pennsylvania
DEPARTMENT OF PUBLIC WELFARE

December 15, 2011

Mr. Kevin M. Friel
Deputy Secretary for Developmental Programs
Health and Welfare Building, Room 512
Harrisburg, Pennsylvania 17120

Dear Mr. Friel:

I am enclosing the final report on Targeted Case Management Services that was completed by this office as a technical assistance project. Your response has been incorporated into the final report and labeled Appendix C.

I would like to extend my appreciation for the courtesy and cooperation extended to my staff during the course of the fieldwork on this project.

The issuance of this report will begin the Departments resolution process. Please contact Alexander Matolyak, Audit Resolution Section, at 717 -783 -7786 if you have any questions concerning this audit.

Sincerely,

Tina L Long

Tina L. Long, CPA
Director

Enclosure

c: Mr. Timothy Costa
Mr. Blaine J Smith
Mr. Joseph Church
Mr. Philip E. Mader

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

December 15, 2011

Mr. Timothy Costa
Executive Deputy Secretary
Health and Welfare building
Room 333
Harrisburg, Pennsylvania 17120

Dear Mr. Costa:

In response to a request from the Office of Administration, the Bureau of Financial Operations (BFO), Division of Audit and Review (DAR) provided technical assistance in the review of Targeted Case Management (TCM) services claimed for federal reimbursement for calendar years 2006 through 2009.

The Department of Health and Human Services (HHS), Office of Inspector General (OIG) issued an audit dated September 2, 2009 of Pennsylvania's Targeted Case Management Services (TCM) under the Medicaid program. The audit included recommendations for the Department of Public Welfare (DPW) to review TCM claims submitted subsequent to the OIG audit period and report any necessary adjustments, and ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with Federal and State requirements. The OIG audit period was Calendar Years 2003 through 2005. In response to the OIG audit recommendations, the DPW Office of Administration appointed the Bureau of Financial Operations, (BFO) Division of Audit and Review, (DAR) to complete an analysis of the TCM services claimed for federal reimbursement for calendar years 2006 through 2009.

The report is considered a final and therefore contains the Office of Developmental Programs (ODP, Appendix C) and the Office of Mental Health and Substance Abuse (OMHSAS, Appendix D) views on the report findings and recommendations.

Results In Brief

Based on our analysis of 952 claims included in the 150 sampled beneficiary months, 12 claims totaling $627 were determined unallowable because the service did not comply with TCM federal and state requirements, and/or the service was not documented in the case notes. As a result of our sample, we estimate DPW claimed $ 6,710,820 ($3,777,521 Federal Share) for unallowable TCM services provided during the period January 1, 2006 through December 31, 2009. The OMHSAS and ODP share of the unallowable federal costs is $2,841,312 and $936,209 respectively. The $3,777,521 should be refunded to the Federal Government.

In response to the OIG audit recommendations, the OMHSAS issued guidelines to TCM providers in October 2010 which address standards for proper documentation, payment, and billing of TCM services. The guidelines reinforce and expand upon existing regulations. The OMHSAS is in the process of issuing the guidelines as a bulletin. We recommend the ODP issue a similar bulletin to its providers to update and consolidate previously issued TCM requirements included in various handbooks, guidelines, and bulletins. The bulletins will provide uniform standards and criteria for use by OMHSAS and ODP providers by ensuring TCM services are properly documented and billed in accordance with federal and state guidelines.

The OMHSAS also needs to evaluate whether the waiver of certain Chapter 5221 regulations provided to MCO's is beneficial to the Department in order to determine whether the wavier should be continued.

Background

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare and Medicaid Services (CMS) administer the program. Each State administers its Medicaid program in accordance with a CMS approved State plan. TCM services in Pennsylvania are handled by two separate offices within the DPW. These offices are the Office of Developmental Programs (ODP) and the Office of Mental Health and Substance Abuse (OMHSAS). For the period January 1, 2006, through December 31, 2009, Pennsylvania's Federal share for TCM services ranged between 54 and 66 percent.

Title XIX of the Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Specifically, Section 1915(g)(2) of the Act defines Medicaid case management as "services which will assist individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services." CMS refers to case management services as targeted case management when the services are furnished to specific populations in a State. CMS also defines what services qualify as TCM.

