The OMIG Who Stole Xmas

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It is difficult to convey the level of anxiety and outright fear with which nonprofit service providers view OMIG – New York State's Office of the Medicaid Inspector General. Established at the end of 2006, OMIG's mandate is to root out fraud, waste and abuse within the state's Medicaid system.

No problem, right?

"If people are consciously defrauding the Medicaid system or abusing it by providing unnecessary and wasteful services, they should be stopped and punished," says Philip Saperia, Executive Director of the Coalition of Behavioral Health Agencies. "We are completely supportive of that effort."

Unfortunately, however, providers now believe that everything – every clerical error, administrative oversight, missing signature, incorrect date, paperwork omission or late billing – is being considered by OMIG to be abuse at best and possibly even fraud at worst. And, OMIG is coming to find them, multiply them by a factor of 100 or 200, and demand repayment.

Making matters even worse, say providers, is the fact that OMIG is no neutral arbiter of right and wrong. OMIG has its own skin in the game via budget targets to recoup staggering and annually increasing amounts of past over payments. Under F-SHRP – the Federal-State Health Reform Partnership – New York State is mandated to generate fraud and abuse recoveries according to the following schedule:

•$215 million in 2008

•$322 million in 2009

•$429 million in 2010

•$644 million in 2011

"They are like a traffic cop with a quota of tickets to give out," says one executive director who, like all agency executives subject to OMIG audits, declined to be identified.

"This is strictly a budget balancing initiative," says another.

"OMIG's agenda is very different from what other auditors had in the past," says Eric Marks of the accounting firm Marks Paneth and Shron. "While others were out there to make sure that services were being provided in accordance with regulations, OMIG is really out there to recapture dollars. That is their goal. That is their mission. They value themselves on the basis of how much they get back."

James G. Sheehan, the actual MIG at OMIG, takes issue with this interpretation.

"I found out about the F-SHRP agreement after I had agreed to take the job and I was not too

happy that this was the obligation the State had undertaken," he says. He indicates that his office's Medicaid fraud and abuse recoveries are dictated by actual audit findings, not by extraneous pressures or budgetary goals. "I expect an increase in recoveries until probably next year. Then, they will probably decline because I think there has been a substantial effort at compliance going forward within New York health care organizations and we are going to see the results of that effort. If you look at the fourth year goal of $644 million, that is tough. If we are not going to make it because the evidence isn't there to support it, we are just going to have to go back to CMS and make that case."

For the moment, however, OMIG has the opportunity to look back at billings which were submitted over several years prior to its creation. "We are finding plenty of issues that are problematic," says Sheehan.

And, with its own budget of close to $100 million and a staff that has grown to almost 600, including over 300 auditors, OMIG is on the case – your case.

OMIG along with colleagues at the Attorney General's office and some other state agencies far exceeded the State's first year goal, recouping a total of $551 million in overpayments during 2008.

While much of this came from hospitals, nursing homes, pharmacies and other major medical providers, a significant chunk was generated in audits of community-based programs, including those licensed by OMH, OASAS and OMRDD:

- Diagnostic and Treatment Centers:$8.5 million from 17 providers;
- Outpatient Chemical Dependence: $2.1 million from 15 providers;
- Inpatient Chemical Dependence: $1.4 million from 3 providers;
- Outpatient Mental Health: $2.1 million from 16 providers;
- OMRDD Providers: $434,907 from 11 providers.

This is only the beginning. Many audits of similar providers have been launched or finalized since 2008. The tide is rushing in. Everyone, it seems, now knows some agency currently undergoing an OMIG audit.

The impact on individual nonprofits can range from significant to staggering.

Create, Inc., a Manhattan provider of substance abuse services and transitional housing, was hit with a recoupment of $454,123, almost half its total Medicaid billings for 2004. (We'll talk about the reasons for this recoupment in a moment.)

The Margaret Sanger Center of Planned Parenthood of NYC was tapped for $1.254 million, roughly 10.6% of its total Medicaid billing during the 2004-2005 two-year audit period.

At Daytop Village, the total was $1.4 million. At Abilities First, it was $528,947. The Center for Family Support got a bill for $294,091.

Fraud and Abuse?

How much of this was fraud and abuse? All of it, says Sheehan. "The concept of abuse under our regulations means failure to comply with existing professional standards for health care, medical necessity or business operations," he explains. The latter apparently includes inaccurate billing or incomplete documentation.

This approach is frightening to nonprofit providers.

"Not every billing error is fraud or abuse," says Saperia.

"If someone billed for sessions that never happened or for services that were never delivered, that is clearly fraudulent and abusive," says John Coppola, Executive Director of Alcoholism and Substance Abuse Providers of New York State (ASAP). "On the other hand, if you have a therapist who didn't initial the case record or filed a progress note that was incomplete, but it is clear from other documentation that the service was provided, that is something different. You would think there would be a substantially different approach to those kinds of errors."

