

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK CLAIMED
FEDERAL REIMBURSEMENT
FOR SOME ASSERTIVE COMMUNITY
TREATMENT SERVICES
THAT DID NOT MEET
MEDICAID REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Deputy Inspector General
for Audit Services

October 2018
A-02-17-01008

Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: October 2018

Report No. A-02-17-01008

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

New York's Assertive Community Treatment (ACT) program delivers treatment, rehabilitation, and support services to Medicaid beneficiaries diagnosed with severe mental illness whose needs have not been met by traditional service delivery approaches. Medicaid reimburses ACT providers at one of two rates: a full payment rate when at least six 15-minute face-to-face contacts are provided during a month and a partial payment rate when fewer than six, but at least two, face-to-face contacts are provided in a month. No payment is allowed when only one contact is provided.

Prior OIG reviews of Medicaid programs administered by the New York State Office of Mental Health identified a significant number of claims improperly submitted for Medicaid reimbursement. Preliminary analysis of New York's claims for Medicaid ACT services identified these services as vulnerable to waste and abuse.

Our objective was to determine whether New York claimed Federal reimbursement for ACT services in accordance with Medicaid requirements.

How OIG Did This Review

Our review covered \$133.9 million (Federal share) for 170,518 ACT services claims reimbursed at the full payment rate and provided during the period April 2011 through March 2016. We reviewed a random sample of 100 of these claims.

New York Claimed Federal Reimbursement for Some Assertive Community Treatment Services That Did Not Meet Medicaid Requirements

What OIG Found

Of the 100 claims in our sample, 87 complied with Medicaid requirements, but 13 did not. Specifically, for nine claims, the ACT services were not identified in the beneficiary's treatment plan or no treatment plan was provided. In addition, for four claims, the documentation did not support the payment rate claimed by the provider. For one other claim, no case record was provided. The total exceeds 13 because 1 claim contained more than 1 deficiency.

These deficiencies occurred because providers did not always ensure that ACT services were provided in accordance with a beneficiary's treatment plan and did not always verify that the required number of contacts needed to claim the ACT full payment rate was provided. Further, certain providers failed to maintain or provide documentation to support ACT services claims. Finally, although New York monitors ACT providers for compliance with Medicaid requirements, it did not ensure that its oversight was effective in preventing the errors identified in our review.

On the basis of our sample results, we estimated that New York improperly claimed at least \$4.4 million in Federal Medicaid reimbursement for ACT services during our audit period.

What OIG Recommends and New York's Comments

We recommend that New York (1) refund \$4.4 million to the Federal Government, (2) ensure that ACT program guidance on claiming Medicaid reimbursement for services is reinforced with providers, and (3) continue to improve its monitoring of the ACT program.

In written comments on our draft report, New York disagreed with our first recommendation and agreed with our remaining recommendations. New York asserted that our findings stemmed from a flawed audit methodology that included an inaccurate interpretation of State regulations on treatment plan requirements. New York also stated that our findings are based solely on our own application of State regulations rather than on any underlying Federal laws or regulations. After reviewing New York's comments, we maintain that our findings are valid; however, we have removed the Medicaid payments for two claims associated with the providers that are no longer in business from our estimate of improper payments and adjusted our report and first recommendation accordingly. The plain language of New York's regulations provides clear requirements for Medicaid providers to be paid.

Notices

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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.

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INTRODUCTION

WHY WE DID THE REVIEW

New York's Assertive Community Treatment (ACT) program delivers treatment, rehabilitation, and support services to Medicaid beneficiaries diagnosed with severe mental illness whose needs have not been met by traditional service delivery approaches. In addition to assisting individuals in achieving personally meaningful goals and life roles, the ACT program aims to reduce hospitalizations and emergency room visits.

Prior Office of Inspector General reviews of Medicaid programs administered by the New York State Office of Mental Health (OMH) identified a significant number of claims improperly submitted for Federal reimbursement.¹ Our preliminary analysis of New York's claims for Medicaid ACT services identified these services as vulnerable to waste and abuse.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Federal reimbursement for ACT services in accordance with Medicaid requirements.

BACKGROUND

Medicaid Program

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.

New York's Medicaid Assertive Community Treatment Program

In New York, the State agency administers the Medicaid program. The State agency elected to provide Medicaid coverage of ACT services through a program administered by OMH.² The

¹ *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), *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), and *New York Improperly Claimed Federal Medicaid Reimbursement for Partial Hospitalization Services* ([A-02-16-01013](#), issued March 1, 2017).

