SEP - 1 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Pennsylvania's Medicaid Payments for Targeted Case Management Services for Calendar Years 2003 Through 2005 (A-03-06-00202)

Attached is an advance copy of our final report on Pennsylvania's Medicaid payments for targeted case management (TCM) services for calendar years 2003 through 2005. We will issue this report to the Pennsylvania Department of Public Welfare (the State agency) within 5 business days. This audit was part of an Office of Inspector General initiative to determine whether State agency claims for TCM services were made in accordance with Federal requirements.

Section 1905(a)(19) of the Social Security Act (the Act) authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) of the Act defines Medicaid case management as "services which will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services." A 2001 Centers for Medicare & Medicaid Services letter to State Medicaid directors refers to case management as TCM when the services are furnished to specific populations in a State.

Pennsylvania's State plan allows TCM services for individuals with a mental health or mental retardation (MH/MR) diagnosis. Two approved State plan amendments describe the coverage of services furnished to persons with MH/MR diagnoses, recordkeeping requirements, and the payment methods the State uses. For the period January 1, 2003, through December 31, 2005, the State agency claimed $258,104,096 ($143,486,037 Federal share) for MH/MR TCM services.

Our objective was to determine whether the State agency's claims for TCM services from January 1, 2003, through December 31, 2005, complied with Federal and State requirements.

The State agency's claims for TCM services did not always comply with Federal and State requirements. Based on our review of 375 claims in our 100 sampled beneficiary-months, 36 claims included in 15 beneficiary-months were unallowable because the services were unsupported by case records or insufficiently documented. The State agency did not ensure that TCM services claimed under the Medicaid program met the documentation requirements. As a result, we estimate that during calendar years 2003 through 2005, the State agency claimed $11,859,692 ($6,497,132 Federal share) in unallowable TCM costs. The remaining 339 claims included in 85 sampled beneficiary-months complied with Federal and State requirements.

We recommend that the State agency:

- refund to the Federal Government the $6,497,132 for undocumented and unsupported claims for TCM services,

- review TCM claims submitted subsequent to our audit period and report any necessary adjustments, and

- ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with Federal and State requirements.

In written comments on our draft report, the State agency concurred with our findings for two beneficiary-months and agreed to strive to ensure that future TCM services claimed under the Medicaid program are properly documented. The State agency provided additional documentation for services claimed in eight of the beneficiary-months, stated that with sufficient time it could retrieve the documentation for services in the remaining undocumented beneficiary-months, did not address insufficiently documented services claimed for one beneficiary-month, and disagreed with our finding for services claimed for one beneficiary-month. Nothing in the State agency's comments made us change that finding.

Based on this additional documentation provided by the State agency, we have revised our report and recommendations to reflect that we are questioning 15 sampled beneficiary-months with 36 errors.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-06-00202.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

SEP - 2 2009

Report Number: A-03-06-00202

Mr. Theodore Dallas
Executive Deputy Secretary
Department of Public Welfare
Health and Welfare Building, Room 234
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Dallas:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Pennsylvania's Medicaid Payments for Targeted Case Management Services for Calendar Years 2003 through 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Robert Baiocco, Audit Manager, at (215) 861-4486 or through email at Robert.Baiocco@oig.hhs.gov. Please refer to report number A-03-06-00202 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PENNSYLVANIA'S MEDICAID PAYMENTS FOR TARGETED CASE MANAGEMENT SERVICES FOR CALENDAR YEARS 2003 THROUGH 2005

Daniel R. Levinson
Inspector General

September 2009
A-03-06-00202

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Pennsylvania, the Department of Public Welfare (the State agency) administers the Medicaid program. For the period January 1, 2003, through December 31, 2005, Pennsylvania's Federal share ranged between 53.84 percent and 57.71 percent.

Section 1905(a)(19) of the Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) of the Act defines Medicaid case management as "services which will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services." A 2001 CMS letter to State Medicaid directors refers to case management as targeted case management (TCM) when the services are furnished to specific populations in a State. The letter provides that allowable TCM services for Medicaid-eligible beneficiaries include assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup.

