



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Excessive Medicaid Payments to Federally Qualified Health Centers for Group Therapy Services

**Medicaid Program
Department of Health**



Executive Summary

Purpose

To determine if Medicaid reimbursement rates for group therapy services provided by Federally Qualified Health Centers were correctly applied. The audit covered the period June 1, 2008 through May 31, 2014.

Background

The Department of Health (Department) administers the State's Medicaid program in accordance with a federally approved Medicaid State Plan. The Department's many responsibilities include establishing Medicaid policies and procedures, certifying providers that participate in the program, and setting Medicaid reimbursement rates. With approval from the federal Centers for Medicare and Medicaid Services, the Department amended the Medicaid State Plan in 2008 to allow Federally Qualified Health Centers (FQHCs) to provide group therapy services, including group therapy provided by clinical social workers, to Medicaid recipients. FQHCs are organizations such as community health centers and public housing centers that provide primary and preventive care to underserved populations. There are 72 FQHCs in New York. Twenty-three provided group therapy services to Medicaid recipients during the audit period.

Key Findings

- Medicaid overpaid four FQHCs \$7.7 million because the FQHCs billed incorrect reimbursement rates on their claims for group therapy services. The FQHCs billed an approximate rate of \$200 per person for group therapy, as opposed to the required \$35.16 rate per person.
- To illustrate, a FQHC billed Medicaid for a group therapy session for eight recipients. The provider did not bill the appropriate FQHC payment rate of \$35.16 for group therapy, but rather billed a rate of \$203.45. As a result, Medicaid reimbursed the provider \$1,627.60 for the one-hour session (\$203.45 x 8 recipients). If the provider billed the appropriate FQHC rate, Medicaid would have reimbursed the provider only \$281.28 (\$35.16 x 8 recipients) for the session. Consequently, Medicaid overpaid the provider \$1,346.32 in this instance.

Key Recommendations

- Review and recover Medicaid overpayments totaling \$7.7 million.
- Clarify to the FQHCs that were overpaid how to properly bill Medicaid for group therapy services.
- Ensure all FQHCs bill Medicaid the correct reimbursement rate for group therapy services.

Other Related Audits/Reports of Interest

[Department of Health: Overpayments for Services Also Covered by Medicare Part B \(2012-S-27\)](#)
[Department of Health: Medicaid Claims Processing Activity October 1, 2011 Through March 31, 2012 \(2011-S-39\)](#)
[Department of Health: Medicaid Claims Processing Activity October 1, 2008 Through March 31, 2009 \(2008-S-155\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

November 18, 2014

Howard A. Zucker, M.D., J.D.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Excessive Medicaid Payments to Federally Qualified Health Centers for Group Therapy Services*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

Medicaid is a federal, State and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the year ended March 31, 2014, New York's Medicaid program had approximately 6 million enrollees and Medicaid claim costs totaled about \$50.5 billion. The federal government funded about 49.25 percent of New York's Medicaid claim costs, the State funded about 33.25 percent, and the localities (City of New York and counties) funded the remaining 17.5 percent.

The Centers for Medicare and Medicaid Services (CMS) oversees states' Medicaid programs. CMS issues regulations that set general parameters for the Medicaid program. Each state administers its Medicaid program in accordance with a CMS-approved Medicaid State Plan (Plan). The Plan dictates the policies and procedures that a state must follow in administering the Medicaid program, including those related to covered services and reimbursement methodologies. Any changes or amendments to the Plan require CMS approval.

The Department of Health (Department) administers New York State's Medicaid program. The Department's many responsibilities include establishing Medicaid policies and procedures, certifying providers that participate in the Medicaid program and setting Medicaid reimbursement rates. The Department is responsible for ensuring the Medicaid program meets all federal requirements.

In 2008, the Department amended New York's Medicaid State Plan to allow Federally Qualified Health Centers (FQHCs) to provide group therapy services, including group therapy provided by clinical social workers. FQHCs are organizations such as community health centers and public housing centers that provide primary and preventive care to underserved populations. Mental health and substance abuse services are among several required services. There are 72 FQHCs in New York. Twenty-three provided group therapy services to Medicaid recipients during the audit period.

