Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK IMPROVED ITS MONITORING OF MEDICAID COMMUNITY REHABILITATION SERVICES BUT STILL CLAIMED IMPROPER FEDERAL MEDICAID REIMBURSEMENT TOTALING $20 MILLION

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

Amy J. Frontz
Deputy Inspector General
for Audit Services

July 2023
A-02-22-01011

Office of Inspector General

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Report in Brief
Date: July 2023
Report No. A-02-22-01011

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

New York Improved Its Monitoring of Medicaid Community Rehabilitation Services But Still Claimed Improper Federal Medicaid Reimbursement Totaling $20 Million

Why OIG Did This Audit

A prior OIG audit of Medicaid community rehabilitation services in New York identified significant noncompliance with Federal and State requirements and recommended that New York develop guidance to physicians. Although New York stated that it would disseminate any necessary guidance, it did not subsequently develop any guidance for physicians. Rather, New York amended State regulations that required a summary of the service plan review to be submitted to physicians prior to the reauthorization of community rehabilitation services. As a result, there is a risk that vulnerabilities that OIG previously identified in the program still exist.

The objective of our audit was to determine whether New York claimed Federal Medicaid reimbursement for community rehabilitation services in accordance with Medicaid requirements.

How OIG Did This Audit

Our audit covered 325,776 claims for community rehabilitation services for which New York claimed Medicaid reimbursement totaling $1.1 billion ($621 million Federal share) during the period January 1, 2018, through December 31, 2021 (audit period). We reviewed a stratified random sample of 120 claims, and for each claim, reviewed medical and billing documentation maintained by providers to determine if the associated services complied with Medicaid requirements.

What OIG Found

New York generally complied with Medicaid requirements for claiming Federal reimbursement for community rehabilitation services. For 111 of the 120 sampled claims, New York properly claimed Medicaid reimbursement for all community rehabilitation services. However, New York claimed reimbursement for some unallowable community rehabilitation services for the remaining 9 sampled claims. Specifically, services were provided although service plans were not timely signed or maintained, claims did not meet Medicaid reimbursement standards, and services were not appropriately authorized.

On the basis of our sample results, we estimated that New York improperly claimed at least $19.9 million in Federal Medicaid reimbursement for community rehabilitation services that did not comply with Medicaid requirements. Although we commend New York for its efforts in improving some aspects of its monitoring of providers, its overall monitoring activities were still not adequate to ensure that providers complied with Medicaid requirements.

What OIG Recommends and New York Comments

We recommend that New York refund $19.9 million to the Federal Government. We also recommend that New York improve its monitoring activities by increasing the number of case files reviewed when conducting monitoring visits at providers, and by providing formal guidance or training to providers to clarify Medicaid requirements related to providing community rehabilitation services.

In written comments on our draft report, New York partially agreed with both of our recommendations and described actions that it had taken or planned to take to increase its oversight of its community rehabilitation services program. Based on our review of New York's comments and additional documentation provided under separate cover, we revised our findings and related recommendations. We maintain that our findings and recommendations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit of Medicaid community rehabilitation services in New York identified significant noncompliance with Federal and State requirements and recommended that New York develop guidance to physicians regarding State regulations on the authorization of community residence rehabilitation services.[1] Although New York stated that it would disseminate any necessary guidance, it did not subsequently develop any guidance for physicians. Rather, New York amended its State regulations, which included removing a section that required a summary of the service plan review to be submitted to physicians prior to the reauthorization of community rehabilitation services. As a result, there is a risk that vulnerabilities that OIG previously identified in the program still exist. This audit was conducted to determine whether New York improved its monitoring of community rehabilitation services and whether any such improvements effectively increased its compliance with Federal and State Medicaid requirements for claiming reimbursement for these services.

OBJECTIVE

The objective of our audit was to determine whether the New York Department of Health (State agency) claimed Federal Medicaid reimbursement for community rehabilitation 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. In New York, the State agency administers the Medicaid program.