The State's approved State plan further describes services covered under this option. The State plan allows TCM services for individuals with a mental health or mental retardation (MH/MR) diagnosis. Two approved State plan amendments (SPA) describe the coverage of services furnished to persons with MH/MR diagnoses, recordkeeping requirements, and the payment methods the State uses. The State covers services to persons with mental retardation under SPA 87-04 and services to persons with serious mental illness under SPA 92-13. For the period January 1, 2003, through December 31, 2005, the State agency claimed $258,104,096 ($143,486,037 Federal share) for MH/MR TCM services.

OBJECTIVE

Our objective was to determine whether the State agency's claims for TCM services from January 1, 2003, through December 31, 2005, complied with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency's claims for TCM services did not always comply with Federal and State requirements. Based on our review of 375 claims in our 100 sampled beneficiary-months, 36 claims included in 15 beneficiary-months were unallowable because the services were unsupported by case records or insufficiently documented. The State agency did not ensure that TCM services claimed under the Medicaid program met the documentation requirements. As a result, we estimate that during calendar years 2003 through 2005, the State agency claimed

$11,859,692 ($6,497,132 Federal share) in unallowable TCM costs. The remaining 339 claims included in 85 sampled beneficiary-months complied with Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $6,497,132 for undocumented and unsupported claims for TCM services,
- review TCM claims submitted subsequent to our audit period and report any necessary adjustments, and
- ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings for two beneficiary-months and agreed to strive to ensure that future TCM services claimed under the Medicaid program are properly documented. The State agency provided additional documentation for services claimed in eight of the beneficiary-months, stated that with sufficient time it could retrieve the documentation for services in the remaining undocumented beneficiary-months, did not address insufficiently documented services claimed for one beneficiary-month, and disagreed with our finding for services claimed for one beneficiary-month. The State agency's comments are presented as Appendix D. We excluded from the comments the case notes that the State agency provided to support its position because the notes contain personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

We accepted supporting documentation for all TCM services claimed in three sampled beneficiary-months and for some of the TCM services claimed in another beneficiary-month. Based on this additional documentation provided by the State agency, we have revised our report and recommendations to reflect that we are questioning 15 sampled beneficiary-months with 36 errors.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Pennsylvania, the Department of Public Welfare (the State agency) administers the Medicaid program. For the period January 1, 2003, through December 31, 2005, Pennsylvania's Federal share ranged between 53.84 percent and 57.71 percent.

Medicaid Targeted Case Management Services

Section 1905(a)(19) of the Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) of the Act defines Medicaid case management as "services which will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services." CMS's State Medicaid Director's Letter 01-013, issued January 19, 2001, refers to case management services as targeted case management (TCM) when the services are furnished to specific populations in a State. Allowable TCM services for Medicaid-eligible beneficiaries include assessment to determine service needs, development of a specific care plan, referral and related activities to help the individual obtain needed services, and monitoring and followup.

Targeted Case Management in Pennsylvania

Pennsylvania's approved State plan further describes services the State covers under this option. The State plan allows TCM services for individuals with a mental health or mental retardation (MH/MR) diagnosis. In Pennsylvania, MH/MR services are coordinated through county MH/MR program offices.

The State agency requests Federal reimbursement at the Federal medical assistance percentage for TCM as services. Two approved State plan amendments (SPA) describe the coverage of services furnished to persons with MH/MR diagnoses, recordkeeping requirements, and the payment methods the State uses. The State covers services to persons with mental retardation under SPA 87-04 and services to persons with serious mental illness under SPA 92-13.

The State agency claims costs for TCM services for persons with mental retardation as service management. Pursuant to SPA 87-04, "service management consists of locating, coordinating and monitoring necessary and appropriate services" for "persons with mental retardation who are eligible for Medical Assistance under the State plan."