Pennsylvania's approved State Plan and State Plan Amendments (SPA) further describes services the State covers under this option. The State Plan allows TCM services be provided to individuals with a mental health or mental retardation diagnosis. The SPA describes the coverage of services furnished, recordkeeping requirements, and the payment method for services. TCM services are also provided through the DPW Medicaid managed care program named HealthChoices. The HealthChoices operational authority originates from two 1915b waivers approved by CMS.

In addition, OMHSAS further clarifies TCM services through DPW regulations 55 PA Code, Chapter 5221, which describe specific requirements providers must follow in order to be reimbursed for services provided. Chapter 5221, section 5221.33(4) (i) (B) states "case notes shall verify the necessity for the contact and reflect the goals and objectives of the intensive case management service plan." The DPW has further clarified recordkeeping

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requirements through various policy guidelines and bulletins issued to TCM service providers.

Objective, Scope and Methodology

Our objective was to determine whether TCM service costs claimed under the Medicaid program for the period January 1, 2006 through December 31, 2009 were properly documented in accordance with Federal and State requirements with identification of any necessary adjustments.

For the period January 1, 2006 through December 31, 2009, ODP and OMHSAS TCM service claims total $701,078,633 ($394,637,162 Federal Share).

In order to accomplish our objective, we:

- Reviewed Federal and State laws, regulations and other requirements.
- Interviewed DPW officials to determine how TCM services are provided and documented.
- Reviewed DPW's policies, procedures, and documentation requirements.
- Obtained TCM service costs which are claimed for Federal Reimbursement on Form CMS-64.
- Selected a random sample of 150 beneficiary-months for Medicaid-eligible beneficiaries. (See Appendix A for Sample Design and Methodology).
- Analyzed documentation from the case notes of 952 claims included in the 150 beneficiary months to determine if the activities performed and documented by the case managers were in compliance with federal and state requirements.
- Estimated, based on the sample results, the unallowable costs in the population of the beneficiary-months. (See Appendix B)

Our analysis of DPW claims for TCM services was performed to determine if TCM claims complied with Federal and State requirements. The claim analysis was performed as a non audit service as we did not extend our review of internal controls to the payment and billing process at the MCO's, County MH-MR Programs, providers, and DPW. Additionally, we did not reconcile claim data obtained from the ODP and OMHSAS data systems to the accounting records of the DPW Controller's office which support the claims reported on the Federal Reimbursement Form CMS-64. Technical assistance is defined by Government Auditing Standards as a non audit service, and therefore, the procedures performed, taken as a whole, cannot be described as being performed in accordance with generally accepted governmental auditing standards.

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Unallowable TCM Claims

The DPW's claims for TCM services did not always comply with Federal and State requirements. Based on our review of 952 claims included in our 150 sampled beneficiary months, 12 claims totaling $627 were determined to be unallowable. The services questioned did not comply with federal and state requirements and/or the service was not documented in the case notes. The $627 is comprised of three (3) ODP claims totaling $110 and nine (9) OMHSAS claims totaling $517. The reasons for the unallowable claims are as follows:

Service Did Not Comply With Federal and State Requirements

For seven (7) claims totaling $408, the documentation in the case notes identified the services did not relate to an allowable TCM service included in the State Plan. The specifics of the seven claims are as follows:

- For three OMHSAS claims totaling $223 the provider billed for a service provided to the consumer's parent, rather than the consumer.
- For one OMHSAS claim totaling $75, the provider billed for a service where the consumer was not present and the service did not benefit the consumer.
- For two ODP claims totaling $35, the service was for an unallowable administrative function.
- For one ODP claim totaling $75, eight units of travel time were billed for unnecessary travel.

Claims Not Documented

For five (5) claims totaling $219, the case notes were not provided and/or the case notes did not document the service. This did not allow a determination to be made on whether the service was provided or allowable. The specifics of the five claims are as follows:

- For four OMHSAS claims totaling $204, case notes were not provided.
- For one non MCO OMHSAS claim totaling $15, the reported service time did not qualify with the time requirements per OMHSAS regulations 5221.42(f).