Sheehan argues that his auditors are looking to verify that past payments were for services which were 1) appropriately delivered and 2) authorized by a physician as medically necessary – the regulatory touchstones of the Medicaid program.

However, providers believe that OMIG audits look beyond these substantively meaningful measures of program performance and focus on the minutia of casework documentation and billing detail – essentially anything they can find to generate a denial of claim.

"Most of the audits have to do with sets of regulations that require providers to comply with certain types of record keeping," says David Glasel, an attorney with Hiscock and Barclay LLP and a former Deputy Commissioner and General Counsel with the New York State Department of Social Services. "And, if you don't do it correctly, you can lose the claim -- even though it may be clear from the audit that the service was provided."

"Much of the potential disallowances are the result of ignorance, not knowing how to dot all your 'i' s and cross all your 't's," says Michael McNee, Partner-in-Charge of Nonprofit and Government Services at the CPA firm Marks, Paneth and Shron LLP.

Examples can be found in the final audits posted on the OMIG website:

- "Patient's progress toward meeting service plan goals not noted";
- "Missing physician signature on treatment plan";
- "The amount, frequency or duration of the service rendered did not comply with the service plan";
- "Start and/or end time of the session was not recorded";
- "Missing treatment plan";
- "HIV Pre-test Counseling records did not contain the required information."
- "Practitioner did not sign the entry in the medical record."
- "Treatment plan review lacked the required signature of a member of the multidisciplinary

team."

• "Medical record did not contain a level of care determination signed and dated within two visits to the service..."

"We have heard about claims being denied because the worker did not note that the meeting was 'face to face'," says Ann Hardiman, Executive Director of the New York State Association of Community and Residential Agencies (NYSACRA). "They are picking at words."

The bill submission process itself – particularly delays in processing bills beyond Medicaid's 90-day submission deadline -- has also become a major focus. OMIG uses "data mining" techniques to identify claims submitted more than 90 days after the date of service, and then requests documentation justifying the "exception codes" used by providers to submit the claim for processing. It was this finding alone which accounted for Create, Inc.'s near half million dollar recoupment.

Extrapolation

Amplifying provider fears is OMIG's ability to "extrapolate" audit findings from a relatively small sample of cases and project an error and overpayment rate across the agency's total Medicaid billing for the audit period.

Create, Inc.'s $454,123 recoupment was based on finding overpayments of $7,703 in a sample of 100 claims. At Planned Parenthood's Margaret Sanger Center, OMIG extrapolated a sample overpayment of just $7,960.01 into a total overpayment estimate of $1.7 million – 214 times the actual overpayment found in the sample.

This kind of negative leverage drives providers crazy as they watch seemingly petty paperwork errors mushroom into enormous financial penalties. In one case, by our rough calculations, a sample finding that one medical entry was not signed by the practitioner – an actual overpayment of $164.02 – was the basis for estimated agency-wide overpayment of $35,121.

In fact, extrapolation has always been used in DOH audits and other financial analyses.

"The concept of extrapolation has been established as an acceptable approach in the courts for more than 20 years," says David Glasel. Yet, the ways in which it is used is almost always an argument when and if agencies appeal OMIG's findings. Was the sample properly constructed? Was the projection done properly?

On Appeal

In fact, relatively few OMIG audits have been appealed. Sheehan argues that the OMIG audit process itself offers providers several opportunities – including a pre-exit conference, exit conference and draft audit -- to rebut and correct any errors in the audit findings. For agencies who are still not satisfied, there is an opportunity to appeal to a DOH Administrative Law Judge. "New York State has more due process built into its audit system than any other state," says Sheehan. "It is about as good as you are going to find and better than what the feds offer."

Providers, however, argue that agencies are intimidated by OMIG's strategy of offering to settle at a "lower confidence limit" estimate of overpayments – often hundreds of thousands of dollars less than OMIG's "point estimate" of overpayments. "If you choose not to settle this

audit...OMIG would seek and defend the point estimate," says the typical OMIG audit letter.

"This is chilling to providers," says one agency executive. "Do we take the risk? Do we hire an attorney and incur that expense? It is terrifying."

Sheehan disagrees. "If we are right, it is a hell of a deal for them. If we are wrong, they should fight us."

Get Real!

Providers argue that OMIG's aggressive auditing approach is unfair for a variety of reasons.

For one thing, they maintain that absolute, 100% compliance with every aspect of Medicaid's myriad rules and regulations is simply beyond the capacity of any provider organization – let alone community-based nonprofits whose administrative infrastructures have been weakened by a steady diet of inadequate government funding.

"The paperwork required is very detailed and there are lots of places where you can make miniscule errors or oversights," says David Glasel.