New York's Medicaid Community Rehabilitation Services Program

At the Federal level, Title 42, section 440.130(d) of the Code of Federal Regulations (CFR) and section 1905(a)(13) of the Social Security Act authorize States to provide optional rehabilitative services to Medicaid enrollees. New York established standards for Medicaid reimbursement of community residence rehabilitation services, as well as standards for service planning and

[1] *Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers* (A-02-08-01006), issued Jan. 3, 2011.

review. The State agency elected to provide Medicaid coverage of community rehabilitation services through a program administered by the New York State Office of Mental Health (OMH).[2]

New York's community rehabilitation services program provides Medicaid rehabilitation services to adults with mental illness and children and adolescents with serious emotional disturbances who reside in State- and non-State-operated community residences (i.e., group homes and supervised apartments). Community rehabilitation services provided in New York include training and assistance in matters such as daily living skills, medication management, socialization, substance use disorder services, and parenting training. These services are designed to improve or maintain the ability of people enrolled in Medicaid to remain and function in the community, as well as develop greater independence.

According to New York State regulations, in order for a Medicaid enrollee to initially receive community rehabilitation services, the services must be authorized by a physician. Physicians' authorizations are valid for up to 6 months for individuals residing in congregate residences and residential programs for children and adolescents and up to 12 months for individuals residing in supervised apartments. Service authorizations that are renewed must be signed by either a physician, physician assistant, or nurse practitioner in psychiatry. In addition, community rehabilitation services must be provided in accordance with an approved service plan that is prepared and signed by a qualified mental health staff person and must be subsequently reviewed and signed at least every 3 months. Also, Medicaid reimbursement for claims for community rehabilitation services is based upon monthly and half-monthly rates, depending on the number of days an individual resides in a group home or supervised apartment and the number of face-to-face contacts an individual has with a provider's staff person.

New York's Community Rehabilitation Services Program During the COVID-19 Public Health Emergency

On March 13, 2020, then-President Trump declared the COVID-19 outbreak a national emergency. Due to the COVID-19 public health emergency, OMH modified some community rehabilitation services program requirements during part of our audit period. Specifically, these modifications waived the regulatory timeframes associated with the development of initial service plans and subsequent service plan reviews, as well as physicians' reauthorization requirements. Further, New York approved the use of telehealth services and audio-only telehealth technology for the provision of Medicaid services.[3] In addition, CMS approved an

[2] Although the program is administered by OMH, providers submit claims for Medicaid reimbursement to the State agency. According to 14 NYCRR § 593.2(b), OMH is responsible for establishing and maintaining standards for the program in accordance with cooperative arrangements with the State agency.

[3] These requirements were waived pursuant to New York Executive Order 202, *Temporary Suspension and Modification of Laws Relating to the Disaster Emergency*; New York Executive Order 202.1, *Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency*; 14 NYCRR § 501.3; and OMH Commissioner's regulatory waivers.

amendment to New York's Medicaid State plan that implemented temporary policies during the public health emergency related to the provision of additional services under existing service plans and services provided during a period of non-residence due to COVID-19.[4]

HOW WE CONDUCTED THIS AUDIT

Our audit covered 325,776 claims for community rehabilitation services for which the State agency claimed Medicaid reimbursement totaling $1,099,264,471 ($620,766,069 Federal share) for the period January 1, 2018, through December 31, 2021 (audit period), from which we selected a stratified random sample of 120 claims. We reviewed medical and billing documentation maintained by providers for each sampled claim to determine whether the community rehabilitation services complied 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 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 generally complied with Medicaid requirements for claiming Federal reimbursement for community rehabilitation services. For 111 of the 120 sampled claims, the State agency properly claimed Medicaid reimbursement for all community rehabilitation services. However, the State agency claimed reimbursement for some unallowable community rehabilitation services for the remaining nine sampled claims. Specifically, services were provided although service plans were not timely signed or maintained (six claims), claims did not meet Medicaid reimbursement standards (three claims), and services were not appropriately authorized (two claims).[5]

These deficiencies occurred because OMH's monitoring of providers was not adequate to ensure that community rehabilitation services complied with Medicaid requirements. OMH has improved its monitoring of these services by streamlining its processes and incorporating a risk-based approach for recertifying providers.[6] Although we commend OMH for its efforts in

[4] New York State Plan Amendment (SPA) 20-0048.

[5] The total exceeds nine because two claims had multiple deficiencies.

