

Department of Health and Human Services

OFFICE OF  
INSPECTOR GENERAL

NEW YORK IMPROPERLY  
CLAIMED FEDERAL  
MEDICAID REIMBURSEMENT  
FOR PARTIAL HOSPITALIZATION  
SERVICES

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Gloria L. Jarmon  
Deputy Inspector General  
for Audit Services

March 2017  
A-02-16-01013

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov>

Section 8M 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

*New York claimed at least \$4 million in Medicaid reimbursement over 5 years for partial hospitalization services that were unallowable.*

### WHY WE DID THIS REVIEW

During prior reviews of New York State's Medicaid outpatient clinic programs, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. On the basis of these results, we decided to review similar services provided under New York's partial hospitalization program.

The objective of this review was to determine whether the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for partial hospitalization services that complied with Federal and State requirements.

### BACKGROUND

In New York, the State agency administers the Medicaid program. The State agency elected to include Medicaid coverage of partial hospitalization services, a form of clinical services administered by the New York State Office of Mental Health (OMH). The partial hospitalization program is designed to serve beneficiaries as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization services include assessment and treatment planning, discharge planning, medication therapy, case management, psychiatric rehabilitation, and activity therapy.

To be eligible for the partial hospitalization program, a beneficiary must have a diagnosis of a designated mental illness and a dysfunction due to a mental illness that requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial hospitalization program, would necessitate admission to or continued stay in an inpatient hospital. 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 2 weeks. Also, the beneficiary's progress notes must be recorded after each visit by the clinical staff members who provided partial hospitalization services to the beneficiary and identify the particular services provided and changes in goals, objectives, and services, as appropriate. Finally, partial hospitalization services must be adequately documented, including type, duration, and need for continuing services.

### HOW WE CONDUCTED THIS REVIEW

During the period July 1, 2010, through June 30, 2015, the State agency claimed Federal Medicaid reimbursement totaling approximately \$31 million (\$17 million Federal share) for 187,627 claims for partial hospitalization services. We reviewed a random sample of 100 of

these claims. Specifically, we reviewed documentation to determine whether partial hospitalization services were provided in accordance with Federal and State requirements.

## **WHAT WE FOUND**

The State agency claimed Federal Medicaid reimbursement for partial hospitalization services claims that did not comply with Federal and State requirements. Of the 100 claims in our random sample, 59 claims complied with Federal and State requirements, but 41 claims did not.

The deficiencies occurred because certain providers did not comply with partial hospitalization program requirements. In addition, although OMH performed licensing renewal visits to providers at least every 3 years, these visits were not effective in preventing instances of noncompliance during our audit period.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$4,050,151 in Federal Medicaid reimbursement for partial hospitalization services that did not meet Federal and State requirements.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund \$4,050,151 to the Federal Government,
- work with OMH to reinforce to partial hospitalization providers the requirements for claiming Medicaid reimbursement for partial hospitalization services, and
- instruct OMH to look for the types of noncompliance we identified in this report when it performs its licensing renewal visits.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and generally agreed 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.” For two claims (sample numbers 61 and 81), the State agency argued that the progress notes provided were sufficient evidence that the therapist who wrote the progress note provided a service on the sampled service date. Finally, the State agency disagreed with our determination that certain sampled claims did not meet reimbursement standards. Specifically, the State agency stated that schedules of group services planned —along with progress notes—support the minimum number of services provided.

After reviewing the State agency’s comments, we maintain that our findings and recommendations are valid. Pursuant to OMB Circular A-87, to be allowable under Federal

awards, costs must be authorized or not prohibited under State or local laws or regulations. Also, for both claims mentioned, there was no documentation that the therapist who wrote the progress note actually provided a service on the sampled service date. Finally, 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.

