

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CALIFORNIA CLAIMED  
MILLIONS OF DOLLARS IN  
UNALLOWABLE FEDERAL MEDICAID  
REIMBURSEMENT FOR SPECIALTY  
MENTAL HEALTH SERVICES**

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# *Office of Inspector General*

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## Report in Brief

Date: August 2018

Report No. A-09-15-02040

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



### Why OIG Did This Review

California provides Medicaid specialty mental health services (SMHS) through county-run managed-care mental health plans (health plans). California reviews a random sample of SMHS claims submitted by each health plan once every 3 years (triennial reviews). From October 2010 through June 2014, California determined that 33 percent of the claims reviewed included services not eligible for Federal reimbursement. However, it collected overpayments only for the SMHS claims it reviewed. Therefore, we conducted this review to estimate the unallowable Federal reimbursement that California claimed for fiscal year (FY) 2014 for SMHS claims that it did not review. At the Federal level, the Centers for Medicare & Medicaid Services administers the Medicaid program.

Our objective was to determine whether California complied with Federal and State requirements when claiming Federal reimbursement for SMHS expenditures.

### How OIG Did This Review

For FY 2014, for service lines totaling \$1.4 billion in Federal reimbursement, we reviewed a stratified random sample of 500 service lines submitted by 43 health plans. (We excluded service lines that were part of California's triennial reviews.) California's medical review staff determined whether the 500 service lines were allowable and, using those results, we estimated the unallowable Federal reimbursement claimed.

## California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services

### What OIG Found

California did not always comply with Federal and State requirements when claiming Federal reimbursement for SMHS expenditures. Of the 500 sampled service lines, 411 complied with requirements. However, 89 service lines did not comply with requirements. For the 89 service lines, the services were not supported by documentation that established medical necessity, the services were not supported by a client plan or progress notes, or no SMHS were provided. On the basis of our sample results, we estimated that California claimed at least \$180.6 million in unallowable Federal reimbursement.

California claimed unallowable Federal reimbursement because its oversight was not effective in ensuring that its SMHS claims complied with Federal and State requirements. Although California issued guidance and provided training and technical support to the health plans, the plans continued to report to California unallowable expenditures as allowable expenditures. In addition, although California's triennial reviews were effective in identifying unallowable expenditures, California did not ensure that adequate corrective action was taken. We found repeat deficiencies at some health plans; that is, at least one service line with a similar deficiency to one that California identified in its previous review of the health plan.

### What OIG Recommends and California Comments

We recommend that California (1) refund to the Federal Government \$180.6 million for unallowable Federal reimbursement claimed for SMHS expenditures and (2) strengthen its oversight of the health plans to ensure that SMHS claims comply with Federal and State requirements. The "Recommendations" section in the body of the report lists in detail our recommendations.

California agreed with our second recommendation and provided information on actions that it had taken or planned to take to address our recommendation. However, California disagreed with our first recommendation. California included comments from the health plans with their determinations that some service lines in our sample had supporting documentation and requested that we consider this information before finalizing our recommendations. At our request, California's medical review staff examined the additional information, and we adjusted our findings and the amount of our recommended refund as appropriate.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

The California Department of Health Care Services (State agency) provides Medicaid specialty mental health services (SMHS) under a waiver approved by the Centers for Medicare & Medicaid Services (CMS). These services are provided through county-run mental health plans (health plans). The State agency reviews a random sample of SMHS claims submitted by each health plan once every 3 years. From October 2010 through June 2014, the State agency determined that 33 percent of the SMHS claims that it reviewed included services not eligible for Federal reimbursement. However, the State agency collected overpayments only for the SMHS claims that it reviewed. Therefore, we conducted this review to estimate the unallowable Federal reimbursement that the State agency claimed for fiscal year 2014 (October 2013 through September 2014) for SMHS claims that it did not review.

### **OBJECTIVE**

Our objective was to determine whether the State agency complied with Federal and State requirements when claiming Federal reimbursement for SMHS expenditures.

### **BACKGROUND**

#### **Medicaid Program**

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In California, the State agency administers the Medicaid program. Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The State agency reports to CMS its expenditures related to Medicaid claims on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). CMS uses the Form CMS-64 to reimburse States for the Federal share of Medicaid expenditures.

#### **Specialty Mental Health Services**

SMHS are special health care services for people who have a mental illness or an emotional disturbance that a general practitioner cannot treat. SMHS are provided to children and adults who meet specific medical necessity requirements related to their diagnosed mental health conditions and related impairments. These services may be provided by a variety of

practitioners, such as psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, and licensed professional clinical counselors.

The State agency provides SMHS under a Medicaid waiver authorized by section 1915(b)(4) of the Social Security Act (the Act) and approved by CMS.<sup>1</sup> The waiver states that these services are provided through the Prepaid Inpatient Health Plan managed-care model.<sup>2</sup> The State agency contracts with 56 county-run health plans, which provide SMHS directly through county owned and operated providers or arrange for these services through contracts with private providers. In California, SMHS include rehabilitative mental health services, psychiatric inpatient hospital services, and targeted case management, among others. Appendix B contains a complete list of the types of SMHS that may be provided under the waiver.

### **Eligibility for Federal Reimbursement of Specialty Mental Health Services**

To be eligible for Federal reimbursement, SMHS must be medically necessary and adequately supported by a client plan and progress notes.

#### *Medical Necessity*

Federal law requires services under the Prepaid Inpatient Health Plan model to be sufficient in amount, duration, and scope to achieve the purpose of the services furnished.<sup>3, 4</sup> States are also permitted to place appropriate limits on a service on the basis of criteria such as medical necessity.<sup>5</sup>

The State agency's Medicaid waiver states that, for SMHS to be eligible for Federal reimbursement, a beneficiary must have at least one diagnosis identified in State regulations,<sup>6</sup> and the provider must document the following:

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<sup>1</sup> A 1915(b) waiver allows a State to implement an alternative delivery system for its Medicaid program as long as that system is cost effective, efficient, and consistent with the principles of the program (42 CFR § 431.55).

<sup>2</sup> A Prepaid Inpatient Health Plan (1) provides services to enrollees under contract with the State and on the basis of capitation payments or other payment arrangements that do not use State-plan payment rates; (2) provides, arranges for, or otherwise has responsibility for providing any inpatient hospital or institutional services to its enrollees; and (3) does not have a comprehensive risk contract (42 CFR § 438.2).

<sup>3</sup> The Act § 1903(i); 42 CFR § 438.210(a)(3)(i).

<sup>4</sup> After our audit period (October 1, 2013, through September 30, 2014), CMS updated its managed-care regulations effective July 5, 2016 (81 Fed. Reg. 27498). In this report, we cite the regulations that were in effect during our audit period, which contain identical language; only the numbering differs.

