert Loftus
Joan Kewley
James Russo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
OHIP Audit BML

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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-02-12-01011 Entitled
New York Claimed Nonhospital-Based Continuing Day
Treatment Services That Were Not in Compliance
With Federal and State Regulations**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) Draft Audit Report A-02-12-01011 entitled, "New York Claimed Nonhospital-Based Continuing Day Treatment Services That Were Not in Compliance with Federal and State Regulations."

Recommendation #1

Refund \$18,093,953 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 \$18,093,953 to the Federal Government on the basis that OIG's underlying audit methodology is flawed.

Continuing Day Treatment Programs provide active treatment and rehabilitation services to the seriously mentally ill. These services are designed to maintain or enhance a patient's current level of functioning and skills, to maintain community living and to develop self-awareness and self-esteem through the exploration and development of patient strengths and interests. Continuing day treatment programs provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity therapy, verbal therapy, crisis intervention services and clinical support services. As such these programs provide a vital service to people in the community. OIG conducted an audit and recommended a disallowance of \$18,093,953. This recommendation results from OIG's review of a sample of 100 claims out of 1,811,039. Of the 100 claims sampled, OIG found 34 claims to be non-reimbursable, despite the facts that: there is no finding that these services were not medically necessary; for all claims the physician who signed the treatment plan was involved in the treatment of that patient; for all but one claim the treatment plan was signed by the patient; for all claims the service plan review was signed by the physician involved in treatment and contained all the required elements; and, for all but two claims OIG found evidence that services were rendered.

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. It is only when a provider of service seeks reimbursement in excess of that provided for in Section 593.7, which sets out the program reimbursement standards, that OMH would make a referral to the Department for the recovery of an overpayment.

Thus, the OIG has issued a recommended disallowance based entirely upon state regulations. In so doing, however, it has chosen to ignore provisions of the regulation it is purporting to enforce.

Further, 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 HHS 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].

¹Chevron 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

Progress Notes Not Properly Recorded

The OIG disallowed cases after determining that progress notes were not properly recorded. For example in Case #73, the OIG determined that the progress note was not prepared by a staff member who provided a service. This determination was made despite there being a progress note written by M. D. (the beneficiary's counselor) on 3/24/14 and co-signed by R. B. covering the two week period, 3/11/10 to 3/24/10, which includes the service date, 3/19/10. This note indicates ongoing familiarity and contact with the beneficiary. "M. stated to worker in a 1:1 session that there are no active feelings of being controlled. Because of M's lack of experience to those feelings, it is apparent that M. remains above baseline during this review period...M. informed worker that she has no desire for self-injury, and she denies wanting to self-inflict. M. has not initiated or discussed the issues of suicidal ideation in the groups....The case worker will continue to encourage, and emphasize the importance of attending group sessions....". The content of the 3/24/14 progress note clearly demonstrates that the treatment provider was actively engaged with the client during the two week period which includes the service date. This claim clearly should have been allowed by OIG.

Reimbursement Standards Not Met

The OIG also disallowed claims in the draft audit report based on the alleged lack of documentation to support that a minimum visit of four hours or three medically necessary services were provided. Preliminary state analysis of the OIG work papers revealed that the OIG auditors were given a schedule of the group services that were provided to each patient for each day they attended the continuing day treatment program. These schedules document the frequency and the types of services planned for the patient. Progress notes also recorded the patient's attendance and progress in group therapies. Included in OIG's work papers are attendance sheets which summarize the patient's participation in groups.

A more thorough review of the case documentation will be performed by Behavioral Organizational Consulting Associates (BOCA) which is an independent consulting firm that has been hired by OMH. BOCA has experience in conducting evaluations, inspections and reviews in behavioral health care since 1988. We expect BOCA to find supporting documentation to refute these disallowed claims.

Recommendation #2:

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

Response #2:

OMH has distributed guidance to continuing day treatment providers regarding reimbursement and Medicaid. In January 2004, OMH disseminated guidance to CDT providers regarding claiming Medicaid reimbursement including, "Medicaid Requirements for OMH Licensed

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).

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

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

Response #3

OMH’s monitoring program ensures that providers complied with Federal and State requirements. Over the four-year audit period, OMH licensing staff conducted 285 recertification surveys at 170 licensed CDT programs. Each 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; and the review of the 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 resurveyed on a more frequent basis. When it is determined that a provider has repeatedly failed to take necessary corrective action or operates in such a 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.