The State agency claims costs for TCM services for adults and children with serious mental illness as "case management services" under SPA 92-13. Pursuant to SPA 92-13, case management services "assist mentally ill individuals eligible under the State Plan in gaining access to needed medical, social, educational and other services." The State covers case management services for individuals with serious mental illness at two levels of coverage: resource coordination and intensive case management.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claims for TCM services from January 1, 2003, through December 31, 2005, complied with Federal and State requirements.

Scope

We reviewed the State agency's claims of $258,104,096 ($143,486,037 Federal share) for MH/MR TCM services from January 1, 2003, through December 31, 2005.

Our objective did not require a review of the overall internal control structure of the State agency. Therefore, we limited our review of internal controls to those controls related to State agency payments and claims for TCM.

We performed our fieldwork at the State agency in Harrisburg, Pennsylvania, and at 14 county MH/MR offices and seven MH/MR providers throughout the State.

Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and other requirements, including the SPAs, governing Medicaid reimbursement for TCM services;

- interviewed State agency and county officials to determine how TCM services are provided and claimed;

- reviewed the State agency's TCM policies, procedures, and documentation requirements;

- reconciled the TCM services claimed for Federal reimbursement on Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," to the accounting records of the State agency that supported the claims;

- reviewed the Medicaid claiming process and case record documentation requirements;

- selected, as detailed in Appendix A, a random sample of 100 beneficiary-months with 375 TCM claims submitted by the State agency for Medicaid-eligible beneficiaries;

- analyzed documentation from the 100 beneficiary case records to determine if the activities performed and documented by the case managers for the 375 TCM claims were in compliance with applicable requirements; and

- estimated, based on the sample results, the unallowable costs in the population of beneficiary-months, as shown in Appendix B.

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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency's claims for TCM services did not always comply with Federal and State requirements. Based on our review of 375 claims in our 100 sampled beneficiary-months, 36 claims included in 15 beneficiary-months were unallowable because the services were unsupported by case records or insufficiently documented. (See Appendix C.) The State agency did not ensure that TCM services claimed under the Medicaid program met the documentation requirements. As a result, we estimate that during calendar years 2003 through 2005, the State agency claimed $11,859,692 ($6,497,132 Federal share) in unallowable TCM costs. The remaining 339 claims included in 85 sampled beneficiary-months complied with Federal and State requirements.

FEDERAL PROGRAM REQUIREMENTS

Federal Law

Section 1905(a)(19) of the Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) of the Act defines Medicaid case management as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services." The Congressional Conference committee report accompanying Public Law 99-272, which added section 1915(g) to the Act, emphasized that payment for case management services must not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Section 1902(a)(27) of the Act requires providers to keep records that fully disclose the extent of the services provided to Medicaid beneficiaries receiving assistance under the State plan and to furnish such records on request.

Centers for Medicare & Medicaid Services "State Medicaid Manual"

The CMS "State Medicaid Manual," section 4302.2(G)(1), establishes the documentation needed to support a claim for case management services:

> Payment for [case management] services is made following the receipt of a valid provider claim. Providers must maintain case records which indicate all contacts with and on behalf of recipients. The case records must document name of recipient, the date of service, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service delivery.

Also, section 2500.2(A) of the "State Medicaid Manual" instructs States to report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is immediately available when the claim is filed.

STATE REQUIREMENTS AND GUIDANCE

State Plan Amendments

The State agency covers TCM for persons with mental retardation as "service management" under SPA 87-04. The SPA requires that providers of service management to individuals with mental retardation must specify recipient information and compensable services. The State agency covers TCM for persons with serious mental illness as "case management services" under SPA 92-13. In addition to specifying recipient information and compensable services, providers of case management services must maintain records that document the nature and extent of the case management service furnished.