<sup>5</sup> 42 CFR § 438.210(a)(3)(iii) (2014).

<sup>6</sup> Appendix C contains a list of the diagnoses that the State agency identified for which SMHS are eligible for Federal reimbursement.

- For nonhospital SMHS, the provider must document that the beneficiary has certain functional impairments and that the intervention will address those impairments and be expected to reduce symptoms.
- For psychiatric inpatient hospital SMHS, a provider must document that the beneficiary cannot be safely treated at a lower level of care and has certain symptoms or behaviors or requires admission for treatment that can reasonably be provided only if the beneficiary is hospitalized.

### *Client Plan*

Health plans are responsible for producing a client plan, which is a written plan for the provision of SMHS to a beneficiary.<sup>7</sup> For SMHS to be eligible for Federal reimbursement, an initial client plan is generally required to be completed within 60 days of the date the provider admitted the beneficiary and should be updated at least annually or when there are significant changes in the beneficiary's condition.<sup>8</sup> Certain services, including but not limited to rehabilitation and therapy, require a client plan to be in place before services are provided. Other services, which are not required to be in a client plan, may be provided before the client plan is in place (such as assessment and plan development) or in crisis situations (such as crisis intervention and stabilization).

### *Progress Notes*

A provider's progress notes must describe how the SMHS provided to a beneficiary reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan.<sup>9</sup> The progress notes must document, among other things, the relevant aspects of the beneficiary's care, the interventions applied, the beneficiary's responses to the interventions, the signatures of the persons providing the services, and the amount of time taken to provide services.<sup>10</sup>

### **State Agency Oversight of Mental Health Plans**

Under its CMS-approved Medicaid waiver, the State agency is required to provide oversight to ensure that the claims submitted for SMHS meet medical necessity requirements for reimbursement and that the documentation in the medical records provides evidence that

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<sup>7</sup> California Code of Regulations (CCR), 9 CCR §§ 1810.205.2 and 1810.440(c).

<sup>8</sup> Mental Health Services Division Information Notice No. 12-05, Enclosure 4: Reasons for Recoupment (Reasons for Recoupment).

<sup>9</sup> 9 CCR § 1810.440(c) and the State agency's contracts with the health plans.

<sup>10</sup> 9 CCR § 1810.440(c) and the State agency's contracts with the health plans.

medical necessity requirements were met. To help ensure that the health plans submit allowable SMHS claims, the State agency issues information notices containing program guidance and provides training and technical support to the health plans.

Under its CMS-approved waiver, the State agency is also required to review a random sample of SMHS claims submitted by each of the health plans once every 3 years<sup>11</sup> to ensure compliance with Federal and State laws and regulations and State contractual requirements. The waiver specifically states that, when the State agency identifies deficiencies in claims it reviews, the corresponding amounts claimed that are not eligible for Federal reimbursement (i.e., disallowances) are determined in accordance with Reasons for Recoupment.<sup>12</sup> Reasons for Recoupment also references the applicable Federal and State requirements and terms in the State agency's contracts with the health plans. The waiver further provides that disallowances are calculated using only the claims for services selected for review and that the State agency will not estimate a disallowance attributable to all claims submitted by the health plan during the period under review. After finishing its review of a health plan, the State agency issues a report to the health plan, collects any amounts disallowed, and requests that it create a plan of correction to identify how it will address any identified deficiencies.

From October 2010 through June 2014, the State agency determined that 33 percent of the SMHS claims that it reviewed had deficiencies that resulted in a disallowance.

## **HOW WE CONDUCTED THIS REVIEW**

For October 1, 2013, through September 30, 2014, the State agency claimed \$1,461,221,801 (Federal share) in medical assistance expenditures for SMHS provided under the Medicaid waiver. We excluded from our review service lines,<sup>13</sup> totaling \$26,872,894 (Federal share), that had been voided,<sup>14</sup> had immaterial or no Federal reimbursement, were reviewed by the State agency during its triennial reviews, or were not included in both the claim processing and payment systems' data files.<sup>15</sup> From the remaining service lines, totaling \$1,434,348,907 (Federal share), we reviewed a stratified random sample of 500 service lines. These service lines were submitted by 43 of the 56 health plans.

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<sup>11</sup> These reviews are referred to as "triennial reviews."

<sup>12</sup> Each year, the State agency issues to the health plans a new version of Reasons for Recoupment. The requirements in those versions issued from 2010 through 2014 did not substantially change over that period.

<sup>13</sup> A service line represented one or more SMHS included on a claim.

<sup>14</sup> Health plans void service lines to remove their claims for the services.

<sup>15</sup> The Short-Doyle Medi-Cal II claim processing system contains claim data submitted by the health plans. The USL Financial payment system contains payment data, which is the basis for the State agency's claim for Federal reimbursement.

The State agency’s medical review staff determined whether the 500 sampled service lines were allowable in accordance with Federal and State requirements. Using the unallowable amounts that the medical review staff identified, we estimated the unallowable Federal reimbursement claimed for SMHS expenditures.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

### FINDINGS

The State agency did not always comply with Federal and State requirements when claiming Federal reimbursement for SMHS expenditures. Of the 500 sampled service lines, 411 complied with requirements. However, 89 service lines did not comply with requirements. Table 1 summarizes the deficiencies noted and the number of service lines that contained each type of deficiency.

**Table 1: Summary of Deficiencies in Sampled Service Lines**

Deficiency	Number of Unallowable Service Lines*
Services were not supported by documentation that established medical necessity	33
Services were not adequately supported by a client plan	29
Services were not adequately supported by progress notes	27
No SMHS were provided	12

\* The total exceeds 89 because 12 service lines contained more than 1 deficiency.

On the basis of our sample results, we estimated that the State agency claimed at least \$180,689,611 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because its oversight was not effective in ensuring that its SMHS claims complied with Federal and State requirements. Although the State agency issued guidance and provided training and technical support to the health plans, the plans continued to report to the State agency unallowable expenditures as allowable expenditures. In addition, although the State agency’s triennial reviews were effective in identifying unallowable expenditures, the State agency did not ensure that adequate corrective action was taken. We found repeat deficiencies at some health plans; that

is, at least one service line with a similar deficiency to one that the State agency identified in its previous review of the health plan.