"We just don't have the administrative infrastructure," says another executive director. "All these administrative hoops and hurdles cost money."

The timing and content of treatment plans, treatment plan updates and progress notes, for example, is a key audit target for OMIG – and an area where providers feel in particular jeopardy.

Social workers in community mental health agencies who generally prepare the treatment plan for approval by a psychiatrist may be far better at therapy than at service documentation. "They may accidentally leave things out," says Patricia Gallo Goldstein, Deputy Executive Director at the Coalition of Behavioral Health Agencies. They may initially propose a series of group therapy sessions and then learn that the patient does better with individual counseling. If that isn't in the treatment plan review, the claim can be denied.

Psychiatrists, who must approve the initial treatment plan as well as all treatment plan reviews, are an expensive and overstretched resource – often available only one or two days per week in underfunded community-based programs. "The treatment plan may be due on Monday but the psychiatrist isn't available until Thursday," says Goldstein. OMIG, however, has indicated that the initial, comprehensive treatment plan, which is due within 30 days from the first visit, will be cited as an error on audit if it is completed even one day late.

Similar issues impact treatment plan reviews updates which are due every 90 days. "Let's say you have treatment plan update that is due on September 30 and you have an appointment with the client on September 25th," says ASAP's John Coppola. "What happens if he doesn't show up? When he comes in next time, the treatment plan update is late. We are hearing that OMIG disallows every claim for service going back a full quarter."

"Our direct care staff who write service notes may only be making $9.00 an hour," says one Executive Director at a developmental disabilities services agency. "Yes, they have issues around writing and language. They may be great direct care staff but they are not great bureaucrats."

As for late payments, there are lots of reasons why providers may not be able to file a claim within 90 days of service. “Providers in mental health or substance abuse programs may have trouble getting accurate information from the patient,” says one executive who deals with the billing process. They may not be told that clients have third party insurance or Medicare, both of which must be billed prior to submitting for payment through Medicaid. Even when invoiced, third party payers or Medicare may not provide the denials of payment which Medicaid requires on a timely basis. There also are systems issues. Batched bill submissions may be only partially processed, leaving providers with unsubmitted bills they don’t even know about. Some of these factors are covered by Medicaid’s legitimate “exception” codes -- which then trigger another whole series of their own processing time limits. Other real life reasons for delay aren’t covered at all.

Sheehan has little sympathy for provider arguments that full compliance with rules and regulations is impossible.

“If you are going to participate in a government program, you have to play by the rules the program has and you have to submit claims that are consistent with the rules that government imposes,” he explains. “Once you move back from that point and say you can skip some rules and you can ignore others, you are on a very slippery slope.”

And, if New York doesn’t enforce these rules, the feds will, says Sheehan. “The feds are doing their own audits of these issues as well. Their position is very clear. If you are spending money that is not consistent with your state plan, we want it back.”

Changing the Rules

Providers also claim that the OMIG’s new stance on billings submitted for services delivered years before the office was even created represents a sharp departure from the standards and requirements which had been established by past auditing practices at the Department of Health and the licensing agencies – OMH, OASAS and OMRDD.

“You could certainly argue that it is more rigid now than in the past,” says David Glasel. “Where you have a miniscule recordkeeping error, there is less likely to be any tolerance now.”

In some cases, providers argue that this is tantamount to retroactively rewriting the regulations.

A DOH Administrative Law Judge (ALJ) recently agreed with this point of view when he ruled in favor of Metropolitan Jewish Geriatric Center (MJGC) on its appeal of an OMIG audit finding. OMIG had sought $927,983 in recoupment of payments made to the nursing home for holding beds open while residents were temporarily hospitalized with an acute medical condition. OMIG had demanded that MJGC provide written documentation from the admitting hospital as justification of the “bed hold”.

The ALJ found that “during the three-year period being audited, no Department policy, communication or directive required a nursing home to obtain the written documentation which the hospital discharge planning coordinator was required to produce.” And, he concluded that “OMIG...cannot retroactively reinterpret regulations that have not materially changed during the past several decades.”

“We think that this is an important decision beyond the specific issues of the ‘bed hold’,” says Patrick Cucinelli, Senior Financial Policy Analyst at the New York Association of Homes and

Services for the Aging (NYASHA). "The Administrative Law Judge condemned the OMIG audit practice of trying to reinterpret regulations years later as a basis for auditing and recouping. These providers operated in good faith based on what they understood to be the practice from DOH." Sheehan declined to comment prior to reviewing the decision in greater detail.

Providers, however, believe that there have been numerous similar instances of this practice. One would be OMIG's efforts to recoup COPS-only payments for mental health visits if the Medicaid managed care plan did not pay a claim. Another is demand for documentation of an individual client's attendance in groups and other various components of service in clinics and Continuing Day Treatment (CDT) programs.