**TABLE OF CONTENTS**

INTRODUCTION ..... 1

    Why We Did This Review ..... 1

    Objective ..... 1

    Background ..... 1

        Medicaid Program ..... 1

        New York’s Medicaid Partial Hospitalization Program ..... 1

        Federal and State Requirements Related to Partial Hospitalization Services ..... 2

    How We Conducted This Review ..... 2

FINDINGS ..... 3

    Reimbursement Standards Not Met ..... 3

    Progress Notes Not Properly Recorded ..... 4

    Treatment Plan Not Reviewed Timely ..... 4

    Treatment Plan Not Signed By A Physician ..... 4

    Treatment Plan Not Completed Timely ..... 4

    Treatment Plan Not Signed By Beneficiary ..... 5

    Conclusion ..... 5

RECOMMENDATIONS ..... 5

STATE AGENCY COMMENTS ..... 5

OFFICE OF INSPECTOR GENERAL RESPONSE ..... 6

APPENDIXES

    A: Federal and State Requirements Relating to Partial Hospitalization Services ..... 7

    B: Audit Scope and Methodology ..... 8

    C: Statistical Sampling Methodology ..... 10

    D: Sample Results and Estimates ..... 11

E: State Agency Comments..... 12

## INTRODUCTION

### WHY WE DID THE REVIEW

During prior reviews of New York State's Medicaid outpatient clinic programs, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement.<sup>1</sup> On the basis of these results, we decided to review similar services provided under New York's partial hospitalization program.

### OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for partial hospitalization services that 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 Partial Hospitalization Program

In New York, the State agency administers the Medicaid program. The State agency elected to include Medicaid coverage of partial hospitalization services, a form of clinical services administered by the New York State Office of Mental Health (OMH).<sup>2</sup> The partial hospitalization program is designed to serve beneficiaries as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization services include assessment and treatment planning, discharge planning, medication therapy, case management, psychiatric rehabilitation, and activity therapy.

To be eligible for the partial hospitalization program, a beneficiary must have a diagnosis of a designated mental illness and a dysfunction due to a mental illness that requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial

---

<sup>1</sup> *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) and *New York Claimed Nonhospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements* (A-02-12-01011, issued July 3, 2014).

<sup>2</sup> Although partial hospitalization services are administered by OMH, providers submit claims for reimbursement directly through the State agency.



hospitalization program, would necessitate admission to or continued stay in an inpatient hospital.

### **Federal and State Requirements Related to Partial Hospitalization 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).<sup>3</sup>

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 (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). To be allowable, costs must be authorized or not prohibited by State or local laws and regulations (2 CFR § 225<sup>4</sup>, App. A, C.1.c).

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 2 weeks. Also, the beneficiary's progress notes must be recorded after each visit by the clinical staff members who provided partial hospitalization services to the beneficiary and identify the particular services provided and the changes in goals, objectives, and services, as appropriate. Finally, partial hospitalization services must be adequately documented, including type, duration, and need for continuing services.

For details on Federal and State requirements relating to partial hospitalization services, see Appendix A.

### **HOW WE CONDUCTED THIS REVIEW**

During the period July 1, 2010, through June 30, 2015, the State agency claimed Federal Medicaid reimbursement totaling approximately \$31 million (\$17 million Federal share) for 187,627 claims for partial hospitalization services. We reviewed a random sample of 100 of these claims. Specifically, we reviewed documentation to determine whether partial hospitalization 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

---

<sup>3</sup> 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.

<sup>4</sup> On Dec. 26 2013, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. The Department of Health and Human Services has codified the guidance in regulations found at 45 CFR part 75, which became effective on Dec. 26, 2014.

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 partial hospitalization services claims that did not comply with Federal and State requirements. Of the 100 claims in our random sample, 59 claims complied with Federal and State requirements, but 41 claims did not. Of these 41 unallowable claims, 11 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 <sup>a</sup>
Reimbursement standards not met	21
Progress notes not properly recorded	14
Treatment plan not reviewed timely	9
Treatment plan not signed by a physician	7
Treatment plan not completed timely	1
Treatment plan not signed by beneficiary	1

<sup>a</sup> The total exceeds 41 claims because 11 claims contained more than 1 deficiency.