Certain FQHCs providing group therapy services, including the providers we identified in this report, are dual-certified by the Department and the New York State Office of Alcoholism and Substance Abuse Services (OASAS). With dual certification, FQHCs providing Medicaid-funded services operate under the authority of operating certificates issued by both the Department (pursuant to Article 28 of the Public Health Law) and OASAS (pursuant to Article 32 of the Mental Hygiene Law). According to Department officials, while OASAS certifies facilities pursuant to Article 32 of the Mental Hygiene Law, rate setters within the Department calculate the actual Medicaid reimbursement amounts. According to the Plan amendment, rates of payment for group therapy are calculated by the Department. Using a CMS-approved methodology, the Department set a Medicaid reimbursement rate of \$35.16 (per person) for FQHC group therapy services effective June 1, 2008.

Audit Findings and Recommendations

Medicaid Overpayments for Federally Qualified Health Center Group Therapy Services

Incorrect Reimbursement Rates

Medicaid overpaid four FQHCs \$7.7 million from June 1, 2008 to May 31, 2014 because the FQHCs billed the wrong reimbursement rate for group therapy services. Medicaid should have paid the FQHCs a rate of \$35.16 per person for group therapy, not a rate of approximately \$200 per person. Further, one FQHC improperly billed an individual therapy rate when group therapy was actually provided. Table 1 summarizes the overpayments by FQHC.

Table 1

FQHC	Number of Claims	Incorrect Group Therapy Rate Paid *	Total Payment	Overpayment
FQHC 1	17,814	\$194.74	\$3,469,131	\$2,842,791
FQHC 2	11,722	\$198.20	\$2,323,356	\$1,911,211
FQHC 3	12,225	\$180.42	\$2,205,599	\$1,775,768
FQHC 4	2,753	\$178.94	\$ 492,620	\$ 395,825
Subtotal	44,514		\$8,490,706	\$6,925,595
FQHC	Number of Claims	Incorrect Individual Therapy Rate Paid *	Total Payment	Overpayment
FQHC 2	5,372	\$185.65	\$ 997,314	\$ 808,434
Total	49,886		\$9,488,020	\$7,734,029

* Average during period.

To illustrate, one FQHC billed Medicaid for a group therapy service in which eight recipients participated. The provider did not bill the appropriate FQHC payment rate of \$35.16 for group therapy, but rather billed a rate of \$203.45. As a result, Medicaid reimbursed the provider \$1,627.60 for the one-hour session (\$203.45 x 8 recipients). If the provider billed the appropriate FQHC rate, Medicaid would have reimbursed the provider \$281.28 for the one-hour group therapy session (\$35.16 x 8 recipients). Consequently, Medicaid overpaid the provider \$1,346.32 (\$1,627.60 - \$281.28).

Further, FQHC 2 incorrectly billed for individual therapy when group therapy was actually

provided. We visited this FQHC and reviewed medical records supporting a sample of 50 claims for individual sessions. Based on the information contained in the medical records, we determined group therapy was actually performed for all 50 claims. In addition, the FQHC's staff confirmed group therapy was performed and not individual sessions. During our audit period, the FQHC inappropriately billed 5,372 claims for individual sessions (at an average rate of \$185.65) when group therapy (rate of \$35.16) was actually provided. As a result, Medicaid overpaid these claims \$808,434.

Inadequate Department Oversight of Federally Qualified Health Center Group Therapy Implementation

In April 2008, the Department formally communicated the new FQHC rate for group therapy to all providers in the Medicaid Update (the official newsletter of the New York Medicaid program used to communicate policies, billing guidance, and other changes in the Medicaid program). The Medicaid Update specified that the new rate was effective for dates of service on or after June 1, 2008. The Medicaid Update further stated FQHCs would receive a notification letter regarding the new FQHC rate.

We reviewed the official notification letters the Department sent the four FQHCs identified in this report. The letter instructed the providers of the new FQHC group therapy rate and amount of \$35.16 to use, effective June 1, 2008. Despite this, the four FQHC providers continued to incorrectly bill Medicaid. Specifically, the providers billed a legacy rate established prior to the Plan amendment (that paid approximately \$200). The providers should have used the CMS-approved FQHC reimbursement rate established by the Department in 2008 for FQHC group therapy services.