Managed Care Contracts in OMHSAS

Managed Care Organization (MCO) expenditures represented 97% of the dollar value of OMHSAS services claimed during calendar 2006 through 2009. The MCO's receive a

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waiver of DPW's 55 PA CODE, section 5221.42, (b) (c) (e) (f) (g) and (h), which reference payment standards including time and travel billing requirements. Based on the wavier, there is no minimum time required to claim a unit of service. Our sample of MCO claims included examples of MCO's reimbursing providers for a unit of service which represented as little as one (1) minute of service time. Additionally, the wavier allows travel time which does not require the caseworker to be in face to face contact with the consumer.

Under the OMHSAS MA fee-for-service model which applies to non MCO's, in order to bill a unit of service regulation 5221.42(f) requires the provider to deliver "a quarter hour of service or portion thereof in which the case manager is in face to face or telephone contact with the consumer ..." .

The OMHSAS issued a letter dated 10/25/10 to County Administrators and MCO's which reiterated the findings reported in the OIG audit and provided guidelines for proper documentation, billing, and payment of TCM services. The guidance retains Chapter 5221 time and travel requirements and in some areas establishes stricter standards than required by Chapter 5221 regulations for documentation and billing. The MCO contracts allow a waiver of certain time and travel requirements included in both Chapter 5221 regulations and the October 2010 guidelines. This allows the MCO behavioral health providers to bill for a service unit which we identified is as low as one minute. This results in a high unit cost which is not justified in comparison to the service benefit received. OMHSAS needs to determine whether the minimal time required to bill a service unit should be allowed to continue through the wavier or whether all providers including the MCO'S should be governed by the Chapter 5221 regulations and the October 2010 guidelines.

ODP Needs to Issue Uniform TCM Billing and Documentation Requirements

The ODP billing and documentation requirements included in the State Plan, TCM Handbook, and various guidelines and bulletins conflict for certain billing and documentation requirements. For example, the ODP State Plan defines a unit of services as "a quarter hour or portion thereof" while the Handbook defines a unit as "15 minutes of billable service function or a major portion thereof" Another example is the State Plan does not address documentation of service time, while the TSM Handbook identifies seven requirements to include documentation of time by minutes and hours. The ODP needs to issue a bulletin to TCM providers which provide uniform TCM billing and documentation requirements. This will assist in ensuring future TCM services are in accordance with federal and state requirements.

Conclusion

For the period January 1, 2006 through December 31, 2009 DPW claimed $6,710,820 for TCM services that did not meet Federal and State requirements. The unallowable Federal Share of these claims or $3,777,521 should be refunded to the Federal Government.

OMHSAS should evaluate the waiver of 5221 regulations provided to the MCOs to determine if the value of services received justifies retention of the MCO wavier. OMHSAS and ODP should also issue a bulletin to TSM providers which provide uniform standards in

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ensuring TCM services are properly documented and billed in accordance with federal and state guidelines.

In accordance with our established procedures, an audit response matrix will be provided to ODP and OMHSAS. The ODP and OMHSAS will be responsible for completing the matrix and forwarding it to the DPW Audit Resolution Section within 60 days. The response to each recommendation should indicate ODP's and OMHSAS' concurrence or non-concurrence, the corrective action to be taken, the staff from ODP and OMHSAS responsible for the corrective action, the expected date that the corrective action will be completed, and any related comments.

Sincerely,

Tina L Long

Tina L. Long, CPA
Director

c: Mr. Kevin Friel
Mr. Blaine J. Smith
Mr. John Cox
Mr. Philip E Mader

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Appendix A

SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was Medicaid TCM services claimed for federal reimbursement during calendar years 2006 through 2009.

SAMPLING UNIT

The sample unit was a beneficiary month.

SAMPLE DESIGN

The sampling method used was a simple random sample.

SAMPLE SIZE

We selected a sample size of 150 beneficiary months The sample of 150 beneficiary months included 952 claims which were included in the review.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was a statistical software package.

METHOD FOR SELECTING SAMPLE ITEMS

The statistical software package uses the random number generator to determine what items would be picked from the population.