## **THE STATE AGENCY IMPROPERLY CLAIMED SPECIALTY MENTAL HEALTH SERVICES**

### **Services Were Not Supported by Documentation That Established Medical Necessity**

For SMHS to be eligible for Federal reimbursement, a beneficiary must have at least one diagnosis identified by the State agency (9 CCR §§ 1820.205(a)(1) and 1830.205(b)(1)), and the medical record must establish the following:

- For nonhospital services, the focus of the proposed intervention addresses the beneficiary's mental health condition, and the proposed intervention is expected to significantly diminish the beneficiary's impairment, prevent significant deterioration in an important area of life functioning, or allow a child to progress developmentally as individually appropriate (9 CCR § 1830.205(b)(3)).
- For psychiatric inpatient hospital services, the beneficiary cannot be safely treated at a lower level of care and has certain symptoms or behaviors (9 CCR § 1820.205(a)(2)).<sup>16</sup>

For 33 sampled service lines, the services were not supported by documentation that established medical necessity:

- For 23 service lines for nonhospital services, the medical records did not show that the focus of the intervention was to address the beneficiary's mental health condition or that the proposed intervention would be expected to significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, or allow a child to progress developmentally as individually appropriate. For example, the medical records for a beneficiary diagnosed with bipolar affective disorder, a type of mood disorder, showed that she was provided assistance with creating a financial budget and writing a narrative justifying an increase in her weekly spending. The State agency's medical review staff determined that the records did not support that this assistance addressed the beneficiary's mental health condition or would diminish the beneficiary's impairment or prevent significant deterioration.
- For nine service lines for psychiatric inpatient hospital services, the medical records did not document that the beneficiaries could not have been treated at a lower level of care or did not document that the beneficiaries had certain symptoms or behaviors. In one example, the medical records documented that the beneficiary was cooperative,

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<sup>16</sup> The symptoms or behaviors are those that (1) represent a current danger to self or others; (2) prevent the beneficiary from providing for or utilizing food, clothing, or shelter; (3) present a severe risk to the beneficiary's physical health; or (4) represent a recent, significant deterioration in ability to function (9 CCR § 1820.205(a)(2)(B)(1)).

calm, alert, oriented, and medication compliant; had no suicidal or homicidal ideation; and had denied experiencing auditory hallucinations. The records also documented that no behavioral problems were observed. The State agency's medical review staff determined that this beneficiary could have been treated at a lower level of care.

- For one service line, the service was provided to a beneficiary who did not have one of the diagnoses identified by the State agency.

### **Services Were Not Adequately Supported by a Client Plan**

Providers must maintain medical records that fully disclose the extent of the services provided to individuals receiving Medicaid services authorized under the State plan (the Act § 1902(a)(27)). States must ensure that health plans produce a treatment plan (i.e., a client plan) for a beneficiary with special health care needs (42 CFR § 438.208(a)(2)). Each health plan must establish a quality management program that includes, among other elements, a beneficiary documentation and medical records system (9 CCR § 1810.440(c)). The system includes client plans and documentation of the beneficiaries' participation in and agreement with the client plans (9 CCR § 1810.440(c)). This documentation may include (1) the beneficiary's signature on the client plan or (2) a reference in the client plan or a description in the medical record of the beneficiary's participation in and agreement with the client plan (9 CCR § 1810.440(c)(2)).

For 29 sampled service lines, the services were not adequately supported by a client plan:

- For 20 service lines, a client plan was not in place that included the service at the time the service was provided.
- For nine service lines, the medical record did not contain a client plan signed by the beneficiary or other documentation of the beneficiary's participation in and agreement with the client plan.

### **Services Were Not Adequately Supported by Progress Notes**

The State agency must recover overpayments to providers for payments determined to be for services not documented in the provider's records (22 CCR § 51458.1(a)(3)). The State agency's contracts with the health plans state that the plans must ensure that the progress notes in the beneficiary's medical record contain the signature, or electronic equivalent, of the person providing the service.

Depending on the type of service, services may be billed in minutes, hours, half or full days, or calendar days. For services billed in minutes, the exact number of minutes used by persons providing a reimbursable service must be reported and billed (9 CCR § 1840.316(b)(1)). When a person provides a service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary (9 CCR § 1840.316(b)(2)). When more than

one person provides a service to more than one beneficiary at the same time, the time used by all those providing the service must be added together to yield the total claimable services (9 CCR § 1840.316(b)(2)). For services billed on the basis of hours, each 1-hour block that the beneficiary receives services may be claimed (9 CCR § 1840.322(b)(2)).

A half day must be billed for each day in which a beneficiary receives face-to-face services for a minimum of 3 hours and no more than 4 hours per day (9 CCR § 1840.318(b)(1)). A full day must be billed for each day in which a beneficiary receives face-to-face services for more than 4 hours per day (9 CCR § 1840.318(b)(2)).

For 27 sampled service lines, the services were not adequately supported by progress notes in the beneficiary medical records:

- For 13 service lines, the health plan could not provide progress notes.
- For five service lines, the progress notes did not document the length of time of the service.
- For four service lines, the number of minutes or hours claimed was greater than what was documented in the progress notes.
- For two service lines, services were billed as a full day, but the progress notes indicated that fewer than 4 hours of face-to-face services were provided.
- For one service line, the progress notes were not signed by the person who provided the service.
- For one service line, an error was made in the progress notes, and the service was billed for 10 hours and 10 minutes instead of 20 minutes.
- For one service line, a group therapy service was provided for which the progress notes did not identify the number of participating beneficiaries or providers, and the apportionment of the time could not be determined.

### **No Specialty Mental Health Services Were Provided**

SMHS include rehabilitative mental health services; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; targeted case management; and psychiatric inpatient hospital services (9 CCR § 1810.247). Each health plan must certify to the State agency that the services included on a claim were actually provided to the beneficiary (9 CCR § 1840.112(b)(3)). Health plans may not claim Federal reimbursement when a beneficiary misses an appointment (California Department of Mental Health Letter No. 02-07 (Nov. 19, 2002)).

For 12 sampled service lines, no SMHS were provided:

- For eight service lines, the services documented in the progress notes were not SMHS. In one example, the progress notes documented the steps that the provider took in identifying the address and phone number of a residential home that a hospital wanted to discharge the beneficiary to.
- For three service lines, services were not provided to the beneficiary. In each instance, a service was provided to a beneficiary who was not the beneficiary identified on the sampled service line.
- For one service line, the beneficiary did not attend the session, i.e., missed the appointment.

### **THE STATE AGENCY CLAIMED AT LEAST \$180.6 MILLION IN UNALLOWABLE FEDERAL REIMBURSEMENT**

On the basis of our sample results, we estimated that the State agency claimed at least \$180,689,611 in unallowable Federal reimbursement for SMHS expenditures.