Based on our review, we recommended that the Department immediately correct the providers' billing of FQHC group therapy to ensure future Medicaid payments to the providers are correct. We also recommended that the Department recover the overpayments made to the four providers. In the Department's response to our preliminary findings, officials agreed to ensure future payments to the providers are correct. However, the Department did not agree with our recommendation to recover the \$7.7 million in overpayments. While the Department agrees Medicaid should reimburse FQHCs the \$35.16 (per person per session) rate amount for group therapy services, the Department disagrees with the implementation date of the rate change. Department officials state the rate change was effective January 1, 2014, not June 1, 2008. Consequently, at the time of our audit fieldwork, Department officials planned to recover about \$130,000 in overpayments – instead of the \$7.7 million we identified. As such, the Department intends to allow the FQHCs to retain nearly \$7.6 million, which we believe were improperly claimed Medicaid payments.

We disagree with the Department's effective date of the rate change. The Department's 2008 amendment to the Medicaid State Plan required both CMS approval and amendments to the Department's Medicaid regulations and policies. Accordingly, in a letter dated September 15, 2006, the Department provided CMS with information regarding questions CMS had concerning the amendment of the Plan to permit FQHCs to provide group therapy. One of the questions CMS posed was whether the Department had developed rates for these services.

In responding to CMS's questions (and in fulfilling the requirement to issue public notice prior to the effective date of any change or amendment to the Plan), the Department attached a portion of the New York State Register, dated July 12, 2006, which provided a reimbursement rate for group therapy of approximately \$35. (The State Register plays a central role in New York's rule-making process by providing the public with information on the rule-making activities of State agencies and newly proposed amendments to State agency rules.) The Department also submitted a document to CMS entitled "Relative Based Relative Value System," which set forth the same rate for FQHC group therapy services.

Next, effective March 2008, Section 86-4.9 of the Department's regulations (10 NYCRR 86-4.9) was amended by adding subdivision (h) to authorize the provision of the FQHC group therapy services. It provides that reimbursement for these services shall be made on the basis of a FQHC group rate calculated by the Department for this specific purpose. As stated previously, the Medicaid Update, dated April 2008, provided the new rate for FQHC group therapy with an effective date of June 1, 2008, as did the official Medicaid notification letters to the providers.

According to Department officials, while OASAS certifies facilities pursuant to Article 32 of the Mental Hygiene Law, rate setters within the Department calculate the actual Medicaid reimbursement amounts. Further, according to the Plan, beginning on July 1, 2002, the Department is responsible for developing Medicaid fees for outpatient services provided by facilities OASAS certifies. During our audit, Department officials also stated FQHCs certified by OASAS and the Department should use the rates set forth in the 2008 Medicaid Update.

In the Department's response to our preliminary audit findings, officials stated they reviewed the appropriateness of the approximate \$200 rate paid for FQHC group therapy during the period in question and determined the amount was appropriate based on their analysis of non-FQHC rates. Specifically, the Department based their \$200 rate calculation and January 1, 2014 effective date on a new Medicaid outpatient payment methodology, called Ambulatory Patient Groups (APGs), which became effective July 1, 2011 for OASAS clinic providers. (Note: the 72 FQHC providers in New York could choose to opt into the new APG payment methodology or continue to receive their existing non-APG payment rates. The four FQHC providers identified in our audit did not opt into APGs.) Officials stated providers receiving the new APG rates received reimbursement amounts that were based on a blending of the existing non-APG rates with the new APG rates over a phase-in period which the Department stated ended December 31, 2013. As such, Department officials assert the – CMS-approved – group therapy rate of \$35.16 for the FQHCs became effective January 1, 2014, at the time other non-FQHC providers were at the full APG rate payment.

After reviewing the Department's comments to our preliminary findings, we maintain that the effective date of the \$35.16 rate was June 1, 2008. Further, our review of FQHC group therapy rates paid to other FQHCs certified by either OASAS, OMH (Office of Mental Health), or the Department during the period 2008 to current showed a \$35.16 rate amount for these services. The providers we identified in this audit had ample notice of the rate change. We, therefore, recommend that the Department review and recover the \$7.7 million in overpayments we identified, and immediately correct the method in which the four FQHCs bill Medicaid for group therapy.