[6] The new recertification process occurs every 3 years and involves a targeted approach based on past performance of individual providers and current performance data. OMH asserted that this approach is focused on increasing provider performance and reducing risk of improper payments.

improving how it monitors providers, its overall monitoring activities were still not adequate to verify that providers complied with Medicaid requirements. During its monitoring visits at providers, OMH conducts only a minimal review of case records to ensure that providers' claims for community rehabilitation services were appropriate.[7] In addition, during our audit period, OMH did not provide any formal guidance or training to providers to clarify requirements related to service plans being timely signed and maintained, claims meeting Medicaid reimbursement standards, and services being appropriately authorized.[8]

On the basis of our sample results, we estimated that the State agency improperly claimed at least $19,888,031 in Federal Medicaid reimbursement for community rehabilitation services that did not comply with Medicaid requirements.[9]

SERVICE PLANS NOT TIMELY SIGNED OR MAINTAINED

Community rehabilitation services must be provided in accordance with an approved service plan that is reviewed and signed by a qualified mental health staff person.[10] These service plans must be subsequently reviewed and signed by a qualified mental health staff person at least every 3 months.[11] In addition, in order for a provider to receive reimbursement for community rehabilitation services, the associated enrollee must have a service plan that documents the delivery of appropriate community rehabilitation services that have been authorized by a physician or reauthorized by a physician, physician assistant, or nurse practitioner in psychiatry.[12]

For 6 of the 120 sampled claims, providers did not ensure that service plans or subsequent service plan reviews were timely signed by a qualified mental health staff person or maintained. Specifically:

- For two claims, the qualified mental health staff person did not sign the enrollee's subsequent service plan review.

[7] Individual providers may have multiple program sites across New York State. The number of case files reviewed during OMH's monitoring visit at each provider program site consists of two to four active cases and two to four closed cases.

[8] The State agency's Office of Medicaid Inspector General provided formal training to community rehabilitation providers in 2014; however, no other trainings have been provided.

[9] To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[10] 14 NYCRR §§ 593.6(c) and (d).

[11] 14 NYCRR § 593.6(f).

[12] 14 NYCRR § 593.7(a).

- For two claims, the qualified mental health staff person did not timely sign the enrollee's subsequent service plan review. Specifically, the plan reviews were signed 78 and 228 days after the required 3-month period.

- For one claim, the enrollee's initial service plan was not signed by a qualified mental health staff person.

- For one claim, the provider did not maintain documentation to indicate that the enrollee's subsequent service plan review was performed.

MEDICAID REIMBURSEMENT STANDARDS NOT MET

Medicaid reimbursement for claims for community rehabilitation services is based upon monthly and half-monthly rates.[13] In order for claims to be reimbursed at the full monthly rate, the enrollee must be in residence for at least 21 days in a calendar month and must have at least 4 face-to-face contacts with a provider's staff person.[14] For claims to be reimbursed at the half-monthly rate, the enrollee must be in residence for at least 11 days and must have at least 2 face-to-face contacts with a provider's staff person.[15] These sessions must be on separate days and at least 15 minutes in length.[16] States must have agreements with Medicaid providers under which providers agree to keep such records as necessary to fully disclose the extent of the services provided to individuals receiving assistance under a State plan.[17]

For 3 of the 120 sampled claims, providers submitted claims for Medicaid reimbursement that did not meet monthly reimbursement standards. Specifically:

- For two claims, the provider submitted a claim for reimbursement at the full monthly rate; however, the associated enrollee did not have at least four face-to-face contacts with the provider's staff person.[18]

- For one claim, the provider did not provide documentation that a staff person had any face-to-face contacts with the associated enrollee.

[13] 14 NYCRR § 593.7(b).

[14] 14 NYCRR § 593.7(b)(1).

[15] 14 NYCRR § 593.7(b)(2).

[16] 14 NYCRR § 593.7(b)(3).

[17] Social Security Act § 1902(a)(27)(A).

[18] For one of the three claims, the provider was eligible for Medicaid reimbursement at the half-monthly rate because at least two face-to-face contacts were made between the individual and the provider's staff person. For this claim, we disallowed the difference between the monthly rate billed and the applicable half-monthly rate.