### **THE STATE AGENCY'S OVERSIGHT WAS NOT EFFECTIVE IN ENSURING COMPLIANCE WITH FEDERAL AND STATE REQUIREMENTS**

The State agency claimed unallowable Federal reimbursement because its oversight was not effective in ensuring that its SMHS claims complied with Federal and State requirements:

- Although the State agency issued guidance and provided training and technical support to the health plans, the plans continued to report service lines that did not meet requirements, as shown by our sample results. Specifically, the health plans continued to submit claims (1) for services that were not supported by documentation that established medical necessity, (2) for services that were not adequately supported by a client plan or progress notes, and (3) when no SMHS were provided.
- Although the State agency's triennial reviews were effective in identifying unallowable expenditures, the State agency did not ensure that adequate corrective action was taken, resulting in repeat deficiencies. Of the 43 health plans that had at least 1 service line in our sample, 25 had at least 1 unallowable service line with a deficiency identified. Of these 25 health plans, 12 had repeat deficiencies; that is, at least 1 service line with a similar deficiency to one that the State agency identified in its previous review of the health plan.<sup>17</sup> In total, 47 of the 89 deficiencies we identified were repeat deficiencies.

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<sup>17</sup> The deficiencies identified in this review that were similar to those identified by the State agency were for dates of services at least 180 days after the State agency's last triennial review.

- Although the State agency required each health plan to develop and submit a plan of correction, the State agency did not have policies and procedures to follow up on the implementation of the plan of correction to ensure that the health plan was compliant until the next triennial review.

During our review, State agency officials told us that the State agency was making changes to its oversight procedures to address noncompliance with Federal and State requirements and included in its waiver renewal application dated June 10, 2015, a description of the oversight procedures that it was considering implementing. Specifically, the State agency indicated that it would conduct more frequent and focused reviews of the health plans; provide additional training and technical assistance to the plans; and impose fines, sanctions, or penalties on the plans. Because these procedures were proposed after our audit period, we did not verify that they were implemented or assess their effectiveness.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund to the Federal Government \$180,688,616 for unallowable Federal reimbursement claimed for SMHS expenditures<sup>18</sup> and
- strengthen its oversight of the health plans to ensure that SMHS claims comply with Federal and State requirements by:
  - implementing oversight procedures, such as conducting more frequent and focused reviews of the health plans, providing additional training and technical assistance to the plans, and imposing fines, sanctions, or penalties on the plans;
  - assessing whether those oversight procedures are effective and, if they are not effective, identifying and implementing additional oversight procedures; and
  - implementing policies and procedures to follow up on the implementation of each health plan’s plan of correction in a timely manner.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency agreed with our second recommendation and provided information on actions that it had taken or planned to take to address our recommendation. However, the State agency disagreed with our first

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<sup>18</sup> As a result of our audit, one health plan voided a claim totaling \$995 for one of the unallowable service lines in our sample. Consequently, we removed the \$995 that the State agency claimed in Federal reimbursement for this service line from the \$180,689,611 in estimated unallowable reimbursement to arrive at the recommended refund of \$180,688,616.

recommendation. As an appendix to its comments, the State agency included comments from the health plans for some of the service lines in our sample and its own summary of those comments and requested that we consider the information in the comments before finalizing our recommendations. The State agency also provided technical comments on our draft report, which we addressed as appropriate.

The State agency's comments, including the State agency's summary of the health plans' comments, appear as Appendix F. We did not include the health plans' comments because of their length. We also did not include the State agency's technical comments.

## **STATE AGENCY COMMENTS**

Regarding our first recommendation, the State agency commented that it acknowledged the historical concerns with the documentation and claiming process for SMHS expenditures and that it has been working closely with the health plans over the past several years to strengthen its oversight and improve compliance with Federal and State requirements. The State agency indicated that, although it believes compliance has improved significantly since our audit period, such progress was not fully evaluated or reflected in our recommendations. In addition, the State agency commented that it believed the extrapolation used to calculate our recommended refund amount would negatively impact the delivery of SMHS and undermine the recent improvements made.

Further, in its summary of the health plans' comments, the State agency commented that the health plans disagreed with our first recommendation. It also commented that the health plans, after a review of medical records, had determined that supporting documentation and evidence existed for 29 of the 105 unallowable service lines that we identified in our draft report and requested that we revise our determinations.

Regarding our second recommendation, the State agency commented that it is conducting more frequent and focused reviews of the health plans; providing additional training and technical assistance to the plans; and imposing fines, sanctions, or penalties on the plans. The State agency also commented that it (1) will analyze and assess the effectiveness of oversight procedures on an annual basis (beginning in 2019) and (2) has added policies and procedures for State agency staff to follow up on health plans' plans of correction, including a validation process and site validation visits.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Regarding our first recommendation, we did not review SMHS expenditures claimed after our audit period. Consequently, we could not evaluate the SMHS program during more recent years or reflect in our recommendations any improvements to the program.

At our request, the State agency's medical review staff examined the health plans' additional information for the 29 sampled service lines that the plans identified as being allowable and

determined that 16 service lines were allowable and 13 service lines were unallowable.<sup>19</sup> We adjusted our findings and the amount of our recommended refund to reflect the results of the State agency's redeterminations.

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<sup>19</sup> For 1 of the 13 sampled service lines, the State agency's medical review staff reduced the amount that was disallowed.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

For October 1, 2013, through September 30, 2014, the State agency claimed \$1,461,221,801 (Federal share) in medical assistance expenditures for SMHS provided under the Medicaid waiver. We excluded from our review service lines, totaling \$26,872,894 (Federal share), that had been voided, had immaterial or no Federal reimbursement, were reviewed by the State agency during its triennial reviews, or were not included in both the claim processing and payment systems' data files. From the remaining service lines, totaling \$1,434,348,907 (Federal share), we reviewed a stratified random sample of 500 service lines. These service lines were submitted by 43 of the 56 health plans.

The State agency's medical review staff determined whether the 500 sampled service lines were allowable in accordance with Federal and State requirements. Using the unallowable amounts that the medical review staff identified, we estimated the unallowable Federal reimbursement claimed for SMHS expenditures.

Our objective did not require a review of the overall internal control structure of the State agency. Therefore, we limited our internal control review to the State agency's procedures for reporting SMHS expenditures on the Form CMS-64 and reviewing claims submitted by health plans.