Recommendations

1. Review and recover, as warranted, the Medicaid overpayments totaling \$7.7 million for group therapy services provided by the four FQHCs we identified.
2. For the FQHCs we identified, clarify how to properly bill Medicaid for group therapy services. Ensure all FQHCs bill the proper Medicaid reimbursement rate for group therapy services.

(Auditor's Note: In their formal response to the draft audit report, Department officials presented a detailed history of Medicaid reimbursement methodologies and practices for certain types of facilities. However, much of the information presented was extraneous or did not relate directly to the specific matter addressed by our report. Department officials contended that the implementation date of the rate reduction (from about \$200 to \$35.16 per person) for group therapy was January 1, 2014 for the FQHCs in question. However, there was no written directive prior to our audit fieldwork which indicated that January 1, 2014 was the implementation date for the rate reduction for the FQHCs. In fact, the Department sent each of the four FQHCs included in our audit a letter stating that \$35.16 was the correct billing rate for group therapy services, effective June 1, 2008.¹ Consequently, we maintain our conclusion that the four FQHCs received excessive payments totaling nearly \$7.7 million, which should be recovered.)

Audit Scope and Methodology

The objective of our audit was to determine whether Medicaid reimbursement rates for group therapy services provided by FQHCs were correctly applied. Our audit covered the period June 1, 2008 through May 31, 2014.

To accomplish our objectives and assess internal controls related to our audit objective, we interviewed officials from the Department and the Office of Alcoholism and Substance Abuse Services. We reviewed the Department's policies, guidance and procedures for establishing Medicaid payment rates. We also reviewed applicable federal and State regulations. We analyzed Medicaid claims FQHCs billed for group therapy services and calculated overpayment amounts in accordance with New York's Medicaid State Plan and the Department's Medicaid reimbursement policies. In addition, we visited one of the largest FQHCs and examined medical records supporting a judgmental sample of 50 Medicaid claims for group therapy services.

We conducted our 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹Two facilities became FQHCs after June 1, 2008; therefore, their rate effective dates were August 1, 2008 and April 9, 2010, respectively (the date each became an FQHC and could begin billing FQHC group therapy services).

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials agree the rate for Article 32 FQHC group therapy services should be reduced to \$35.16 (from about \$200). However, officials disagree that the implementation date of the rate reduction was June 1, 2008; rather, officials contended the implementation date was January 1, 2014. Consequently, officials believe overpayments totaling approximately \$130,000 should be recovered, not \$7.7 million as our audit concludes. Our rejoinders to several Department comments are included in the report's State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

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Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health



Sue Kelly
Executive Deputy Commissioner

August 12, 2014

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2013-S-51 entitled, "Excessive Medicaid Payments to Federally Qualified Health Centers for Group Therapy Services."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in cursive script that reads "Sue Kelly".

Sue Kelly
Executive Deputy Commissioner

enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgersen
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2013-S-51 Entitled
Excessive Medicaid Payments to Federally Qualified
Health Centers for Group Therapy Services**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-51 entitled, "Excessive Medicaid Payments to Federally Qualified Health Centers for Group Therapy Services."

General Comments:

Background

A. Rate Setting Authority

The Department of Health (the Department) administers New York State's Medicaid program. As the single state agency for Medicaid rates, the Department is charged with developing reimbursement methodologies for Medicaid services. Prior to May, 2013, this responsibility was exercised concurrently with the several offices that assist the Department.

The Department has, historically, been responsible for the oversight of facilities licensed under Article 28 of the health law. This includes hospitals, nursing homes, diagnostic and treatment facilities and other such facilities.

The Department has, historically, delegated oversight of facilities licensed under the Mental Hygiene Law (MHL). Facilities licensed under the MHL include substance abuse disorder and mental health facilities that are administered by the Office for Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH) and the Office for People with Developmental Disabilities (OPWDD).

These historic practices are exercised pursuant to New York State's "State Plan" for Medicaid Services. The State Plan and its numerous amendments are negotiated with the Centers for Medicare and Medicaid Services (CMS) and set the general parameters of the Medicaid services to be reimbursed by the State. The authority of the Department and the several Offices to set rates are derived from statute, and in addition, the State Plan.