SERVICES NOT APPROPRIATELY AUTHORIZED

For a provider to receive reimbursement for community rehabilitation services, the associated enrollee must have a service plan that documents the delivery of appropriate services that have been initially authorized by a physician or reauthorized by a physician, physician assistant, or nurse practitioner in psychiatry.[19, 20] Service authorizations must be renewed every 6 months for adults residing in congregate residences and residential programs for children and adolescents, and every 12 months for adults residing in supervised apartments.[21]

For 2 of the 120 sampled claims, providers did not ensure that community rehabilitation services were appropriately authorized. Specifically, for one claim, the initial authorization was not completed by a physician. For the other claim, the service reauthorization did not contain a signature date to indicate if the reauthorization was completed within the required timeframe.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund $19,888,031 to the Federal Government;

- work with the New York State Office of Mental Health to improve monitoring activities by:

    - increasing the number of case files reviewed when conducting provider site visits to ensure that service plans and subsequent service plan reviews are timely signed and maintained, community rehabilitation claims meet Medicaid reimbursement standards, and services are appropriately authorized; and

    - providing formal guidance or training to providers to clarify requirements related to service plans and subsequent service plan reviews being timely signed and maintained, community rehabilitation claims meeting Medicaid reimbursement standards, and services being appropriately authorized.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency partially agreed with our recommendations and described actions that it had taken or planned to take to address them. Under separate cover, the State agency provided additional documentation related to

[19] 14 NYCRR § 593.7(a) and NYS Medicaid State Plan Attachment 3.1-B Supplement.

[20] 14 NYCRR § 593.6(b).

[21] 14 NYCRR §§ 593.6(b)(1) and (2).

10 sampled claims that we identified in our draft report as containing some unallowable community rehabilitation services.

Based on our review of the State agency's comments and additional documentation provided, we revised our findings and related recommendations for four sampled claims. We maintain that our findings and recommendations, as revised, are valid. The State agency's comments are included in their entirety as Appendix D.

STATE AGENCY COMMENTS

Regarding our first recommendation (financial disallowance), the State agency indicated that it disagreed with the amount of our recommended disallowance and stated that provider records justify Medicaid reimbursement for some sampled claims that we identified in our draft report as containing some unallowable community rehabilitation services. Under separate cover, the State agency provided additional documentation related to 10 sampled claims. The State agency also indicated that its Office of Medicaid Inspector General (OMIG) has initiated audits of community rehabilitation services that overlap with the scope of our audit and that it will refund the Federal share of any identified overpayments to the Federal Government.

Regarding our second recommendation, the State agency indicated that it will work with OMH to review OMH's protocols and ensure that OMH reviews a sufficient number of case files during provider site visits. The State agency also stated that it will work with OMH to ensure that OMH conducts training to clarify requirements related to service plans, Medicaid reimbursement standards for community rehabilitation claims, and the appropriate authorization of services. In addition, the State agency indicated that OMIG will collaborate with OMH to issue formal guidance to providers.

The State agency also commented on two statements in our draft report related to OMH monitoring visits and a change in provider requirements. Specifically, the State agency clarified that, during OMH monitoring visits, OMH reviews case files by program site rather than by provider. Therefore, according to the State agency, OMH reviews significantly more case files during monitoring visits than our draft report suggested. Additionally, the State agency indicated that we misinterpreted the intent of a prior requirement for a physician to be provided with a summary of an individual's service plan review prior to reauthorizing community rehabilitation services.[22] According to the State agency, OMH's intent was to ensure that a physician was familiar with an individual, not to require a formal summary to be developed and provided to a physician. Once OMH amended State regulations to change this requirement, OMH determined that service reauthorizations were sufficiently straightforward and common practice for physicians to perform without specific guidance.

[22] According to the State agency, OMH amended its regulations to address the OIG's interpretation of the requirement that a physician reauthorizing services be provided with a review form summarizing the patient's case prior to reauthorization.

OFFICE OF INSPECTOR GENERAL RESPONSE

Based on our review of the State agency's comments and additional documentation provided, we revised our findings and related recommendations for four sampled claims.[23] We also revised our report to clarify the number of case files reviewed during OMH monitoring visits. Regarding the State agency's assertion that we misinterpreted the intent of a prior requirement, we note that we only indicate that the State agency removed the prior requirement for a physician to be provided with a summary of the service plan review before an individual was reauthorized for community rehabilitation services. We maintain that our findings and recommendations, as revised, are valid.