We performed fieldwork at the State agency's offices in Sacramento, California.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed the State agency's Medicaid State plan and its SMHS Medicaid waiver;
- reviewed the State agency's health plan contract terms;
- interviewed State agency officials to obtain an understanding of the State agency's policies and procedures for claiming SMHS expenditures;
- reviewed the State agency's reports containing the results of its triennial reviews conducted from October 2010 through June 2014 and compiled the findings;
- obtained SMHS claims that the State agency reviewed during its triennial reviews;

- obtained SMHS claim data from the State agency’s claim processing and payment systems for our audit period;
- reconciled the claim data amounts with the amounts that the State agency reported on the Form CMS-64;
- selected a stratified random sample of 500 service lines from the sampling frame (Appendix D);
- obtained from the health plans medical records for the 500 sampled service lines and provided the records to the State agency’s medical review staff;
- obtained the results of the State agency’s medical review for the sampled service lines and:
  - compared those results with the results of the State agency’s triennial reviews to identify any repeat deficiencies at each health plan and
  - using the unallowable amounts identified by the State agency’s medical review staff, estimated the unallowable Federal reimbursement claimed for SMHS expenditures (Appendix E); and
- discussed the results of our review with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: TYPES OF SPECIALTY MENTAL HEALTH SERVICES

SMHS consist of the following services:

- rehabilitative mental health services, including:
  - mental health services,
  - medication support services,
  - day treatment intensive,
  - day rehabilitation,
  - crisis intervention,
  - crisis stabilization,
  - adult residential treatment services,
  - crisis residential treatment services, and
  - psychiatric health facility services;
- psychiatric inpatient hospital services;
- targeted case management;
- psychiatrist services;
- psychologist services;
- EPSDT supplemental SMHS; and
- psychiatric nursing facility services.<sup>20</sup>

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<sup>20</sup> 9 CCR § 1810.247.

## APPENDIX C: BENEFICIARY DIAGNOSES FOR WHICH SPECIALTY MENTAL HEALTH SERVICES ARE ELIGIBLE FOR FEDERAL REIMBURSEMENT

For SMHS to be eligible for Federal reimbursement, a beneficiary must have one of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, Fourth Edition (1994), published by the American Psychiatric Association:<sup>21</sup>

- pervasive developmental disorders;
- disruptive behavior and attention deficit disorders;
- feeding and eating disorders of infancy or early childhood;<sup>22</sup>
- tic disorders;
- elimination disorders;
- other disorders of infancy, childhood, or adolescence;
- cognitive disorders (only dementias with delusion or depressed mood);
- substance-induced disorders (only with a psychotic, mood, or anxiety disorder);
- schizophrenia and other psychotic disorders;
- mood disorders;
- anxiety disorders;
- somatoform disorders;<sup>23</sup>
- factitious disorders;
- dissociative disorders;

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<sup>21</sup> 9 CCR §§ 1820.205(a)(1) and 1830.205(b)(1). The DSM, Fifth Edition (2013), revised some of these diagnoses. In its waiver renewal application dated June 10, 2015, the State agency said that it was reviewing and analyzing the diagnostic codes affected by the Fifth Edition and that it would make a determination regarding the impact on the SMHS program.

<sup>22</sup> Called avoidant/restrictive food intake disorders in the DSM, Fifth Edition.

<sup>23</sup> Called somatic symptom and related disorders in the DSM, Fifth Edition.

- eating disorders;
- paraphilias;
- gender identity disorders;<sup>24</sup>
- intermittent explosive disorder;
- pyromania;
- impulse control disorders not elsewhere classified;
- adjustment disorders;<sup>25</sup>
- personality disorders; and
- medication-induced movement disorders related to other included diagnoses.

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<sup>24</sup> Called gender dysphoria in the DSM, Fifth Edition.

<sup>25</sup> Called stress-response syndromes in the DSM, Fifth Edition.

## APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

Our target population consisted of SMHS expenditures that the State agency claimed for Federal reimbursement on the Form CMS-64 for the quarters ended December 31, 2013, through September 30, 2014.

### SAMPLING FRAME

We obtained from the State agency Medicaid claim data files containing SMHS expenditures, which consisted of 13,886,150 service lines totaling \$1,461,221,801 (Federal share).

We removed 473 service lines that had \$0 in Federal reimbursement, 114,370 service lines totaling \$12,571,439 (Federal share) that had been voided, and 8,545 service lines totaling \$2,217,462 (Federal share) that State agency had reviewed during its triennial reviews. Additionally, we removed 93 service lines totaling \$9,409 (Federal share) that were not included in both the claim processing and payment systems' data files.

We established a materiality level of \$20 or more and removed 1,041,928 service lines that had a reimbursement amount of less than \$20, totaling \$12,074,584 (Federal share).

After we removed these service lines, our sampling frame consisted of 12,720,741 service lines totaling \$1,434,348,907 (Federal share).

### SAMPLE UNIT

The sample unit was an individual service line for one or more SMHS provided to a beneficiary.

### SAMPLE DESIGN AND SAMPLE SIZE

We selected a stratified random sample of 500 sample units, with 150 sample units for each of the first 3 strata and 50 sample units for the fourth stratum. Table 2 describes the four strata.

**Table 2: Description of Strata**

Stratum	Sample Size	No. of Service Lines	Payment Range	Value (Federal Share)
1	150	7,614,817	\$20 to \$99.99	\$439,546,209
2	150	3,306,444	\$100 to \$174.99	426,283,784
3	150	1,671,499	\$175 to 549.99	429,286,260
4	50	127,981	\$550 to \$33,141.30	139,232,654
<b>Total</b>	<b>500</b>	<b>12,720,741</b>		<b>\$1,434,348,907</b>

## **SOURCE OF RANDOM NUMBERS**

We used the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software to generate the random numbers.

## **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units in each of the four strata. After generating the random numbers for each stratum, we selected the corresponding frame items in each of the strata.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of unallowable Federal reimbursement for SMHS expenditures. To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

**APPENDIX E: SAMPLE RESULTS AND ESTIMATES**

**Table 3: Sample Details and Results**

<b>Stratum</b>	<b>No. of Service Lines in Sampling Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Unallowable Service Lines</b>	<b>Value of Unallowable Service Lines (Federal Share)</b>
1	7,614,817	\$439,546,209	150	\$8,637	43	\$1,973
2	3,306,444	426,283,784	150	18,878	19	2,314
3	1,671,499	429,286,260	150	37,430	16	3,554
4	127,981	139,232,654	50	50,836	11	10,469
<b>Total</b>	<b>12,720,741</b>	<b>\$1,434,348,907</b>	<b>500</b>	<b>\$115,781</b>	<b>89</b>	<b>\$18,310</b>

**Table 4: Estimated Value of Unallowable SMHS Expenditures (Federal Shares)**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	\$217,559,288
Lower limit	180,689,611
Upper limit	254,428,965

## APPENDIX F: STATE AGENCY COMMENTS

### Department of Health Care Services Response to: The Office of the Inspector General's report entitled, *California Claimed Hundreds of Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services*