The oversight responsibilities of the Department and such offices include rate-setting authority for the reimbursement of Medicaid services. Thus, prior to 2013, the Department held general rate-setting authority, but the offices exercised rate-setting authority for the Medicaid services administered by such office.

Since May, 2013, the Department and the Offices have been engaged in the consolidation of rate-setting authority solely within the Department.

B. Reimbursement for Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs), are licensed under federal law and thus governed by federal regulations. FQHCs are eligible for enhanced reimbursement rates and are subject to different requirements than facilities licensed under state law. FQHCs may hold dual licensure under Articles 28 and 32.

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Comment
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* See State Comptroller's Comments on Page 18.

FQHCs are reimbursed according to a prospective payment system (PPS). A PPS rate is a method of reimbursement whereby payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.

i. Reimbursement under Article 28

Prior to January 1, 2008, the Department reimbursed FQHCs pursuant to a threshold rate described below. Subsequent to such time, the Department has reimbursed Article 28 services pursuant to a new payment methodology, the Ambulatory Patient Group (APGs). APGs is a service specific reimbursement methodology. That is to say, the rate paid under APGs are specific to a diagnosis code and refer to the service provided. APGs have been phased in by the Department across provider groups.

One notable exception to APGs have been FQHCs. Prior to January 1, 2014, FQHCs had discretion to opt into the APG system or continue with the PPS rate. The facilities at issue all declined to opt into APGs.

ii. Reimbursement under Article 32

Prior to January 1, 2014, FQHCs licensed under Article 32 received a “threshold rate,” as their PPS rate, which is a single, fixed rate for any services provided per patient per visit. Such rate is called a “threshold rate” because, once a patient crosses the threshold of an FQHC for any service or group of services, the FQHC is eligible to receive the fixed reimbursement amount per patient. A threshold rate represents an average across services. That is to say, the threshold rate is not a rate based on the reimbursement of any particular service, but rather, represents total service costs divided by total patient visits.

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Comment
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Subsequent to January 1, 2014, FQHCs licensed under Article 32 of the Mental Hygiene Law will receive rates derived from the APG methodology currently in place for FQHCs licensed under Article 28 of the Public Health Law.

iii. Reimbursement for Group Therapy Services

Prior to 2008, the Department did not reimburse Article 28 facilities for group therapy. CMS objected to Department policy, at least with regard to FQHCs. CMS insisted that the Department develop a rate for group therapy services. The Department, which, at this time (pre-2008) was reimbursing FQHCs pursuant to a threshold rate, objected to paying the threshold for all of the individuals within a group therapy session. The Department submitted that it should not reimburse a single service (group therapy) with multiple payments (for each individual in the group therapy session). Ultimately, CMS agreed and negotiated a lesser reimbursement rate for group therapy services. As discussed, the Department subsequently developed a different methodology for reimbursement of FQHCs.

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Comment
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Prior to 2008, OASAS did, in fact, reimburse Article 32 facilities for group therapy. As discussed, OASAS utilized a threshold rate for FQHC reimbursement. Thus, FQHCs licensed under Article 32 received their threshold rate for group therapy services.

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Comment
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Issue

At issue is the reimbursement of FQHCs. Specifically, such FQHCs that are dually licensed under Article 28 and Article 32.

Recommendation #1:

Review and recover as warranted the Medicaid overpayments totaling \$7.7 million for group therapy services provided by the FQHCs we identified.

Response #1:

The Office of the State Comptroller (OSC) is of the opinion that Medicaid overpaid dually licensed FQHCs approximately \$7.7 million from June 1, 2008 to May 31, 2014 because the FQHCs billed the wrong reimbursement rate for group therapy services. The OSC states, in its draft report, "Medicaid should have paid the FQHCs a rate of \$35.16, not a rate of approximately \$200 per person."

Within the OSC's analysis, the Department's negotiated rate with CMS is referenced (\$35.16), as well as the threshold rate reimbursed by OASAS (\$200). According to the OSC, the Department's negotiated rate for group therapy services was in effect as of June 1, 2008 and such rate should have applied to all group therapy services, regardless of the classification of such service (i.e., whether such service was provided in an Article 28 or Article 32 context).

The OSC recommends recoupment of \$7.7 million from such providers.