² Although the ACT program is administered by OMH, providers submit claims for Medicaid reimbursement to the State agency.

program provides treatment, rehabilitation, and support services to Medicaid beneficiaries diagnosed with severe and persistent mental illness.³ ACT services include a full range of clinical treatment, psychosocial rehabilitation, and community support services designed for beneficiaries to ultimately function in work, school, home, and social relationships. Services are provided by mobile multidisciplinary mental health treatment teams.⁴ These teams are required to conduct beneficiary assessments, develop treatment plans based on assessment outcomes, and track the progress of beneficiaries. Only services identified and provided in accordance with a beneficiary's treatment plan are eligible for Medicaid reimbursement.⁵

ACT services are reimbursed at two rates: (1) a full payment rate for services provided to beneficiaries who receive at least six face-to-face contacts in a month and (2) a partial payment rate for services provided to beneficiaries who receive at least two, but less than six, face-to-face contacts in a month.⁶ A contact is defined as a face-to-face interaction of at least 15 minutes.⁷

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid claims for ACT services reimbursed at the full payment rate and provided during the period April 1, 2011, through March 31, 2016 (audit period).⁸ During this period, 62 ACT services providers submitted 170,518 claims at the full payment rate and received Medicaid reimbursement totaling \$263,644,046 (\$133,902,494 Federal share). From these claims, we selected a random sample of 100 claims to determine compliance with Medicaid 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

³ Typically, these beneficiaries have histories characterized by frequent psychiatric hospitalizations and emergency room visits, involvement with the criminal justice system, alcohol or substance abuse, and lack of engagement in traditional outpatient services.

⁴ A mobile multidisciplinary mental health treatment team is a group of mental health professionals who travel into the beneficiary's community to provide services. The team includes, at a minimum, a clinical staff member, professional staff member, team leader, psychiatrist, registered nurse, program assistant, substance abuse specialist, employment specialist, and family specialist.

⁵ Title 14 § 508.5(b)(8) of the New York Compilation of Codes, Rules & Regulations (NYCRR).

⁶ 14 NYCRR § 508.5(c).

⁷ 14 NYCRR § 508.4(i).

⁸ During our audit period, claims reimbursed at the full payment rate accounted for 87 percent of total payments for ACT services. The audit period encompassed the most current data available at the time we initiated our review.

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

FINDINGS

The State agency claimed Federal reimbursement for some ACT services that did not comply with certain Medicaid requirements. Of the 100 claims in our random sample, 87 complied with Medicaid requirements, but 13 did not.⁹ The following table summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Unallowable Claims ^a
Services not identified in beneficiary's treatment plan or no treatment plan provided	9
Documentation did not support payment rate claimed	4
Case record not provided	1

^a The total exceeds 13 because 1 claim contained more than 1 deficiency.

These deficiencies occurred because providers (1) did not always ensure that ACT services were provided in accordance with a beneficiary's treatment plan, (2) did not always verify that the required number of contacts needed to claim the ACT full payment rate was provided, or (3) failed to maintain or provide documentation to support ACT services claims. Further, although OMH monitored ACT providers for compliance with Medicaid requirements, the State agency did not ensure that OMH's oversight was effective in preventing the errors identified in our review.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$4,414,469 in Federal Medicaid reimbursement for ACT services during our audit period.¹⁰

⁹ Nine of the thirteen claims qualified for the partial payment reimbursement rate. For these nine claims, we questioned the difference between what was claimed and the partial payment rate.

¹⁰ 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 95 percent of the time.

SERVICES NOT IDENTIFIED IN BENEFICIARY'S TREATMENT PLAN OR NO TREATMENT PLAN PROVIDED

To be eligible for Medicaid reimbursement, ACT services must be identified and provided in accordance with a beneficiary's treatment plan.¹¹

For 9 of the 100 sampled claims, ACT services provided were not in accordance with a beneficiary's treatment plan. Specifically, for eight claims, ACT services were not identified in the associated beneficiary's treatment plan, and for one claim, the treatment plan was not provided. Services not specified in a beneficiary's treatment plan may be unnecessary.