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SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Office of Developmental Programs (ODP)

Beneficiary -Months in Frame	Value of Frame (Federal & State)	Sample Size	Value of Sample Beneficiary -Months	Number of Beneficiary-Months With Documentation Errors	Value of Documentation Errors
5,229,328	$223,320,747	66	$14,770	3	$110

Estimated Dollar Value of Documentation Errors

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$1,663,188
Lower Limit	$1,411,982
Upper Limit	$1,947,383

Office of Mental Health and Substance Abuse (OMHSAS)

Beneficiary-Months in Frame	Value of Frame (Federal & State)	Sample Size	Value of Sample Beneficiary -Months	Number of Beneficiary-Months With Documentation Errors	Value of Documentation Errors
5,806,210	$477,757,886	84	$48,934	9	$517

Estimated Dollar Value of Documentation Errors

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$5,047,632
Lower Limit	$4,689,857
Upper Limit	$5,426,175

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ODP response to the BFO audit of TCM:

On May 26, 2010, DPW issued Developmental Programs Bulletin Number 00-10-06 which established policies and communicated requirements for the consistent statewide delivery of Supports Coordination services. The bulletin contained standards for the documentation of Supports Coordination service notes.

DPW is now using an automated billing system (HCSIS) which captures the units of service billed through the service notes. The Service Notes document all Supports Coordination activities performed or required by the Waiver. If service notes are not entered in HCSIS, units of service are not recorded.

ODP has also given Supports Coordination training to Supports Coordinators and SC Supervisors in each region of the State. The training curriculum, "Using Service Notes in HCSIS", is posted in HCSIS on the Learning Management System site for use by the Supports Coordinators. The training describes the use of service notes in HCSIS and is intended to help the Supports Coordinators to:

- Understand how Service Notes are used to track the health, welfare, service needs and provision of services for persons receiving ODP services and supports
- Know how the Service Definitions apply to Service Notes
- Identify how the content elements of Service Notes support the provision of services by the SC (billable and non-billable) and other approved services identified in the Individual Service Plan
- Understand when Service Notes should be entered in HCSIS
- Locate Service Notes in HCSIS
- Review the various types of Service Notes in HCSIS
- Review existing Service Notes for an individual in HCSIS
- Create Service Notes for interactions with the individual

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OMHSAS Response to draft BFO audit of Targeted Case Management

The Office of Inspector General (OIG) audit of Targeted Case Management covered calendar years 2003 through 2005. The engagement letter was sent by the OIG in February 2006. During 2008 and 2009, OMHSAS worked with counties and providers identified in the sample drawn by the OIG, to review claims and return case notes to the OIG. It was at this time that OMHSAS became aware that not all data was complete for the claims submitted.

The subsequent Targeted Case Management audit (by BFO) covers the period of 2006 through 2009. The auditor's sample was selected in September 2010. The Bureau of Financial Operations (BFO) review of case notes was completed in 2011 with the report planned to be issued to the Office of Inspector General in September 2011.

In terms of corrective action, it was in 2009 that OMHSAS began talking to counties about better reporting practices. OMHSAS developed a bulletin, Targeted Case Management Provider Billing Guidelines, to clarify Medicaid billing guidance and expectations for case management service providers in documentation, record retention, aggregating partial units of service, transportation of consumers, and travel. This bulletin is currently under review by the Office of Medical Assistance Programs (OMAP) within the Department of Public Welfare. A draft of the TCM bulletin is attached. The bulletin is expected to be issued by the end of 2011.

Additionally, in the winter of 2010, OMHSAS met with vendors and identified our expectation for revising the training curricula to reflect emphasis on billing, documentation, and record retention. While TCM training through our designated vendors is ongoing, the goal was to have the curricula updated and congruent with the dissemination of the bulletin. There is currently online training through Western Psychiatric Institute and Clinic (WPIC) and didactic instruction through Drexel University.

In summary, OMHSAS has taken steps to ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with Federal and State requirements. It is felt that the corrective actions already taken will ensure that the issues identified in the previous audits will not be repeated. The prior audits covered the years 2003 through 2009. Since OMHSAS started talking to counties and providers in 2009, we feel that any future audits of 2010 and beyond would be unnecessary.

Again, thank you for the opportunity to comment on the progress we have made on correcting deficiencies in provider documentation of, and record-keeping for, services billed to Medicaid.

OMHSAS, September 2011

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