The deficiencies occurred because certain providers did not comply with partial hospitalization program requirements. In addition, although OMH performed licensing renewal visits to providers at least every 3 years, these visits were not effective in preventing instances of noncompliance during our audit period.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$4,050,151 in Federal Medicaid reimbursement for partial hospitalization services that did not meet Federal and State requirements.<sup>5</sup>

### REIMBURSEMENT STANDARDS NOT MET

Partial hospitalization services are reimbursed at an hourly rate. To be eligible for reimbursement, between 4 and 7 hours of service must be provided per recipient per day (14 New York Compilation of Codes, Rules, & Regulations (NYCRR) § 588.9(a)(1)).

---

<sup>5</sup> To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

For 21 of the 100 claims in our sample, the partial hospitalization provider did not meet reimbursement standards. Specifically, for seven claims, the hours documented were less than the hours billed.<sup>6</sup> For six other claims, the minimum 4 hours of service was not met. For six additional claims, no duration of time was recorded. Finally, for two claims, the provider did not provide documentation to support that a service was provided on the sampled service date.

#### **PROGRESS NOTES NOT PROPERLY RECORDED**

Progress notes for each beneficiary must be recorded after each visit by the clinical staff members who provided partial hospitalization services to the beneficiary (14 NYCRR § 587.16(f)).

For 14 of the 100 claims in our sample, progress notes were not properly recorded by the partial hospitalization provider. Specifically, for 11 claims, progress notes were recorded by individuals who did not provide services on the sampled service date. For the remaining three claims, no progress notes were provided for the sampled service date.

#### **TREATMENT PLAN NOT REVIEWED TIMELY**

A beneficiary's treatment plan must be reviewed every 2 weeks (14 NYCRR § 588.9(d)) and include the signature of the physician involved in the treatment (14 NYCRR § 587.16(g)(5)).

For 9 of 100 claims in our sample, the associated treatment plan was not reviewed timely. Specifically, for five claims, the physician signed the associated treatment plan after our sampled service date. For the remaining four claims, there was no review of the associated treatment plan during the 2-week period that encompassed our sampled service date.

#### **TREATMENT PLAN NOT SIGNED BY A PHYSICIAN**

A beneficiary's treatment plan, as well as a periodic review of the plan, must include the signature of the physician involved in treatment (14 NYCRR § 587.16(e)(1)).

For 7 of the 100 sample claims, the associated treatment plan was not signed by a physician.

#### **TREATMENT PLAN NOT COMPLETED TIMELY**

A beneficiary's treatment plan must be completed before the beneficiary's fourth visit after admission (14 NYCRR § 588.9(d)).

For 1 of the 100 claims in our sample, the associated treatment plan was not completed until after the beneficiary's sixth visit.

---

<sup>6</sup> For five of the seven claims, we questioned the difference in Medicaid reimbursement between what was claimed and what was documented. We questioned the entire amount of the two remaining claims because they contained at least one other deficiency that rendered them completely unallowable.

## **TREATMENT PLAN NOT SIGNED BY BENEFICIARY**

A beneficiary's treatment plan, as well as a periodic review of the plan, must include the beneficiary's signature to document their participation in treatment-planning and approving the plan. If the beneficiary cannot participate, reasons for the nonparticipation must be documented (14 NYCRR § 587.16(c)).

For 1 of the 100 claims in our sample, the associated treatment plan was not signed by the beneficiary and the case record did not include a reason for the beneficiary's nonparticipation.