DOCUMENTATION DID NOT SUPPORT PAYMENT RATE CLAIMED

ACT services are reimbursed at one of two payment rates. Services provided to beneficiaries who receive a minimum of six 15-minute face-to-face contacts in a month, up to three of which may be collateral contacts, are eligible for the full payment rate.¹² Services provided to beneficiaries who receive a minimum of two, but fewer than six, face-to-face contacts in a month are eligible for the partial payment rate.¹³ No payment is allowed when only one contact is provided.

For 4 of the 100 sampled claims, documentation did not support the payment rate claimed.¹⁴ Specifically, for three claims, the documentation provided indicated that less than six, but at least two 15-minute contacts were provided. For these claims, the providers should have claimed Medicaid reimbursement at the lesser partial payment rate.¹⁵ For the other claim, the documentation provided supported only one 15-minute contact; therefore, this claim did not qualify for any Medicaid reimbursement.

¹¹ 14 NYCRR § 508.5(b)(8).

¹² Collaterals are defined as significant others or members of the beneficiary's family or household, academic, or workplace setting who regularly interact with the beneficiary and are directly affected by, or have the capability of affecting, his or her condition (14 NYCRR § 508.4(f)).

¹³ 14 NYCRR §§ 508.4(i) and 508.5(c)(2).

¹⁴ The dollar amount associated with one of these claims is not included in our estimate of improper payments as the provider is no longer in business, and the State agency is not required to refund overpayments associated with such providers.

¹⁵ For these three claims, we questioned the difference between the full payment and the partial payment rates. However, for one of these claims, the entire claim was unallowable because it did not meet treatment plan requirements.

CASE RECORD NOT PROVIDED

Medicaid providers are required to keep records that fully disclose the extent of the services provided.¹⁶

For 1 of the 100 sampled claims, no case record was provided to support the ACT services. The provider associated with the claim was no longer in business at the time of our fieldwork, and the entity that took ownership of the provider's records did not respond to multiple requests to provide the case record.¹⁷

RECOMMENDATIONS

We recommend that the State agency:

- refund \$4,414,469 to the Federal Government,
- ensure that ACT program guidance on claiming Medicaid reimbursement for services is reinforced with providers, and
- continue to improve monitoring of the ACT program.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and agreed with our second and third recommendations.

Regarding our first recommendation, the State agency asserted that our findings and financial disallowance stemmed from a flawed audit methodology that included an inaccurate interpretation of State regulations on treatment plan documentation requirements. According to the State agency, the ACT program allows flexibility for treatment teams to amend beneficiaries' service plans when changes would support the achievement of recovery goals. Further, ACT program guidelines specifically allow for adjusting service plans as appropriate. The State agency also argued that we disallowed claims based on contacts when progress notes

¹⁶ Social Security Act § 1902(a)(27). ACT providers are required to maintain records for 6 years (18 NYCRR § 517.3 and 14 NYCRR § 508.6).

¹⁷ The dollar amount associated with this claim is not included in our estimate of improper payments as the provider is no longer in business, and the State agency is not required to refund overpayments associated with such providers.

associated with these claims described activities not explicitly delineated in the treatment plan. Further, according to the State agency, OMH's reviews of the providers' records determined such activities were consistent with the associated treatment plan and OMH guidelines. The State agency contends that, based on Federal regulations,¹⁸ it is not required to refund Medicaid reimbursement associated with one claim for which no record was provided (sample number 81) and one claim for which the documentation supported only one contact (sample number 28) because the providers associated with these claims are no longer in business. According to the State agency, these two claims should not have been disallowed and therefore should not be included in our estimate of improper payments.

The State agency also stated that, because our findings are based solely on our own application of State regulations rather than on any underlying Federal laws or regulations, discretion should be afforded to the State agency's interpretation of its own regulations.

Regarding our second and third recommendations, the State agency indicated that it will redistribute guidance to ACT providers related to claiming Medicaid reimbursement and that it will review its processes to ensure the areas of noncompliance identified in our audit report are reviewed. Finally, the State agency stated that OMH has hired independent consultants to perform a more thorough review of case documentation and, upon completion of that review, will work with the New York State Office of Medicaid Inspector General to determine the appropriate course of action.

The State agency's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings are valid; however, we have removed the Medicaid payments for the two claims associated with the providers that are no longer in business from our estimate of improper payments and adjusted our report and first recommendation accordingly.

We did not misinterpret State regulations related to treatment planning. Rather, these regulations (14 NYCRR § 508.5(b)(8)) clearly state that to be eligible for Medicaid reimbursement, ACT services must be identified and provided in accordance with beneficiaries' treatment plans. Any services not included in treatment plans do not comply with this requirement and therefore are unallowable. Also, while we agree that the ACT program allows for flexibility to amend services as appropriate, State requirements are clear that treatment plans must be updated to reflect such changes, which was not the case for the claims we questioned.