We commend the State agency for the actions it has taken or plans to take to address our recommendations. We also commend the State agency for working with OMIG to initiate audits of community rehabilitation services and issue formal guidance to providers.

OTHER MATTERS: QUALITY-OF-CARE ISSUES RELATED TO COMMUNITY REHABILITATION SERVICES DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY

In response to the COVID-19 public health emergency, OMH waived some State requirements and implemented temporary policies during the public health emergency that differed from policies and procedures otherwise applied under its community rehabilitation services program. We interviewed community rehabilitation service providers to determine whether they encountered any quality-of-care issues during the public health emergency. While these issues would not be considered findings due to the waivers and temporary policies in place during this time, they may have negatively affected enrollees receiving community rehabilitation services.

We found that 28 of the 65 providers associated with our sampled claims reported quality-of-care issues while providing community rehabilitation services during the COVID-19 public health emergency. Specifically:[24]

- Fifteen providers stated that they experienced difficulties providing certain services (e.g., daily living skills, medication management, and socialization services) while social distancing.

- Nine providers stated that they experienced difficulties completing service authorizations and renewals. For example, several mentioned that they had difficulty

[23] Specifically, for three sampled claims, the State agency provided documentation that the enrollee's subsequent service plan review was appropriately signed by the qualified mental health staff person. For the other sampled claim, the State agency provided documentation demonstrating that Medicaid reimbursement standards were met. Specifically, the documentation indicated that the enrollee had at least four face-to-face contacts with the provider's staff person.

[24] Total number of providers exceeds 28 because some providers reported multiple quality-of-care issues.

completing physician authorizations or completing reauthorizations as timely as they had prior to the public health emergency. While physician reauthorization requirements were waived during the public health emergency, this may have resulted in inappropriate or unnecessary services.

- Six providers stated that they experienced difficulties completing service plans, which may have resulted in individuals receiving services that did not properly align with their needs. For example, while the regulatory timeframe associated with the development of service plans was waived during the public health emergency, some providers mentioned that service plans were not completed and signed as timely as they had prior to the public health emergency because staff persons worked remotely during the COVID-19 public health emergency and were encouraged to limit face-to-face interactions.

- Five providers stated that they experienced difficulties related to staff turnover and exhaustion.

- One provider described difficulties it had with getting medications delivered from pharmacies to enrollees' residences.

These quality-of-care issues may have had a significant negative impact on individuals receiving Medicaid community rehabilitation services. Many providers indicated that the COVID-19 public health emergency negatively impacted their ability to effectively provide some services and retain enough staff persons to provide these services to people. We encourage the State agency to work with OMH, in the event of a future public health emergency, to minimize potentially negative impacts to the quality of care provided to enrollees receiving community rehabilitation services.[25]

[25] The Biden administration ended the COVID-19 public health emergency on May 11, 2023.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 325,776 claims for community rehabilitation services for which the State agency claimed Medicaid reimbursement totaling $1,099,264,471 ($620,766,069 Federal share) for the period January 1, 2018, through December 31, 2021 (audit period). We reviewed a stratified random sample of 120 of these claims to determine whether community rehabilitation services complied with Medicaid requirements. We determined that the State agency's control activities, information and communication, and monitoring were significant to our audit objective. We assessed the design, implementation, and operating effectiveness of the State agency's internal controls related to payments made to community rehabilitation providers. We also met with State agency officials to gain an understanding of the procedures in place for monitoring community rehabilitation service providers.

We conducted our audit from April 2022 to March 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid requirements;

- met with officials from the State agency and OMH to discuss the administration and monitoring of New York's community rehabilitation services program;

- obtained from New York's Medicaid Management Information System (MMIS) claims for community rehabilitation services performed by providers in New York during our audit period;

- created a sampling frame of 325,776 claims for community rehabilitation services with Medicaid reimbursement totaling $1,099,264,471 ($620,766,069 Federal share);

- reconciled the claims for Federal Medicaid reimbursement of community rehabilitation services claimed by the State agency on the Forms CMS-64, *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program*, covering our audit period with the data obtained from the MMIS file;

- selected a stratified random sample of 120 claims from our sampling frame, and for each claim, reviewed medical and billing documentation maintained by providers to determine if the associated services complied with Medicaid requirements and interviewed providers about providing services during the COVID-19 public health emergency;

- estimated the total amount of improper Federal Medicaid reimbursement made to the State agency for community rehabilitation services claims in our sampling frame; 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 B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame contained 325,776 claims with Medicaid payments totaling $1,099,264,471 ($620,766,069 Federal share) with Federal Medicaid reimbursement greater than $0, claimed by the State agency for community rehabilitation services provided during the period January 1, 2018, through December 31, 2021.