Pennsylvania's Administrative Code and Related State Agency Bulletins

The State's Administrative Code (55 PA. CODE section 5221.33 (1993)) requires that case notes must verify the necessity for the contact and reflect the goals and objectives of the intensive case management service plan for persons with serious mental illness. The State has further clarified recordkeeping requirements in its State plan and State regulations through policy bulletins issued to mental health providers. Mental Health Bulletin 5221-93-01 (September 21, 1993) clarifies the requirements for intensive case management records contained in 55 PA CODE section 5221. The Bulletin states that case notes documenting intensive case management services must verify the necessity for the contact and reflect the goals and objectives of the intensive case management service plan. Mental Health and Substance Abuse Services Bulletin OMH-93-09, effective April 1, 1993, clarifies that case records for resource coordination must contain "documentation of each contact indicating the date and time (beginning and end) of service, purpose of the contact, staff person(s) involved, services provided, and the outcome(s) of the contact."

UNALLOWABLE TARGETED CASE MANAGEMENT COSTS

We estimate that the State agency claimed at least $11,859,692 ($6,497,132 Federal share) for unallowable TCM services provided during the period from January 1, 2003, through December 31, 2005. Of the 375 claims we reviewed in the 100 sampled beneficiary-months, 36 claims included in 15 beneficiary-months were unallowable because case managers did not properly support 31 claims or sufficiently document the case management services in the case notes for 5 claims.

Unsupported Claims

The State agency did not provide any documentation or case notes to support the provision of 31 claimed services during the sampled months:

- 22 claims for Mental Retardation service management for which the State agency did not comply with the CMS "State Medicaid Manual" and SPA 87-04 to document, at a minimum, beneficiary information and compensable services and

- 9 claims for Mental Health intensive case management services for which the State agency did not comply with the CMS "State Medicaid Manual," SPA 92-13, and 55 PA CODE § 5221.33 to provide specific documentation of the necessity, circumstances, and recipient of the service.

Because the State agency did not provide any documentation for these 31 claims, we were unable to determine whether the service was performed or whether it was a compensable or necessary service.

Insufficiently Documented Claims

The State agency did not provide sufficient documentation or case notes to support the provision of five claimed services during the sampled beneficiary-months.

- For three intensive case management services claimed during a sampled beneficiary-month, a contact or activity entry was recorded; however, the case notes did not support that the case manager performed a compensable service under SPA 92-13 or complied with the documentation requirements of 55 PA CODE § 5221.33. For one claim, the case notes documented that the case manager attempted to contact the client's mother by telephone but received no answer. For another claim, the case manager attempted to meet with the client, but the client was not at home. In both cases, case notes provided no documentation that the case manager ever successfully provided the service billed. Case notes for the third claim were illegible.

- For two resource coordination services claimed during a sampled beneficiary-month, the case notes did not describe the nature and extent of the case management service or provide sufficient documentation to support that case managers had provided compensable services under SPA 92-13. The case notes for both claims indicated that the case manager was trying to resolve the client's outstanding bench warrants. However, the case notes did not indicate how the services related to coordinating access to mental health services.

Because the State agency did not provide sufficient documentation for these five claims, we were unable to determine whether the service was performed or whether it was a compensable or necessary service.

CONCLUSION

The State agency did not ensure that TCM services were documented in accordance with Federal and State requirements. As a result, the State agency claimed $6,497,132 (Federal share) in Medicaid reimbursement for TCM services that did not meet Federal and State requirements and were, therefore, unallowable.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $6,497,132 for undocumented and unsupported claims for TCM services,
- review TCM claims submitted subsequent to our audit period and report any necessary adjustments, and
- ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings for services claimed in two sampled beneficiary-months and said that it would strive to ensure that future TCM services claimed under the Medicaid program are properly documented. The State agency provided additional documentation for services claimed in eight beneficiary-months, and stated that, with sufficient time, it could retrieve the documentation for services claimed in other beneficiary-months that may have been archived. The State agency did not address services claimed in one insufficiently documented beneficiary-month and disagreed with our finding for two services claimed in one beneficiary-month that assisting the beneficiary with outstanding bench warrants did not relate to coordinating access to mental health services. The State agency said that clearing the bench warrants allowed the client to apply for Supplemental Security Income, which provided income "to obtain housing and a more stable medical benefit." The State agency's comments are presented as Appendix D. We excluded from the comments the case notes that the State agency provided to support its position because the notes contain personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