We maintain that our decision to question Federal payments based on the violation of State law and regulations was correct. The plain language of the State's regulations provides clear

¹⁸ Social Security Act § 1903(d)(2)(D), 42 CFR §§ 433.318 and 433.320.

requirements for Medicaid providers to be paid. Further, Federal regulations state that to be allowable under Federal awards, costs must be authorized or not prohibited under State or local laws or regulations.¹⁹

OTHER MATTERS: TREATMENT PLANS NOT SIGNED IN ACCORDANCE WITH PROGRAM GUIDELINES

A beneficiary's treatment plan for ACT services must be prepared within 30 days of a beneficiary's admission to the ACT program and contain specific objectives and the services necessary to facilitate achievement of the beneficiary's recovery goals. The treatment plan must be reviewed every 6 months and should document the beneficiary's progress in relation to their recovery goals, objectives, and planned services and assess changes in the beneficiary's status. Individual treatment plans and the 6-month treatment plan review must be approved and signed by a physician.²⁰

In May 2015, prior to the start of our audit, the New York State Office of State Comptroller (OSC) completed a review of New York's Medicaid ACT program. The audit covered the period April 1, 2012, through October 31, 2014, which coincided with our audit period. OSC found that, among other things, treatment plans were not completed timely with the appropriate approvals.²¹ OSC recommended that OMH establish controls to ensure providers are complying with program requirements and improve its monitoring to ensure treatment plans are completed on time with the required approvals. In June 2015, to address these findings and recommendations, OMH issued a Standards of Care survey tool that specified that every beneficiary must have a comprehensive treatment plan developed within 30 days of admission to the ACT program that documented involvement of the beneficiary, physician, and ACT services providers. To assess the extent of the implementation of its recommendations, OSC tested a sample of 15 cases and found that each treatment plan was completed timely with all required signatures and therefore concluded that OMH had implemented OSC's recommendations.

While the State agency and OMH have made progress to ensure treatment plans are completed timely and contain required signatures, some improvements are still needed. Specifically, our review identified 49 claims for which a physician did not sign the treatment plan or the

¹⁹ See 2 CFR part 225, App. A, C.1.c. On December 26, 2013, the Office of Management and Budget 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 December 26, 2014.

²⁰ *ACT Program Guidelines 2007*. Available online at https://www.omh.ny.gov/omhweb/act/program_guidelines.html. Accessed on April 26, 2018.

²¹ Assertive Community Treatment Program. Available online at <https://osc.state.ny.us/audits/allaudits/093015/14s25.pdf>. Accessed on May 15, 2018.

treatment plan review in accordance with program guidelines.²² The treatment plans associated with most of these 49 claims were developed prior to June 2015, when OMH issued the Standards of Care survey tool. However, three claims for which the associated treatment plans were developed after June 2015 did not comply with ACT program guidelines.²³ Physician involvement is integral to ensuring that the goals of ACT program participants are met and that ACT services are adequate and appropriate. We encourage the State agency to continue working with OMH to ensure treatment plans comply with ACT program guidelines.

²² The 49 claims included 27 claims where the treatment plan or treatment plan review was signed after the effective date of the plan, 18 claims for which the physician did not sign the treatment plan or treatment plan review, and 4 claims where the physician signed but did not date the treatment plan or treatment plan review; therefore, we were unable to determine when the physician reviewed and approved the plan.

²³ These three claims included two claims for which the physician did not sign the treatment plan review and one claim for which the physician signed the treatment plan review *after* its effective date.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to Medicaid claims for ACT services reimbursed at the full payment rate. During our audit period, 62 ACT providers submitted 170,518 claims at the full payment rate and received Medicaid reimbursement totaling \$263,644,046 (\$133,902,494 Federal share).

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS)²⁴ for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claim data in the MMIS to the State agency's claims for reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures (CMS-64).

