

**Senate Standing Committee on Investigations and Government Operations  
Senator Craig M. Johnson, Chair**

***Reforming Medicaid: Investigating Current Strategies Targeting Waste, Fraud and Abuse***

**March 17, 2010**

**Testimony on behalf of The Coalition of Behavioral Health Agencies, Inc.**

**James W. Lytle  
Manatt, Phelps & Phillips, LLP**

Senator Johnson, members of the Committee:

On behalf of The Coalition of Behavioral Health Agencies, Inc., thank you for the opportunity to testify before the Committee on issues relating to the current strategies being undertaken by the Office of Medicaid Inspector General (“OMIG”) to target waste, fraud and abuse in the State’s Medicaid program.

The Coalition of Behavioral Health Agencies is the umbrella advocacy organization for the behavioral health community, representing over 100 non-profit community-based mental health and substance abuse agencies that serve more than 350,000 clients primarily in the five boroughs of New York City and Westchester County. In addition to representing the Coalition before the Legislature and the Executive on legislative and regulatory matters, our firm has represented the Coalition on Medicaid compliance issues for several years. We have represented individual members of the Coalition in Medicaid audits undertaken by OMIG and its predecessors and have represented a broad array of other healthcare providers who have been subject to Medicaid-related audits and investigations for many years.

***The impact of OMIG on the behavioral health community:***

Even before OMIG was created in 2006, smaller not-for-profit community-based providers were placed at a considerable disadvantage in defending themselves from Medicaid audits and investigations. With smaller administrative staffs, less sophisticated data management, medical record and billing systems, and fewer resources to retain the legal assistance they need to defend themselves from overpayment allegations, the smaller community-based programs—like the members of the Coalition, but also other community-based clinics and family planning programs—have long been vulnerable to aggressive Medicaid enforcement activity.

With the advent of OMIG, the explosion in its staff and resources and the ever-increasing targets for Medicaid recoveries that have been assigned to it, the smaller

community-based agencies have been placed at even greater risk: not because they are engaged in systematic fraud or abuse of the Medicaid program, but because they may be more prone to hyper-technical allegations of billing errors, less able to afford the administrative and legal expense of a prolonged audit, and very dependent on Medicaid as a source of revenue.

For large and sophisticated healthcare providers that receive payments from a broad array of private and public sources and have a substantial administrative infrastructure, an OMIG audit may be viewed as the cost of doing business. To smaller, community-based agencies, the outcome of an OMIG audit may mean the difference between life and death and may threaten the very survival of services to patients that depend on these agencies for their care.

Moreover, behavioral health agencies—those licensed by the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities and the Office of Alcoholism and Substance Abuse Services—face an additional challenge: inevitably, auditors and investigators, whose experience may have been forged in the more generic healthcare system, are less familiar with the unique clinical and programmatic requirements and practices governing these specialized services. The Coalition agencies frequently have encountered auditors who are entirely unfamiliar with the programs they have been sent to audit—and whose interpretations of the applicable regulations and guidelines governing these programs frequently differ from long-established practices and protocols of the applicable licensing agencies.

***Concerns over the current approaches to Medicaid audits and investigations:***

I should note, at the outset, that we do not question the intentions or integrity of OMIG and its personnel. The Medicaid Inspector General, James Sheehan, brought to his position a national reputation as an extraordinarily dedicated and skilled prosecutor of Medicaid fraud and abuse and has assembled a talented team, in a relatively short period of time, to meet the substantial and expanding responsibilities of his office. Audit recovery targets, first established in F-SHRP (the Federal-State Health Reform Partnership)<sup>1</sup> and then escalated through the establishment of increasingly ambitious targets in successive State Budgets and Deficit Reduction Plans have obligated OMIG to recover unprecedented amounts of Medicaid payments: the proposed State Budget contemplates that over one billion dollars in Medicaid payments will be recouped by the agency.

It is, however, incumbent on the Legislature to make certain that the ground rules by which OMIG operates be clear, even-handed and fair, even if the agency is expected to achieve these substantial recoveries. Clarifying the rules of engagement between

---

<sup>1</sup> Under F-SHRP, the State agreed to increase its Medicaid fraud and abuse recoveries to at least 1.5 percent of its total Medicaid expenditures for FFY 2005. The first year of the demonstration required development of an audit plan to increase recoveries. Specific dollar recovery targets have been established for years 2 through 5 starting with \$215 million in annual recoveries for year 2 and increasing to \$644 million in recoveries for year 5.

OMIG and the behavioral health field is not only in the best interests of the Coalition and its members, but will serve OMIG's best interests in the long run as well.

A number of concerns have been raised by Coalition members that have experienced audits by OMIG in recent years:

*The administrative burden on a small agency:* Coalition members have reported being asked to produce a large volume of files, often dating back as long as five or six years ago, for OMIG review in unrealistic timeframes, only then to endure a prolonged delay before receiving any information relating to the outcome of the OMIG review. One agency has undergone three unannounced audits of three of its clinics in just the past year—draining already over-taxed senior clinical and administrative leadership attention just to satisfy OMIG's requests. In some instances, the data management and billing infrastructure of small agencies is severely tested by audits—particularly audits that may seek information from services rendered as many as six or seven years ago. The billing systems available five or six years ago—and even those often still being utilized by smaller providers today—may not be capable of providing some of the detailed information required by auditors and the barely sufficient levels of funding received by these programs is not sufficient for them to install state-of-the-art electronic billing systems and software.