## **CONCLUSION**

The deficiencies occurred because certain providers did not comply with partial hospitalization program requirements. In addition, although OMH performed licensing renewal visits to providers at least every 3 years, these visits were not effective in preventing instances of noncompliance during our audit period, as evidenced by the 41 claims we determined to be in error.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$4,050,151 in Federal Medicaid reimbursement for partial hospitalization services that did not meet Federal and State requirements.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$4,050,151 to the Federal Government,
- work with OMH to reinforce to partial hospitalization providers the requirements for claiming Medicaid reimbursement for partial hospitalization services, and
- instruct OMH to look for the types of noncompliance we identified in this report when it performs its licensing renewal visits.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and generally agreed with our remaining recommendations. Specifically, the State agency 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."

For two claims (sample numbers 61 and 81), the State agency argued that the progress notes provided were sufficient evidence that the therapist who wrote the progress note provided a service on the sampled service date. In addition, the State agency disagreed with our determination that certain sampled claims did not meet reimbursement standards. Specifically,

the State agency stated that schedules of group services planned for specific days document the frequency and types of planned services, and that the schedules—along with progress notes—support the minimum number of services provided. The State agency stated that it has hired an independent consulting firm to review these cases.

Regarding our second and third recommendations, the State agency stated that it will re-distribute guidance to partial hospitalization providers and it will review its processes for monitoring the partial hospitalization program.

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 OMB Circular A-87, to be allowable under Federal awards, costs must be 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 both claims mentioned in the State agency's comments, there was no documentation that the therapist who wrote the progress note actually provided a service on the sampled service date.

The State agency was correct in its assertion that the schedules provided to us for certain claims documented the frequency and types of 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 PARTIAL HOSPITALIZATION SERVICES**

2 CFR Part 225 (OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*) 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. OMB Circular A-87 was relocated to 2 CFR part 225 and made applicable by 45 CFR § 92.22(b). On Dec 26, 2013, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. The Department of Health and Human Services has codified the guidance in regulations found at 45 CFR part 75.

Section 1902(a)(27) of the Social Security Act and Federal regulations (42 CFR § 431.107) require States to ensure providers keep medical records necessary to fully disclose the extent of services provided to beneficiaries.

14 NYCRR Part 588.9 (a) requires that partial hospitalization visits shall be reimbursed on the basis of duration of hours provided as follows: Reimbursement shall be provided for visits of at least 4 hours in duration and not more than 7 hours per recipient per day.

14 NYCRR Part 587.16 (f) requires that progress notes shall be recorded by the clinical staff member who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded for each visit/contact.

14 NYCRR Part 588.9 (d) requires that treatment plans shall be completed prior to the fourth visit after admission and a review of the treatment plan shall be every 2 weeks.

14 NYCRR Part 587.16 (c) and (e) requires recipient participation in treatment planning by an adult and approval of the plan shall be documented by the recipients signature. Reasons for nonparticipation and/or approval by the recipient shall be documented in the case record. The treatment plan shall include signature of the physician involved in the treatment.

14 NYCRR Part 587.16 (g) requires a periodic review of the treatment plan that shall include the signature of the physician involved in the treatment.

## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our review covered 187,627 partial hospitalization claim lines, totaling \$30,752,992 (\$16,575,535 Federal share), submitted by 41 partial hospitalization providers in New York for the period July 1, 2010, through June 30, 2015. (In this report, we refer to these lines as claims).

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State's claims for reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

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

We performed fieldwork at the MMIS fiscal agent in Rensselaer, New York, and, during March and April 2016, at 26 partial hospitalization providers throughout the State.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with the State agency and OMH officials to gain an understanding of the State's partial hospitalization program and its oversight of the program;
- obtained an electronic file of Medicaid partial hospitalization claims submitted by 41 providers in New York during our audit period from the State agency's MMIS;
- reconciled the partial hospitalization services claimed for Federal reimbursement by the State agency on the Form CMS-64 for our audit period with the data obtained from the MMIS file;
- ran computer programming applications that identified a sampling frame of 187,627 claims, totaling \$30,752,992 (\$16,575,535 Federal share);
- selected a simple random sample of 100 claims from our sampling frame of 187,627 claims; and for each of the 100 claims:
  - obtained and reviewed beneficiary records to determine if claims complied with Federal and State requirements;

- estimated the unallowable Federal Medicaid reimbursement paid in the total sampling frame of 187,627 claims; and
- discussed our results 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 partial hospitalization claims submitted by providers in New York during our July 1, 2010, through June 30, 2015, audit period that the State agency claimed for Federal Medicaid reimbursement.