The Department disagrees based on the facts presented below.

Department of Health Response to OSC Concerns

As discussed above, prior to 2013, rates for services reimbursed by the Department and the offices were effectively "siloeed." That is to say, although rates were developed by the Department, each office made the policy decisions that would determine what services would be reimbursed and the acceptable level of reimbursement for such services. This historic practice is the crux of the OSC's position.

A. OASAS was mandated by law to set both its reimbursement rates and methodology

Pursuant to subdivision (a) of section 43.02 of the mental hygiene law, which states, as follows:

"Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of Article five of the social services law for services provided by any facility licensed by the OMH pursuant to Article thirty-one of this chapter or licensed or operated by the OPWDD pursuant to Article sixteen of this chapter or certified by the OASAS pursuant to this chapter to provide inpatient chemical dependence services, as defined in section 1.03 of this chapter, shall be at rates or fees certified by the commissioner of the respective office and approved by the Director of the Division of the Budget, provided, however, the commissioner of mental health shall annually certify such rates or fees which may vary for distinct geographical areas of the state and, provided, further, that rates or fees for service for inpatient psychiatric services or inpatient chemical dependence services, at hospitals otherwise licensed pursuant to Article twenty-eight of the public health law shall be established in accordance with section two thousand eight hundred seven of the public health law."

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Comment
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OASAS was required to determine rates and methodology of reimbursement for facilities licensed under Article 32 of the mental hygiene law.

When OASAS policy makers determined that group therapy services would be a reimbursable service, such service was subject to the reimbursement methodology chosen by OASAS, in this case, threshold rates.

Thus, although the Department assisted in calculation of rates and the technical implementation of such rates, each office, including OASAS, made the policy decisions that impacted the reimbursement of services.

B. The actual issue is with the threshold rate methodology

The OSC objects to different rates provided for the same service under different reimbursement methodologies. As discussed, both the Department and OASAS were required, by separate statutory regimes (i.e., Public Health and Mental Hygiene, respectively) to develop methodologies for reimbursement.

The Department, beginning in 2008, transitioned to a service specific methodology called APGs. OASAS utilized a different methodology, called a threshold rate, which was not service specific, but instead was an average across services. Threshold rates, because they are an average across all services provided, may sometimes distort the reimbursement of a single specific service.

In this case, the OSC believes that the threshold rate was too high for group therapy services, and instead the services should have been reimbursed at the Department's negotiated rate.

However, the Department's rate was not available to Article 32 services. Services reimbursed under the FQHC reimbursement regime are to be paid under the classification of such service. In this case, the only reimbursement rate available for services provided to a patient with a substance abuse diagnosis was the threshold rate.

As noted previously, the OSC objects to the threshold rate as being too high for the services rendered. However, this objection is actually an objection to the threshold methodology, which, due to being an average across services, resulted in a higher reimbursement for group therapy services.

C. The billing codes were valid and appropriate

Threshold rates are valid CMS approved rates, derived according to a CMS approved methodology. The non-Ambulatory Patient Group (APG) rate code (4275) for Article 32 services should be brought to the \$35 level for (FQHCs) at the time other non-FQHC providers are at the full APG rate payment. At APG implementation for Article 32 services, the APG rate was calculated using a phase-in by blending the existing payment rate with the APG payment rate. This phase-in calculation was effective from the implementation date through December 31, 2013.

As discussed above, services under Article 32 were reimbursed under a different system than those services provided under Article 28. In order to receive a threshold rate, the patient being treated is required to have a diagnosis of chemical or substance abuse. That is to say, the diagnosis of the patient drives the services provided to such patient. In the instance where a patient suffers from chemical dependence, treatment at an Article 32 licensed FQHC where chemical and substance abuse services are available is appropriate. This is true even if the FQHC in question is also licensed under Article 28.

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Comments
2, 3, 5

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Comment
5

D. Group therapy services provided under article 32 are different than those provided under Article 28

Article 32 clinics and Article 28 clinics are separate and distinct entities, even where a clinic is licensed to provide services under both regulatory regimes.

Group therapy services provided in an Article 28 setting may or may not be appropriate for a person with a chemical dependence.

Further, different counselors and level of care are required for services under the two regulatory regimes.