During our audit, we did not assess 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 State agency's office in Albany, New York, the MMIS fiscal agent in Rensselaer, New York, and at 48 ACT providers throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicaid requirements;
- held discussions with State agency and OMH officials to gain an understanding of the ACT program;
- obtained from New York's MMIS a sampling frame of 170,518 ACT claims reimbursed at the full payment rate (rate code 4508), totaling \$263,644,046 (\$133,902,494 Federal share);
- reconciled the State agency's CMS-64 covering our audit period with the data obtained from the MMIS;
- selected a random sample of 100 claims from our sampling frame and, for each claim, reviewed beneficiary records supporting the claim to determine whether the associated services complied with Medicaid requirements;

²⁴ The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

- estimated the total amount of improper Federal Medicaid reimbursement for ACT services made to the State agency during the audit period; and
- discussed our results with State agency and OMH officials.

See Appendix B for our statistical sampling methodology and Appendix C for our sample results and estimates.

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: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of claims for Medicaid ACT services reimbursed at the full payment rate (rate code 4508) for services provided during our audit period.

SAMPLING FRAME

The sampling frame was an Access file containing 170,518 Medicaid claims for ACT services with rate code 4508, totaling \$263,644,046 (\$133,902,494 Federal share). The Medicaid claims were extracted from the claim files maintained at the MMIS fiscal agent.

SAMPLE UNIT

The sample unit was a Medicaid claim for ACT services at the full payment rate (Medicaid claim).

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 Medicaid 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 170,518 Medicaid claims. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of improper Medicaid payments associated with the unallowable Medicaid claims at the lower limit of the two-sided 90-percent confidence interval. We also used this software to calculate the corresponding point estimate and upper limit of the two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal share)	Sample Size	Value of Sample (Federal share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal share)
170,518	\$133,902,494	100	\$78,422	13 ²⁵	\$5,169

Estimated Value of Unallowable Claims (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$8,813,223
Lower limit	4,414,469
Upper limit	13,211,977

²⁵ The dollar amounts associated with 2 of these 13 claims were not included in our estimate of unallowable claims because the providers were no longer in business.

APPENDIX D: STATE AGENCY COMMENTS



Department
of Health

ANDREW M. CUOMO
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HOWARD A. ZUCKER, M.D., J.D.
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Executive Deputy Commissioner

August 9, 2018

Ms. Brenda Tierney
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-02-17-01008

Dear Ms. Tierney:

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-02-17-01008 entitled, "New York Claimed Federal Reimbursement for Some Assertive Community Treatment Services That Did Not Meet Medicaid Requirements."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
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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-02-17-01008 entitled
“New York Claimed Federal Reimbursement for Some Assertive
Community Treatment Services That Did Not Meet Medicaid
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 (OIG) Draft Audit Report A-02-17-01008 entitled, “New York Claimed Federal Reimbursement for Some Assertive Community Treatment Services That Did Not Meet Medicaid Requirements.”

Recommendation #1:

Refund \$5,969,422 to the Federal Government.

Response #1

The Department and the New York State Office of Mental Health (OMH) strongly disagree with OIG’s recommendation to refund \$5,969,422 to the Federal Government. These recommendations stem from a flawed audit methodology, which included extrapolating from two claims where records were unavailable to the OIG to review as a result of the providers’ insolvency, and an inaccurate interpretation of the state regulation by OIG regarding treatment plan documentation requirements.

New York State’s ACT program is a unique, intensive treatment approach for individuals with severe functional deficits related to a mental illness which inhibit their ability to obtain services from the traditional office-based delivery system, possess insight into their functional limitations, and provide for their safety. For these reasons, OMH requires ACT service providers to be flexible in numerous aspects of service delivery. As described in further detail in OMH’s ACT Program guidelines, available at https://omh.ny.gov/omhweb/act/program_guidelines.html, ACT Providers must be creative with their engagement strategies and tailor their contacts based on the changing clinical or rehabilitative needs and circumstances of these difficult to serve clients, many of whom suffer from homelessness and lack critical social supports that are linked to positive health outcomes. Because individuals served by ACT teams have significant, diverse, and constantly evolving needs, the ACT program model incorporates significant flexibility, especially in the area of service planning.

As such, OMH expects that ACT providers will be constantly working with admitted recipients to determine their needs and circumstances, assess their ability to cope in an unexpected time of crisis, and that their progress notes detailing such interactions will reflect both current and reasonably foreseeable needs based on such circumstances as well as the delivery of services necessary to maintain the individual in the community, even if formal updates to the individual’s treatment plan may be required.