### **SAMPLING FRAME**

The sampling frame was an Access file containing 187,627 detailed claims for partial hospitalization services submitted by 41 providers in New York during our audit period. The total Medicaid reimbursement for the 187,627 claims was \$30,752,992 (\$16,575,535 Federal share). The Medicaid claims were extracted from the claim 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 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**

<b>Claims in Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Unallowable Claims</b>	<b>Value of Unallowable Claims (Federal Share)</b>
187,627	\$16,575,535	100	\$8,343	41	\$2,806

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

Point estimate	\$5,265,695
Lower limit	4,050,151
Upper limit	6,481,240

## APPENDIX E: STATE AGENCY COMMENTS



**Department  
of Health**

**ANDREW M. CUOMO**  
Governor

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

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

January 12, 2017

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-02-16-01013

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-16-01013 entitled, "New York Improperly Claimed Federal Medicaid Reimbursement for Partial Hospitalization Services."

Thank you for the opportunity to comment.

Sincerely,

*Sally Dreslin*

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

Enclosure

cc: Marybeth Hefner  
Jason A. Helgerson  
Dennis Rosen  
Erin Ives  
Brian Kiernan  
JoAnn Veith  
Elizabeth Misa  
Geza Hrazdina  
Jeffrey Hammond  
Jill Montag  
James Dematteo  
James Cataldo  
Diane Christensen  
Lori Conway  
OHIP Audit SM

**New York State Department of Health  
Comments on the  
Department of Health and Human Services  
Office of Inspector General  
Draft Audit Report A-02-16-01013 entitled  
“New York Improperly Claimed Federal Medicaid Reimbursement for  
Partial Hospitalization Services”**

---

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 (OIG) Draft Audit Report A-02-16-01013 entitled, "New York Improperly Claimed Federal Medicaid Reimbursement for Partial Hospitalization Services"

**Background**

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to \$8,305 in 2015, consistent with levels from a decade ago.

**Recommendation #1:**

Refund \$4,050,151 to the Federal Government.

**Response #1**

The Department and the New York State Office of Mental Health (OMH) strongly disagree with the OIG's recommendation to refund \$4,050,151 to the Federal Government as the underlying audit methodology is flawed. This recommendation results from OIG's review of a sample of 100 of 187,627 total claims, of which OIG found 41 claims to be non-reimbursable despite the fact that these services were medically necessary.

Partial hospitalization services provide intensive, time-limited outpatient behavioral health services designed to assist patients with stabilization of acute symptoms and functioning, which might otherwise require inpatient care. Patients may enter the program from either an outpatient or inpatient setting and individualized, focused, goal-oriented treatment is provided by a multi-disciplinary team. The maximum length of stay is six weeks, and programming is structured with active treatment provided four hours per day, five days per week. Patients are assessed and supported by staff in ratios similar to inpatient settings, and staff work actively with patients to engage and involve community supports to help them manage safely in the community during, and after, program participation. Partial hospitalization programs provide the following services: assessment and health screening services, treatment and discharge planning, health referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitation readiness determination and referral; crisis intervention services; activity

therapy and clinical support services. As such, these programs provide a vital service to people in the community.