Given the difference between such services, it is no surprise that some services that are provided to Article 32 patients are not reimbursable in the Article 28 setting.

For example, art therapy is not a recognized therapy in the Article 28 setting, yet can be utilized and may be reimbursed for Article 32 services.

Thus, although the OSC has taken the stance that group therapy is a service that must be reimbursed at the same level across all clinics, it is not true that the services are the same, nor that the reimbursement for such services should necessarily be the same.

E. The implementation date of January 1, 2014 is consistent with Department policy across other industries

Consistent with the adoption of APGs in other settings, the Department has recommended a January 1, 2014 implementation date for the negotiated reimbursement rate of \$35.16. As discussed in the OSC's draft report, FQHCs have had the option of opting into APGs. As of January 1, 2014, that option is no longer available and all FQHCs are subject to the APG methodology.

Providers receiving the new APG rates received reimbursement based on a blend of the existing non-APG rates with the new APG rates during a transition period that ended December 31, 2013. As noted above, APGs are service specific reimbursement.

The lower rate for group therapy services provided by FQHCs, that was developed for Article 28 group therapy services, and paid using rate code 4011, should be paid for Article 32 group therapy services, however, the Department disagrees with the OSC implementation date of the rate change and the \$7.7 million recoupment. The OSC is adjusting the rate retroactively back to August 1, 2008, however, the Department is implementing this rate change for rate code 4275 effective January 1, 2014.

As of January 1, 2014, providers will receive the full APG rate payment and the blending will no longer occur. FQHCs are to receive an enhanced rate and, since the non-FQHCs are receiving the benefit of the higher 4275 rate due to the phase-in period, FQHCs should still receive the benefit of the higher rate. Once the non-FQHCs are no longer receiving a benefit of the higher rate due to the phase-in period ending and the prior existing payment rate has been completely eliminated from their payment, then the FQHCs should no longer receive the higher rate. Based on the phase-in schedule for APGs, FQHC providers for Article 32 group therapy services should receive the lower group therapy rate effective January 1, 2014. The impact has been calculated as (\$131,390).

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Comment
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Rate codes 4273 and 4274 have also been updated in our analysis of the FQHC rate in effect on October 1, 2013 as FQHC rates are required to be increased every year on October 1st by the Medicare Economic Index (MEI). However, the group therapy 4275 rate is not affected by the MEI since this rate is a price that has been approved by CMS and will not be updated.

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Comment
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The Department believes that because FQHCs were not required to adopt the reimbursement methodology until January 1, 2014, such date should control any potential recoupment.

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Comment
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F. Recoupment for the period recommended would expose the Department to an unacceptable litigation risk

Regardless of the Department's objections to the findings by the OSC, the OSC's recommended course of action would expose the Department to an unacceptable litigation risk.

Were the Department to move forward and recoup the \$7.7 million alleged overpayment, there exists a high likelihood of potential lawsuits. The outcome of such litigation is uncertain and the Department may, in fact, expose itself to further fees and costs associated with litigation.

Conclusion

The Department respectfully disagrees with the findings made by the OSC. The Department believes that, at all times, facilities were reimbursed appropriately, according to their licensure. The Department will decline to recover such alleged overpayments, provided, however, that any such reimbursements made subsequent to January 1, 2014 may be subject to recoupment.

Based on this information, the Office of the Medicaid Inspector General (OMIG) may review and recover, after determination by the Department and the OASAS, as to appropriateness of claims cited in error by OSC.

Recommendation #2:

Clarify to the FQHCs we identified on how to properly bill Medicaid for group therapy services. Ensure all FQHCs bill the proper Medicaid reimbursement rate for group therapy sessions.

Response #2:

OASAS and the Department agree that communication and clarification to the remaining two OASAS FQHC providers is necessary. ACCESS Community Health Care, formally AHRC, Inc. and Project Renewal, Inc., were notified by OASAS in a direct communication dated April 24, 2014.

Lutheran Medical Center, Provider Numbers 02996078 and 00243729 have opted into APGs; they are no longer affected by this issue since they do not bill the FQHC rate codes.