Finally, 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 OIG 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

¹ See *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 Comm.* 3 A.D. 3d 345, 770 N.Y.S. 2d 344 (1st Dep’t 2004), leave to

Services not identified in beneficiary's treatment plan or no treatment plan provided

OIG disallowed claims stating payment was made for services not identified in the individual's treatment plan. OIG's interpretation of the regulation regarding treatment plans is inconsistent with the purposes and intent of the ACT program, which are described in the OMH ACT Program Guidelines, available at https://omh.ny.gov/omhweb/act/program_guidelines.html. These published guidelines, which have previously been provided to your auditors, form the basis of the tool OMH's Bureau of Inspection and Certification uses to certify and survey ACT providers in New York State. The ACT program allows flexibility to amend the service and service plan where those changes would support the achievement of the recovery goals. The ACT Program Guidelines specifically allow for adjusting the service plan as appropriate, in order achieve recovery goals. For example, section 3 of the guidelines provides that "scheduled contacts should be purposeful and designed to carry out interventions in the service plan *or to address critical needs or situations.*" See also, § 4.10.

It is also relevant to note that Service Planning and Coordination is a subcomponent ACT service in which providers are required to collaborate with recipients during scheduled visits regarding their current needs and circumstances, which may result in the alteration of the stated goals, or services and supports contained in the recipient's treatment plan. See §§ 3.1, 4.6(2), 4.10(2), 4.10(5).

In addition, there appear to be cases in which the OIG disallowed claims based on contacts wherein progress notes describe activities not explicitly delineated in the individual's treatment plan. However, upon further review of provider records, OMH determined such activities were consistent with the individual's treatment plan and OMH guidelines. For example, in Case #53, the recipient's treatment goals were medication management, vocation, and a third goal related to parenting, which made reference to an order of protection. The note OIG uses to question whether the contact may be used to claim ACT reimbursement was written by the recipient's social worker who had arranged to see the recipient at the recipient's boyfriend's home. When the social worker went to the home, she had a collateral contact with the boyfriend and documented the following: "visited at BF/Frank's apt. She wasn't yet present, so writer engaged BF on relationship, and their child (he has complete custody). He appeared very supportive. Apt. (studio) was very cluttered and Frank acknowledged needing to get organized better before baby gets old enough to move around." The OIG disallowed this claim stating it was unrelated to a goal stated in the treatment plan. OMH avers that this contact was relevant to assessing and supporting the ACT recipient's goal of ultimately restoring her legal ability to parent her biological children whom she was then unable to see, as documented in her treatment plan. An essential aspect of ACT treatment for this recipient is supporting her family relationships in an effort to prevent further court involvement.

Case Record Not Provided

OIG disallowed the sampled claim (Case #81) because the "case record could not be found." However, this provider is bankrupt and therefore the State is not obligated to refund the Federal share.

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.").

Under certain circumstances, States are not required to refund the Federal share of overpayments made to providers. Federal regulations state, "In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof)."²

To meet the bankruptcy exception, the provider must file for bankruptcy and the State must be on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment. That exception is met here. The provider filed for bankruptcy on March 18, 2015, and the State (here OMH) filed their proof of claim on October 1, 2015. Therefore, the State is not required to refund the Federal share for Case #81.

OIG disallowed the entire claim for Case #28 because documentation of only one contact was provided by the provider. This case also meets the federal exception cited above as this provider went out of business and the overpayment is uncollectable. A provider is considered to be out of business on the effective date of a determination to that effect under State law. According to 42 CFR § 433.318, to meet this exception, the State agency must document its efforts to locate the party and its assets, and these efforts must be consistent with applicable State policies and procedures. The agency also must provide an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures, and cite the effective date of that determination under State law.

In conclusion, since both of these providers are no longer in operation, the State is not required to refund the Federal share for these cases. OIG should not have disallowed these claims, and further, these cases should not be extrapolated across the universe.

Independent Review

A more thorough review of the case documentation will be performed by independent consultants that have been hired by OMH. These consultants have experience in conducting evaluations, inspections and reviews in behavioral health care and we expect them to find supporting documentation to refute these disallowed claims. Upon completion of their review, OMH will work in conjunction with the NYS Office of the Medicaid Inspector General to determine the appropriate course of action.

Recommendation #2:

Ensure that ACT program guidance on claiming Medicaid reimbursement for services is reinforced with providers.

Response #2

OMH agrees with this recommendation and will re-distribute guidance to ACT providers regarding reimbursement and Medicaid.

² SSA 1903(d)(2)(D); 42 CFR §§ 433.318, 433.320.