To help resolve these issues, provider associations have been seeking OMIG audit protocols outlining the documentation and service requirements auditors will be seeking when reviewing case records for various OMH-, OASAS- and OMRDD-licensed programs.

"We have been trying to get audit protocols for Medicaid audits for years, first from DOH and now from OMIG," says Patricia Gallo Goldstein, "OMH gives them to us. NYC DOHMH gives them to us. Just give us your audit protocols. Let us know what you expect to see."

Sheehan has committed to do just that, once he has them. "We have started to develop audit protocols in specific business areas, for example pharmacy and home health," he explains.

In the meantime, however, he questions the argument that providers don't know – or shouldn't have to know -- the regulations and standards to which they must be held accountable.

"For every audit finding we cite a regulation," says Sheehan. "Usually it is a regulation that was written or approved by the licensing agencies that says this is what you have to do to get paid. The other guidance we use are the Medicaid Provider Manuals."

Sheehan also expresses a dim view of the argument that OMIG is reinterpreting regulations by enforcing them more aggressively. "If the regulations say you must do 'a', 'b' and 'c', the fact you were only audited on 'a' and 'b' in the past doesn't mean you don't have to do 'c'. It is the law. You are stuck with that," he says.

And, Sheehan explains, the good old days weren't really very good. He credits OMIG's existence to a series of articles in The New York Times from 2005 which reported that "New York Medicaid Fraud May Reach Billions". "When I hear people say that in the past, agencies were much more willing to tolerate lapses, I think that is how the State got into that situation," he says.

Off Target

Nonprofit providers argue that Sheehan is missing his target – unless of course his aim is solely to maximize F-SHRP recoupments.

"We are not Medicaid mills," says one agency executive director. "We are not billing for imaginary patients or luring clients in for service by giving away clock radios."

"At the end of the day, crooks should get what is coming to them," says Lori Cole, Executive Director of the New York State Council for Community Behavioral Healthcare. "For the other 99% of providers who do good work and make human error type mistakes from time to time,

the discussion should be about quality of care. An audit should be instructive, should leave the agency in a better position to correct errors, make investments in staff and ultimately improve performance."

"It is a matter of public policy," says ASAP's John Coppola. "If New York State wants to penalize people for clerical errors and oversights in the same way that somebody would be penalized for stealing, that would seem to be a dramatic departure from what the average person would consider to be fair. And, it has the ultimate consequence of shrinking resources for the treatment services we are trying to provide."

The OMIG is Coming!

Meanwhile, anxiety is increasing as OMIG's audits of community based providers begin to pick up steam.

"If they come in and start to extrapolate on minor errors in our case files, they will shut us down," says one substance abuse treatment agency executive.

"These audits and onerous financial penalties are going to destabilize individual providers and weaken the entire system at a time when it is already under extreme stress," says Philip Saperia.

As we went to press, two separate provider associations were holding meetings specifically to discuss issues raised by the OMIG audits. Another group was considering proposals for legislation which they hope would mandate some relief.

And, OMIG has upped the ante with a requirement effective October 1st that many Medicaid providers must have a full-blown compliance plan in place. (See "Got Your Mandatory Compliance Plan?" on page 8.) At the end of this month, providers will have to certify that they are in compliance.

Don't have the certification? Don't bother to submit a bill?

"If you fail to comply with the program requirements, the statute says you can't participate in the program," says Sheehan. "They do have to get their certification in. We will be looking closely at providers who don't."

Got Your Mandatory Compliance Plan?
The Answer Had Better Be Yes!!!

Effective October 1st, New York State Medicaid providers who bill for more than $500,000 annually – plus all Article 28, 31,16 and 36 providers regardless of billings – are required to have implemented a mandatory compliance plan.
The purpose of such programs is "to organize provider resources" so that providers themselves will be able "to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences."
The plans must include the following eight elements.

- Written policies and procedures.
- An employee vested with responsibility for day-to-day compliance program operation.
- Training and education of all affected employees and persons.
- Communication lines to the responsible compliance position.
- Disciplinary policies to encourage good faith compliance program participation.
- A system to routinely identify compliance risk areas.
- A system for responding to compliance issues as they arise.
- A policy of non-intimidation and non-retaliation for good faith compliance program participation.

"It is critical that these programs be more than just a loose leaf binder of policies sitting on the shelf," says Kelly Mathews, Senior Vice President for Financial Accountability and Compliance Services at the New York Council of Nonprofits, which has been providing joint training on Medicaid compliance and accountability issues as part of its State Board Training Consortium program. "These plans have to become a living breathing part of the agency's practices and culture."

By the end of December, all providers will have an opportunity, i.e. a requirement, to certify that they have implemented the mandated compliance program.

COMMENTS

Anon 0

Do private insurance companies tolerate the loose billing and procedural practices which the article argues Medicaid should overlook?

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