State Comptroller's Comments

1. We agree FQHCs are licensed under federal law and are thus governed by federal regulations. Therefore, FQHCs are subject to different requirements than facilities licensed solely under State law. Further, federal law generally supersedes State law. Accordingly, the facilities' federal FQHC designation took precedent over Article 28-Health or Article 32-OASAS designations under State law.

During the State Medicaid Plan (Plan) amendment process, the Department objected to Medicaid paying approximately \$200 for each person in a group therapy session, and CMS agreed. As a result, using a CMS-approved methodology, the Department set a reimbursement rate of \$35.16 (per person) for FQHC group therapy services effective June 1, 2008. Further, the Plan and Medicaid regulations confirm the approved rate of about \$35 for FQHC group therapy services and the corresponding effective date of June 1, 2008 – regardless of an FQHC's certification status under either Article 28 or Article 32 of the applicable State laws. Nevertheless, it was not until August 5, 2014 (after the completion of our audit fieldwork) that the Department actually reduced the rate, from approximately \$200 to \$35.16.

2. As stated on page 7 of our report, FQHCs (including those not the subject of our audit) that were certified by OASAS, OMH and/or the Department from 2008 to now received non-threshold reimbursement rates of \$35.16 (per person) for FQHC group therapy services. Thus, the \$35.16 rate was available for all FQHCs, including those provided in an Article 32 setting, for billing group therapy services.
3. The Department asserts that the CMS-approved rate of \$35 for group therapy applied to FQHCs certified under Article 28-Health, but not those certified under Article 32-OASAS. We disagree. In fact, neither the amended Plan nor the amended regulations distinguish between FQHCs certified under Article 28 or Article 32. Moreover, the Department sent each FQHC included in our audit a letter specifically stating that the \$35.16 rate should be billed by the FQHCs for their group therapy services, effective June 1, 2008 (see footnote 1) - regardless of whether or not the FQHC was certified under Article 28 or Article 32.
4. The Department's citation for OASAS rate-setting authority is misleading. The Department states OASAS was mandated by law to set its reimbursement rates and methodology, but then cites a section of Mental Hygiene Law pertaining to rates for inpatient chemical dependency services. Our audit, however, did not address inpatient services. Rather, we addressed outpatient (group therapy) services. Moreover, OASAS officials informed us that the Department (and not OASAS) calculated the reimbursement rates for outpatient services (including group therapy) performed in Article 32-certified facilities. As stated in our report and State Comptroller's Comment 1, the Department set a Medicaid reimbursement rate of \$35.16 for FQHC group therapy services effective June 1, 2008.
5. The Department's statements are contradictory. Officials state "the only reimbursement rate available for services provided to a patient with a substance abuse diagnosis was the threshold rate." However, officials also indicated that FQHCs had the discretion to opt into the Ambulatory Patient Group (APG) system and receive an APG rate (instead of the threshold rate) at that time. APG implementation for Article 32 services began in July 2011.

Further, according to the Department, January 1, 2014 was chosen as the effective date of the rate reduction due, at least in part, to the implementation of APGs in Article 32 facilities. According to Department officials, the FQHC providers identified in our audit should be brought to the \$35.16 level at the same time non-FQHC providers were brought to the full APG rate payment. However, the adoption of APGs is irrelevant to our findings. In fact, the facilities in question declined to opt into APGs and chose to be paid predetermined fixed rates established specifically for FQHCs. Furthermore, the Department's assertion is inconsistent with its position that FQHCs are an exception to the APG methodology, and it is also inconsistent with the manner in which other FQHC providers (certified by OASAS, OMH, and/or the Department) were paid for group therapy during our audit period.

6. The Department notes a rate change for individual therapy services (codes 4273 and 4274). However, our audit did not address the propriety of those rates. Rather, our audit focused on group therapy services.
7. We are pleased that the Department acknowledges that the FQHC providers should receive \$35.16 per person for Article 32 group therapy services and that overpayments totaling \$131,390 should be recovered. However, we are concerned that the Department will apparently forgo recoveries of nearly \$7.6 million in excessive payments. The Department provides no clear rationale why taxpayers should have paid nearly \$200 for the service in question prior to January 1, 2014 when the very same service costs \$35.16 after that date. As such, we encourage Department officials to reassess our audit findings and take the appropriate actions to implement our recommendation to recover all excessive payments.