SAMPLE UNIT

The sample unit was a Medicaid claim for community rehabilitation services.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample and divided the sampling frame into five strata. Our first four strata were based on whether the community rehabilitation service was provided to adults before or during the COVID-19 public health emergency, and then by the total claim payment amount. Our fifth strata represented all community rehabilitation service that were provided to children (under 18 years of age):

Stratum	Description	Dollar Range (Federal share)	Frame Payment Amount (Federal share)	Number of Claims in Frame	Sample Size
1	Calendar Years (CYs) 2018 and 2019 Claims for Adults	>$0 and ≤$1,648	$139,554,369	101,021	25
2	CYs 2018 and 2019 Claims for Adults	>$1,648	130,487,125	57,833	25
3	CYs 2020 and 2021 Claims for Adults	>$0 and ≤$1,738	148,494,557	99,908	25
4	CYs 2020 and 2021 Claims for Adults	>$1,738	138,225,379	57,152	25
5	Claims for Children	>$0	64,004,640	9,862	20
Totals			**$620,766,069**[26]	**325,776**	**120**

[26] Due to rounding, the individual stratum values listed in this table do not add up to the total amount claimed.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the claim's transaction control number and then consecutively numbered the items in each stratum in the sampling frame. After generating 120 random numbers according to our sample design, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG, OAS statistical software to estimate the total amount of improper Medicaid payments (Federal share) made for community rehabilitation services in the sampling frame at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual improper payment total 95 percent of the time. We also used this software to calculate the corresponding point estimate and upper limit.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum Number	Number of Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Improper Claim Payments	Value of Improper Claim Payments (Federal Share)
1	101,021	$139,554,369	25	$35,847	3	$4,330
2	57,833	130,487,125	25	51,138	3	5,233
3	99,908	148,494,557	25	36,825	0	0
4	57,152	138,225,379	25	64,425	2	3,987
5	9,862	64,004,640	20	123,120	1	12,033
Total	**325,776**	**$620,766,069**[27]	**120**	**$311,355**	**9**	**$25,583**

Estimated Value of Improper Claim Payments in the Sampling Frame (Federal Share)
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	$44,650,877
Lower limit	19,888,031
Upper limit	$69,413,722

[27] Due to rounding, the individual stratum values listed in this table do not add up to the total amount claimed.

APPENDIX D: STATE AGENCY COMMENTS

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

June 5, 2023

Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-22-01011

Dear Brenda 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-02-22-01011 entitled, "New York Improved Its Monitoring of Medicaid Community Rehabilitation Services but Still Claimed Improper Federal Medicaid Reimbursement Totaling $34 Million."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Amir Bassiri
Jacqueline McGovern
Andrea Martin
Timothy Brown
Amber Rohan
Brian Kiernan
James DeMatteo
James Cataldo
Michael Atwood
Melissa Fiore

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

New York State Department of Health
Comments to Draft Audit Report A-02-22-01011 entitled, "New York Improved Its Monitoring of Medicaid Community Rehabilitation Services But Still Claimed Improper Federal Medicaid Reimbursement Totaling $34 Million" by the Department of Health and Human Services Office of Inspector General

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The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report A-02-22-01011 entitled, "New York Improved Its Monitoring of Medicaid Community Rehabilitation Services But Still Claimed Improper Federal Medicaid Reimbursement Totaling $34 Million" by the Department of Health and Human Services, Office of Inspector General (OIG).

Recommendation #1:

Refund $34,423,989 to the Federal Government.

Response #1:

The Department and the New York State Office of Mental Health (OMH) do not agree with the amount of the recommended refund as some of the findings can be disproven by provider records. To date, OMH has identified at least ten claims for which provider records justify Medicaid reimbursement, and those claims should be removed from the audit extrapolation calculation. For several claims, it appears as though providers may not have been able to locate responsive records during the OIG audit but subsequently produced records justifying reimbursement to OMH. OMH will conduct a thorough review of the case record documentation prior to the issuance of the final audit report, and will provide all of these records to the OIG under separate cover.