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#### **Finding #1: The state did not always comply with Federal and State requirements when claiming Federal reimbursement for SMHS expenditures.**

For 41 sampled service lines, the services were not medically necessary:

- For 28 service lines for nonhospital services, the medical records did not show that the focus of the intervention was to address the beneficiary's mental health condition or that the proposed intervention would be expected to significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, or allow a child to progress developmentally as individually appropriate. For example, the medical records for a beneficiary diagnosed with bipolar affective disorder, a type of mood disorder, showed that she was provided assistance with creating a financial budget and writing a narrative justifying an increase in her weekly spending. The State agency's medical review staff determined that the records did not support that this assistance addressed the beneficiary's mental health condition or would diminish the beneficiary's impairment or prevent significant deterioration.
- For nine service lines for psychiatric inpatient hospital services, the medical records did not document that the beneficiaries could not have been treated at a lower level of care or did not document that the beneficiaries had certain symptoms or behaviors. In one example, the medical records documented that the beneficiary was cooperative, calm, alert, oriented, and medication-compliant; had no suicidal or homicidal ideation; and had denied experiencing auditory hallucinations. The records also documented that no behavioral problems were observed. The State agency's medical review staff determined that this beneficiary could have been treated at a lower level of care.
- For four service lines, the services were provided to beneficiaries who did not have one of the diagnoses identified by the State agency.

For 39 sampled service lines, the services were not adequately supported by a client plan:

- For 27 service lines, a client plan was not in place that included the service at the time the service was provided.
- For 12 service lines, the medical record did not contain a client plan signed by the beneficiary or other documentation of the beneficiary's participation in and agreement with the client plan.

For 25 sampled service lines, the services were not adequately supported by progress notes in the beneficiary medical records (1 service line had multiple deficiencies):

- For 11 service lines, the health plan could not provide progress notes.
- For five service lines, the progress notes did not document the length of time of the service.

- For four service lines, the number of minutes or hours claimed was greater than what was documented in the progress notes.
- For two service lines, the progress notes were not signed by the person who provided the service.
- For two service lines, services were billed as a full day, but the progress notes indicated that fewer than 4 hours of face-to-face services were provided.
- For one service line, an error was made in the progress notes, and the service was billed for 10 hours and 10 minutes instead of 20 minutes.
- For one service line, a group therapy service was provided for which the progress notes did not identify the number of participating beneficiaries or providers, and the apportionment of the time could not be determined.

For 14 sampled service lines, no SMHS were provided:

- For 10 service lines, the services documented in the progress notes were not SMHS. In one example, the progress notes documented the steps that the provider took in identifying the address and phone number of a residential home that a hospital wanted to discharge the beneficiary to.
- For three service lines, services were not provided to the beneficiary. In each instance, a service was provided to a beneficiary who was not the beneficiary identified on the sampled service line.
- For one service line, the beneficiary did not attend the session, i.e., missed the appointment.

On the basis of the sample results, the OIG estimated the State agency claimed at least \$230,065,438 in unallowable Federal reimbursement for SMHS expenditures.

**Recommendation 1:** The OIG recommends that the State agency refund to the Federal Government \$230,065,438 for unallowable Federal reimbursement claimed for SMHS expenditures.

**Response:** **DHCS disagrees with the recommendation.**

The Department acknowledges the historical concerns with the documentation and claiming process for SMHS expenditures in California. The Department has been working closely with its county mental health plans (MHPs) over the past several years to strengthen oversight and improve compliance with federal and state rules. This intensive work, as described in more detail below, has led to a significant decrease in disallowance rates across the counties. Specifically, overall triennial disallowance rates decreased from 35 percent in FY12/13 to 18 percent in FY15/16 (a 17 percentage point reduction) and from 47 percent in FY13/14 to 10 percent in FY16/17 (a 37 percentage point reduction). Preliminary findings from the current fiscal year are showing similar results. The State believes that while compliance with SMHS claiming has significantly improved, such progress was not fully evaluated nor reflected in the immediate draft audit report recommendations. Due to the significant improvement in

disallowance rates, the State believes the extrapolation used to calculate the recommended refund amount does not reflect recent efforts, and would negatively impact the delivery of services to adults and children in need of specialty mental health services in California and undermine the recent improvements made.

Furthermore, counties reviewed the specific disallowed claim lines and have identified new information related to a limited number of claim lines that indicate that those particular claim lines may have been allowable. This new information includes beneficiary-specific information in some instances, and is being forwarded as an appendix to this response. Based on the significant amount of recoupment and its impact on California's mental health delivery system, we request that the OIG review these specific claim examples and consider this new information before finalizing its recommendations.

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**Finding 2: The state agency's oversight was not effective in ensuring compliance with Federal and State requirements.**

The State agency claimed unallowable Federal reimbursement because its oversight was not effective in ensuring that its SMHS claims complied with Federal and State requirements:

- Although the State agency issued guidance and provided training and technical support to the health plans, the plans continued to report service lines that did not meet requirements, as shown by our sample results. Specifically, the health plans continued to submit claims (1) for services that were not medically necessary, (2) for services that were not adequately supported by a client plan or progress notes, and (3) when no SMHS were provided.
- Although the State agency's triennial reviews were effective in identifying unallowable expenditures, the State agency did not ensure that corrective action was taken, resulting in repeat deficiencies. Of the 43 health plans that had at least 1 service line in our sample, 28 had at least 1 unallowable service line with a deficiency identified. Of these 28 health plans, 15 had repeat deficiencies; that is, at least 1 service line with a similar deficiency to one that the State agency identified in its previous review of the health plan. In total, 56 of the 105 deficiencies we identified were repeat deficiencies.
- Although the State agency required each health plan to develop and submit a plan of correction, the State agency did not have policies and procedures to follow up on the implementation of the plan of correction to ensure that the health plan was compliant until the next triennial review.

**Recommendation 2:** The OIG recommends that the State agency strengthen its oversight of the health plans to ensure that SMHS claims comply with Federal and State requirements by:

- Implementing oversight procedures, such as conducting more frequent and focused reviews of the health plans, providing

additional training and technical assistance to the plans, and imposing fines, sanctions, or penalties on the plans;

- Assessing whether those oversight procedures are effective and, if they are not effective, identifying and implementing additional oversight procedures
- Implementing policies and procedures to follow up on the implementation of each health plan's plan of correction in a timely manner.