OMH maintains various means of monitoring and enforcing provider compliance with program standards. Among these are: on-site monitoring visits and 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. The auditors ignored the appropriateness of remedies other than disallowance for alleged regulatory violations. Additionally, the type of violations alleged by the OIG would not have rendered the services non-reimbursable even if they had violated the regulatory provisions cited and applied by the OIG. Instead, these violations would have resulted in alternative enforcement actions by the state, which are documented in Section 587.22 of New York Codes, Rules and Regulations. 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].

#### Progress Notes Not Properly Recorded

The OIG disallowed cases after determining that progress notes were not properly recorded. For example, in Case #81 the OIG determined that "there was no evidence to show that the writer of the progress note also led a group or provided any service to the beneficiary on our service date." This

---

<sup>1</sup>[Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.](#) 467 U.S. 837, 104 S.Ct. 2778, 81 L. 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 (1<sup>st</sup> 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](#), 387 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 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).

determination was made despite there being a progress note written by SG (the beneficiary's primary therapist) on the actual service date which was 8/5/2013. The progress note clearly states "Patient came in late and also did not attend 1 p.m. group. Patient reports she is taking ½ dose of Seroquel. Pt. seems to be calmer but comments continue to be disorganized and disconnected." The note indicates which groups the patient attended on 8/5/13, including notes about the beneficiary's participation in each group. For example, Vocation Assessment is checked and then a hand written note by SG that states "sat quietly through group." Smoking Cessation/Healthy living with handwritten comments by SG that read "comments were unclear and she required some redirection." This note clearly indicates what groups the beneficiary attended on the service date, the beneficiary's interactions during the group and the therapists own observations about the beneficiary's interactions and affect. The content of the 8/5/13 progress note clearly demonstrates that the treatment provider was actively engaged with the beneficiary by noting and commenting which groups the beneficiary attended, her interactions within the group, and the therapist's observations.

For case #61, the claim was disallowed as the OIG stated "there is no evidence that the progress note writer performed a service for the beneficiary. We have a progress note for our 5/22/13 service date. However, provider officials stated there is no records of who led groups on our service date." The provider did not have to provide such a record, as the progress note written by the beneficiary's therapist on the service date clearly demonstrates that she provided services to the beneficiary on the service date. The note by the therapist states the following: "The patient attended program and participated passively in groups and activities. Mood is depressed and pt. endorses sx's of anxiety that interfere with more active participation in groups...is interactive 1:1 during Social Skills (which is the name of the group the beneficiary attended that day) and answers questions asked of her in sx management group but offers nothing spontaneously. Denies SLP, no SI/HI." These notes indicate the therapist's observations about the beneficiary during the group sessions. Additionally, in order to write "denies SI/HI" the therapist would have had to have asked the beneficiary directly if she were feeling suicidal or homicidal. The beneficiary's group schedule dated the week of 5/20/13 indicates that the beneficiary was in attendance at a Social Skills Group and a Symptom Management Group. There is documentation that the beneficiary signed in and out on the service date. Therefore, there is ample documentation that the therapist provided services and interacted with the beneficiary on the service date.

#### 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 were provided. Preliminary analysis of the OIG work papers revealed that for some of these cases the OIG auditors were given a schedule of the group services that were provided to each patient for each day they were seen at the 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.

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 that there was supporting documentation that refutes OIG's findings related to these disallowed claims.

#### Recommendation #2:

Work with OMH to reinforce to partial hospitalization providers the requirements for claiming Medicaid reimbursement for partial hospitalization services.

**Response #2**

OMH will re-distribute guidance to partial hospitalization providers regarding reimbursement and Medicaid.

**Recommendation #3:**

Instruct OMH to look for the types of noncompliance we identified in this report when it performs its licensing renewal visits.

**Response #3**

OMH will review its processes in order to ensure that the areas of noncompliance included in the audit report are reviewed, however, OMH's monitoring program ensures that providers complied with State requirements. Over the audit period of 7/1/10 to 6/30/15, OMH licensing staff conducted 57 recertification surveys at 36 licensed Partial Hospitalization 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.