*Conflicting interpretations of clinical and programmatic requirements:* OMIG auditors have, from time to time, interpreted regulatory, record-keeping and clinical requirements in a manner that is not consistent with the licensing agency. Clinics whose practices and procedures have routinely been commended by their applicable State agency have undergone OMIG audits that found these same procedures wanting. In some instances, auditors have not appreciated the distinctions between requirements that govern, for example, clinic services from those applicable to continuing day treatment programs or have wrongly assumed that treatment plans were required for patients who were still in pre-admission status. Although OMIG has indicated its willingness to share its audit protocols with providers, the behavioral health field has not, as of yet, received protocols from OMIG that pertain to their services.

*Timely billing requirements:* Frequently, Coalition members have found that a significant percentage of their potential Medicaid recoupments relate to their alleged failure to bill for their services on a timely basis. The 90 day billing timeframe, set forth in regulation at 18 NYCRR 540.6(a)(1), allows providers to submit claims beyond the otherwise prescribed 90 days if the delay is “due to circumstances outside of the control of the provider.” Nevertheless, providers are often hard-pressed to document the exact circumstances that may have resulted in a late claim that was submitted several years ago, often because, again, of limitations in their billing and data management systems. Coalition members have every incentive to bill as soon as they possibly can and bill on a timely basis wherever possible—and only fail to meet these deadlines due to delays in obtaining Medicaid eligibility determinations or other factors outside of their control. In the absence of any potential abuse or fraud connected to late billing, singling out timely

billing requirements seems less like an effort to target fraud and abuse and more like a relatively easy target for large Medicaid recoupments.

*Third party liability:* Often Coalition members have had Medicaid payments challenged because the patient may have had third party insurance coverage, other than Medicaid, or was enrolled in a Medicaid managed care plan when the services were rendered. Although providers are obligated to “take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services,” 18 NYCRR 540.6 (e)(1), they cannot be reasonably expected to know, in every case, whether the patient may have other coverage. It is particularly unfair where, as in the case of Medicaid managed care enrollment, the State Medicaid program should be in a better position than the provider to know of the enrollment—and yet the State Medicaid program still paid the provider’s claim. To make matters worse, OMIG has proposed, by regulation, to eliminate hearing rights for providers subject to recoupment for third party liability, effectively nullifying the decision by the Court of Appeals in *Visiting Nurse Service v. Department of Health*, 5 N.Y.3d 499 (2005).

*Extrapolations based on technical errors:* Even technical or record-keeping errors—including such details as a rare missing signature on an authorizing progress note or treatment plan or some other missing information—are extrapolated across the universe of claims submitted by the program. As a result, what may be technical error in a single medical record translates into a massive Medicaid recoupment, even in the absence of any evidence that the defect in the reviewed file ever occurred elsewhere.

*Providers unable to exercise their due process hearing rights:* As has been noted previously (and has been the case long before OMIG arrived on the scene), Medicaid providers are faced with the threat of a much higher audit recovery if they exercise their right to a hearing as opposed to the lower confidence limit if they forego the hearing. Balancing the risk of this higher audit payment (along with the legal and any other costs that may be associated with actually undergoing a hearing) against the potential for prevailing on one or more points during the administrative hearing leads many providers to forego their hearing rights—and leaves OMIG’s findings and procedures unchallenged. Under existing rules, moreover, even a provider that has requested a hearing may face the initiation of recoupment before being given the opportunity to be heard.

***Recommendations:***

1. ***Require consistency with the licensing agency.*** Require OMIG to abide by the interpretations of the licensing agencies of payment and clinical requirements, to defer to the regulatory agency if any program or billing audit by that agency was conducted governing the same time period as the OMIG audit and to issue audit protocols to the field subject to such audit to provide as much guidance as possible to ensure higher rates of compliance.

2. ***Eliminate 90 day billing rule recoupments:*** Preclude recovery of Medicaid payments for services validly rendered to eligible clients solely on the basis that that were billed to Medicaid beyond the 90 day billing timeframe, as long as they were billed within two years of the service.

3. ***Limit extrapolations:*** Prohibit the extrapolation of overpayment findings, unless it can be reasonably determined that they resulted from fraud or intentional misconduct by the provider.

4. ***Apply reasonable third party-liability rules:*** Eliminate recoupments in cases where the provider failed to bill a responsible third party for the cost of care, where the provider can demonstrate that it took reasonable steps to ascertain whether a third party was responsible for the care—and, in particular, preclude recoupments where the State Medicaid program knew or reasonably should have known of the third party (e.g. in cases where the Medicaid recipient had enrolled in a Medicaid managed care plan) and should have rejected the claim in the first instance.

5. ***Preserve due process protections and hearing rights:*** Prohibit OMIG from adopting regulations that deprive providers of their hearing rights, as they have proposed in third party liability cases. Require OMIG to utilize the lower confidence limit in its projections of extrapolated Medicaid liability, whether or not the provider chooses to avail itself of an administrative hearing, and preclude OMIG from commencing the recoupment if a hearing has been requested until the administrative law judge makes a determination of Medicaid liability.

Thank you again for the opportunity to present testimony on these issues and we welcome any questions or comments you might have on this testimony.

---

James W. Lytle  
Manatt, Phelps & Phillips, LLP, on behalf of  
The Coalition of Behavioral Health Agencies