**Response:**

**DHCS agrees with the recommendation.**

To provide context for this audit response, it is important to acknowledge three important factors. The first is that DHCS has had a heightened focus on decreasing MHP disallowance rates over the past few years, and significant efforts have been made by both DHCS and the MHPs to address the long-standing disallowance rates issue. As noted above, these collective efforts have resulted in dramatic improvements in disallowance rates found the triennial reviews conducted over the past two fiscal years, and are continuing to improve in the current fiscal year. The second factor is that the majority of identified claim disallowances resulted from non-compliance with documentation requirements even though valid services were provided to eligible beneficiaries. Very few claims in a single fiscal year are disallowed because the client does not meet medical necessity criteria. Rather the disallowances result when the documentation in the medical record does not technically establish how the intervention and impairment criteria are addressed by the service provided. Most claims are disallowed because treatment plan requirements are not met (e.g., not signed by the client) and/or progress notes do not tie to the diagnosis. So, although the beneficiary almost always meets the mental health diagnostic and impairment medical necessity criteria, the documentation of the treatment does not clearly demonstrate that the interventions were appropriate or met technical requirements (e.g., signatures). Finally, SMHS are authorized in California's State Plan under the Medicaid rehabilitation option; therefore, there is a broader range of covered service modalities to provide assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. This introduces complexity with documentation since these services do not directly address the mental health symptoms, but rather address issues experienced by beneficiaries as a result of their

mental health condition and associated functional impairment (e.g., helping a beneficiary who has major depression to develop a plan to seek employment if it is an identified goal and/or functional impairment on the treatment plan). Clinicians often find it challenging to document these rehabilitative services in a manner that meets the specified documentation requirements. We recognize the difficulty this poses and are examining ways to address and make improvements in this area.

Within this context, and relevant to this OIG recommendation, DHCS included an enhanced monitoring plan in its CMS-approved 1915(b) SMHS Waiver in an effort to strengthen State oversight and improve MHP compliance with regard to state, federal and contractual requirements. This Enhanced Monitoring Framework defines a tiered review structure, which includes seven tiers delineated by compliance percentiles, criteria for tier identification, and monitoring activities representing a continuum of progressive corrective actions. The continuum includes monitoring activities ranging from technical assistance to focused reviews and levying fines, sanctions, and penalties.

#### **Implementing Oversight Procedures**

As part of the Enhanced Monitoring Framework, DHCS is conducting more frequent and focused reviews of the health plans, providing additional training and technical assistance to the plans, and imposing fines, sanctions, or penalties on the plans, as described below:

**More Frequent and Focused Reviews:** DHCS conducts more frequent and focused reviews, including additional chart reviews, of a county MHP if it determines there are significant or long-standing issues with non-compliance. For example, DHCS may conduct focused chart reviews to determine whether the MHP has corrected identified compliance issues related to documentation and claiming. DHCS is in the process of scheduling focused reviews for at least two MHPs during 2018 based on results from their most recent review.

**Statewide Technical Assistance and Training:** DHCS continues to provide technical assistance and training to MHPs on documentation requirements by developing and providing multi-media training and technical assistance, including teleconferences, webinars, and site trainings, as well as posting training materials on the DHCS website for MHPs to access and reference. Currently, DHCS is working on the development of electronic training modules to train the MHPs on documentation requirements, best practices for clinical documentation, as well as how to develop and implement an effective plan of correction (POC). The goal of the POC training is to improve the corrective action process and outcomes by implementing practices focused on quality improvement techniques. These electronic training modules will be posted and available online the latter part of 2018 for MHPs to access and use to improve their local processes.

In addition, in January 2018, DHCS instituted monthly individual calls with each MHP. These calls are intended to monitor and follow up on non-compliance issues and the implementation of each MHP's POC in a timely manner. These calls will also help determine needed technical assistance, training or other issues. In February 2018, DHCS began providing statewide monthly quality improvement and technical assistance conference calls open to all MHPs.

**Fines, Sanctions, and Penalties:** DHCS is in the process of establishing an appropriate structure and process for implementing Sanctions, Fines, and Penalties (SFP) at the MHP level based on findings of non-compliance. DHCS will determine a SFP model and begin implementing by mid-2018. The model will be used in coordination with findings that result from the triennial reviews and Enhanced Monitoring Framework, as well as other findings from other sources.

#### **Assessing the Effectiveness of the Enhanced Monitoring Framework**

On an annual basis, beginning 2019, DHCS will analyze and assess the effectiveness of oversight procedures, including triennial reviews and the Enhanced Monitoring Framework. DHCS will identify and implement additional oversight procedures, if and when needed.

#### **Implementing Timely POC Follow-Up Policies and Procedures**

Triennial reviews will continue as the foundation of monitoring for the continuum of enhanced monitoring activities, and MHPs will still be required to submit a POC in response to all findings of non-compliance. As an enhancement, DHCS has added policies and procedures for DHCS staff to follow up on the MHP POC, which include a POC validation process and POC Site Validation Visits.

- **POC Validation:** The validation process entails reviewing, analyzing, and scoring the MHPs' POCs to determine the likelihood that the MHPs' corrective actions will result in compliance with Federal and State requirements, as well as MHP Contract requirements. As a part of the validation process, DHCS requires the MHPs to submit revised POCs if DHCS determines that the POC is not likely to be effective. The process is designed to ensure the MHPs develop specific strategies to address findings of non-compliance, and that the MHPs' corrective actions will result in sustainable improvements. This monitoring activity was implemented in Fiscal Year 2016/2017.

Once DHCS completes the validation process and approves the MHP's POC, on a regular basis DHCS monitors the MHPs' corrective actions. This includes following up with the MHPs to determine the status of POC implementation and the effectiveness of corrective actions, as well as providing technical assistance and instructing the MHPs about additional improvements to further ensure compliance. MHPs are required to submit evidence of their quality improvement (QI) through the submission of quarterly reports to DHCS documenting evidence of its QI actions implemented to address findings of non-compliance. These quarterly reports are required until DHCS determines the corrective actions have effectively addressed the findings of non-

compliance. If corrective actions are not determined to be adequate and/or effective, DHCS requires the MHPs to refine and/or implement new corrective actions and QI efforts. Beginning 2017/2018 this activity requires identified MHPs to submit quarterly reports to DHCS of the MHPs QI actions.

- **POC Validation Site Visits:** POC validation site visits are onsite reviews conducted after an MHP has implemented its corrective actions. The purpose of these site visits is to verify implementation and determine effectiveness of corrective actions. DHCS may also provide MHP specific training and technical assistance while onsite during the POC validation site visit. Beginning in Fiscal Year 2018/19, DHCS will conduct these POC validation site visits based upon an identified need in a particular county. For example, DHCS may conduct an onsite review in counties where there were significant or repeat findings and/or based on the compliance percentile resulting from the MHP's most recent onsite compliance review. At the end of the FY 2017/2018 review cycle, an analysis of the tiers that counties are in will be done, along with a review of repeat findings, in order to determine which counties will require a POC Validation Site Visit beginning in FY 2018/2019. If it is determined a POC validation site visit is appropriate, DHCS will conduct the site visit approximately six months following approval of the MHPs' POC.