With respect to OIG's findings related to the adequacy of OMH's monitoring of providers to ensure that community rehabilitation services comply with Medicaid requirements, it should be clarified that OMH reviews case files by program site rather than by provider, and therefore reviews significantly more case files during monitoring visits than OIG's draft report suggests.

The draft report states, "Although New York stated that it would disseminate any necessary guidance, it did not subsequently develop any guidance for physicians. Rather, New York amended its State regulations, which included removing a section that required a summary of the service plan review to be submitted to physicians prior to the reauthorization of community rehabilitation services."

OMH amended its regulations regarding physician authorizations to address the OIG's interpretation of the requirement that a physician reauthorizing services be provided with a review form summarizing the patient's case prior to reauthorization. OIG misinterpreted the intent of this requirement. OMH's intent was to ensure that the physician was familiar with the individual, not to require a formal summary be developed and provided. Further, once this regulation was amended, OMH determined that service reauthorizations were sufficiently straightforward and common practice for physicians to perform without specific guidance from OMH.

OMH rehabilitation services in community residences provide critical remedial services for individuals diagnosed with mental illnesses and functional impairments who require psychiatric rehabilitation services to improve functionality and regain the skills necessary to live in more integrated settings. OMH rehabilitation services are provided in three types of discrete programs and licensed providers may operate multiple program types. Both Children's and Adult Congregate

type community residence programs provide onsite 24-hour supervision for residents. Apartment Treatment type community residence programs provide psychiatric rehabilitation services to individuals residing in individual apartments within the program, who are capable of self-preservation and do not require 24-hour supervision.

These services, which have been reimbursed by the Medicaid program for 30 years, have helped to transition thousands of individuals with mental illnesses from less integrated settings into the community. As indicated in the OIG's review of OMH's regulations and processes, OMH has adopted various controls to ensure community residence programs are providing medically necessary services and to preserve these critical resources for those who need them. Additionally, the NYS Office of the Medicaid Inspector General (OMIG) also conducts regular audits of OMH-licensed programs to ensure compliance with federal and state requirements for Medicaid services.

Upon completion of a thorough review of case records, OMH will work in conjunction with OMIG to determine the appropriate course of action. OMIG has initiated audits of community rehabilitation services that overlap with the OIG audit scope and will continue its reviews in this area. The federal share of any identified overpayments will be refunded to the Federal government. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2:

Work with the New York State Office of Mental Health to improve monitoring activities by:

- increasing the number of case files reviewed when conducting provider site visits to ensure that service plans and subsequent service plan reviews are timely signed and maintained, community rehabilitation claims meet Medicaid reimbursement standards, and services are appropriately authorized; and

- providing formal guidance or training to providers to clarify requirements related to service plans and subsequent service plan reviews being timely signed and maintained, community rehabilitation claims meeting Medicaid reimbursement standards, and services being appropriately authorized.

Response #2:

In the draft audit report, the OIG notes that OMH conducts only a "minimal review of case records to ensure that providers' claims for community rehabilitation services were appropriate." In a footnote, the OIG adds that the number of case files reviewed during OMH's monitoring visit at each provider consists of two to four active cases and two to four closed cases.

Based on discussions with OMH, this is not an accurate statement. The minimum sample size is for each community residential program site, and not per provider. As noted above, a provider may operate multiple programs. For example, in a review of a large provider with 37 Residential Programs, OMH reviewed 74 unique open and 74 closed case records. However, the Department will work with OMH to review its protocols and ensure that a sufficient number of case files are reviewed during site visits.

The Department will also work with OMH to ensure that OMH conducts training to clarify requirements related to service plans, Medicaid reimbursement standards for community rehabilitation claims, and the appropriate authorization of services.

Finally, the Department notes that OMIG has initiated audits of community rehabilitation services and has audit protocols which address the findings in this OIG draft audit report, including but not limited to reviewing for signed service plans, that services are appropriately authorized, and claims meet applicable State requirements. OMIG is in the process of updating its audit protocols to address more recent changes to the program, including changes necessitated in response to COVID. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

OMIG will collaborate with OMH to issue formal guidance to providers.