DHCS is in the process of developing draft policies and procedures for each of the Enhanced Monitoring activities and expects to complete them by January 2019. DHCS is committed to continuing to strengthen its monitoring and oversight, as well as work with MHPs towards their improvement with compliance of federal and state regulations and contract requirements.

### **Additional Information**

#### *1915(b) SMHS Waiver Special Terms and Conditions*

In July 2015, the Centers for Medicare and Medicaid Services (CMS) approved a five year 1915(b) Specialty Mental Health Services (SMHS) Waiver renewal for July 1, 2015 through June 30, 2020, with Special Terms and Conditions (STCs). For the purpose of transparency, and related to this OIG audit, the STCs provide the public with performance data and information on access to and quality of SMHS provided by each MHP. Among other requirements, the STCs require the following:

- Publish on the State website the county MHPs' POCs
- Post MHP Quality Improvement Plans on both the DHCS and MHP websites.
- Submit to CMS the External Quality Review Organization (EQRO) quarterly and annual reports regarding the required Performance Improvement Projects, as well as the annual grievance and appeal reports.
- Develop and publish a SMHS Performance Dashboard for each MHP, which must be published on both the state and MHP websites in a manner that is easily accessible by the public. The SMHS Performance Dashboards must include the following performance areas: quality, access, timeliness, and translation/interpretation capabilities.

Now that DHCS has operationalized the STCs, it is shifting its focus to analyzing and interpreting the STC-related reports. Over time, these reports will provide additional information that will support the monitoring and oversight activities.

#### *Final Rule Monitoring*

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule)<sup>[1]</sup>, which revised Title 42 of the Code of Federal Regulations. These changes aimed to align Medicaid managed care regulations with requirements of other major sources of health care coverage. MHPs are classified in the Final Rule as Prepaid Inpatient Health Plans (PIHPs) and must therefore comply with federal managed care requirements (with some exceptions). The rulemaking is designed to advance delivery system reform and improve quality of care for beneficiaries; strengthen the beneficiary experience of care and key beneficiary protections; and, strengthen program integrity by improving accountability and transparency.

The Final Rule resulted in significant changes to the overall Medi-Cal SMHS delivery system, adding requirements for both DHCS and the 56 county MHPs. The new rules expand the scope and magnitude of MHSD's oversight, monitoring, technical assistance and quality assurance activities related to key areas of responsibility including: timely access to services, quality of services, program integrity, beneficiary protection and support, and network adequacy.

DHCS continues to implement applicable provisions of the Final Rule, and is strengthening its monitoring and oversight of the 56 county MHPs to integrate the required components. For example, DHCS submitted a new contract boilerplate to CMS for approval, which includes all of the applicable Final Rule provisions. In addition, for Fiscal Year 2017-18, DHCS incorporated several new Final Rule provisions into its Annual Compliance Review Protocol for SMHS.

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<sup>[1]</sup> Managed Care Final Rule, Federal Register, Vol. 81, No. 88:  
<https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>

## State Agency's Summary of Health Plans' Comments

On behalf of the counties of California, the California Department of Health Care Services is submitting this document. California counties disagree with the United States Department of Health and Human Services, Office of the Inspector General (OIG), recommendation that California refund \$230,065,438 to the Federal Government. The OIG reviewed a stratified random sample of 500 service lines submitted by 43 of the 56 mental health plans. Of these 500 claims, the OIG found that 105 service lines did not comply with Federal and State requirements when claiming Federal reimbursement for Specialty Mental Health Services (SMHS) expenditures. California counties agree that 76 disallowed service lines did not comply with Federal and State requirements. However, it has been determined by a review of medical records for all 105 service lines that supporting documentation and evidence exist for 29 of the 105 disallowed service lines.

Based on further review of the medical records and supporting documentation, California counties respectfully request the OIG revise its determination for these 29 service lines. A listing of the disputed service lines is enclosed in this letter. California counties also respectfully request that the error rate and amount of the refund be recalculated based upon OIG review of forthcoming documentation. There are generally three reasons for which California counties request that OIG revise its determination for 29 of the 105 disallowed service lines contained in the OIG draft report:

- 
- (1) For 23 claims, a review of the beneficiary's medical record provides evidence that the claim is for SMHS that were:
- a. medically necessary;
  - b. adequately supported a client plan; and
  - c. adequately supported by progress notes.
- 

As listed in the enclosed document, supporting documentation in the medical records for these service lines provide evidence that OIG should revise its determination for 23 of the disallowed claims. The DHCS' audit response to OIG Recommendation 2 provides relevant information about the complexities associated with documenting the broad range of allowable rehabilitative specialty mental health services (SMHS) modalities, as well as the infrequency with which the Department's audits find that the "documentation in the medical record does not establish that the beneficiary has an included diagnosis or that, as a result of that diagnosis, the beneficiary does not meet impairment criteria." Based on the available documentation in beneficiary medical records and for these reasons, California counties request the OIG revise its determination for these 23 claims.

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- (2) For three claims, a review of the beneficiary's medical record indicates a non-substantial coding error was made when the provider submitted the claim. Documentation for each of these claims substantiated that the rendering provider delivered a medically necessary and clinically appropriate SMHS. In one case, a service was coded by the rendering provider as "psychotherapy" when an assessment service had been provided. However, both psychotherapy and assessment fall under the broader category of "Mental Health Services". For these claims, while the rendering provider incorrectly coded the service, the services each "roll up" to the same category and adequate documentation was available to support the claims. For these reasons, California counties request the OIG revise its determination for these three claims.
- (3) For three claims, a review of the beneficiary's medical record indicates a non-substantial administrative error was made by the county mental health plan (MHP) or OIG during performance of the audit. In two cases, the MHPs found that follow-up communication with OIG occurred during the audit process in which the OIG medical reviewers requested additional documentation from the plan. The requested documentation was subsequently provided to OIG staff. However, the MHPs believe that the OIG may have erroneously utilized the incorrect documentation in its review and thus disallowed the claims. In one case, the county submitted the incorrect documentation to the OIG. In follow-up communication between OIG medical reviewers and the plan, OIG staff requested information that was irrelevant to substantiating the claim being reviewed. Thus, the county was unaware that it had not submitted the information needed to support the claim. For these reasons, California counties request the OIG revise its determination for these three claims.
-