Of the eight beneficiary-months for which the State agency provided additional documentation, we accepted all TCM services claimed in three beneficiary-months and accepted some TCM services claimed in another. The documentation provided for an additional four beneficiary-months either supported or did not address our findings. Nothing in the State agency's comments made us change our finding on the outstanding bench warrants. Based on the additional documentation provided by the State agency, we have revised our report and

recommendation to reflect that we are questioning 15 sampled beneficiary-months with 36 errors (see appendix C).

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was beneficiary-months for Medicaid targeted case management (TCM) services claimed for reimbursement during calendar years 2003 through 2005.

SAMPLING FRAME

The sampling frame was a database contained in a Microsoft Access file. The database contained details on 1,395,411 beneficiary-months in calendar years 2003 through 2005 for which the Department of Public Welfare received $143,486,037 (Federal share) in reimbursements for TCM services.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample size of 100 beneficiary-months.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services, statistical software. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiary-months in our sampling frame from 1 to 1,395,411. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We estimated the dollar value of unallowable claims in each beneficiary-month.

APPENDIX B

SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample Beneficiary-Months	Number of Beneficiary-Months With Documentation Errors	Value of Documentation Errors
1,395,411	$143,486,037	100	$11,118	15	$998

Estimates
(Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Dollar Value of Documentation Errors
Point Estimate	$13,932,621
Lower Limit	$6,497,132
Upper Limit	$21,368,110

SAMPLE RESULTS
WITH DOCUMENTATION ERRORS

Beneficiary-Month (By Sample Number)	Number of Claims With Errors	Documentation Error[1]	Error Amount (Federal Share)
1	1	Unsupported	$36.00
18	2	Unsupported	67.50
20	1	Unsupported	9.94
23	1	Insufficient	40.20
53	1	Unsupported	126.96
55	2	Insufficient	93.80
60	1	Insufficient	20.43
61	6	Unsupported	36.89
63	1	Insufficient	46.90
67	1	Unsupported	8.02
69	4	Unsupported	62.62
76	5	Unsupported	188.50
83	3	Unsupported	163.18
92	1	Unsupported	0.94
97	6	Unsupported	96.58
Total	**36**		**$998.46**

[1]For beneficiary-months with more than one unallowable claim, the reason for the error—unsupported or undocumented—was the same for each unallowable claim.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

Theodore Dallas
Executive Deputy Secretary

(717) 787-2600
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JUL 0 1 2009

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region III
150 South Independence Mall West – Suite 316
Philadelphia, Pennsylvania 19106-3499

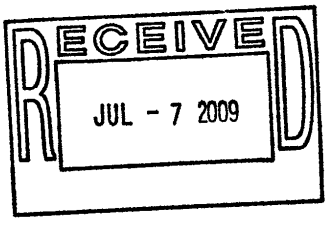
Dear Mr. Virbitsky:

Thank you for the April 6 letter in which you transmitted the draft report entitled "Review of Pennsylvania's Medicaid Payments for Targeted Case Management Services for Calendar Years 2003 through 2005," Report Number A-03-06-00202. We appreciate the opportunity to review the draft report, as well as the extension granted for submitting a response.

Targeted Case Management (TCM) Services within Pennsylvania are handled by two separate offices within the Department of Public Welfare (DPW). These offices are the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Developmental Programs (ODP). Therefore, our response to the Summary of Findings and Recommendations included in the draft report is set forth below in two parts.

SUMMARY OF FINDINGS

The State agency's claims for TCM services did not always comply with Federal and State requirements. Based on our review of 375 claims in our 100 sampled beneficiary-months, 49 claims included in 18 beneficiary-months were unallowable because the services were unsupported by case records or insufficiently documented. The State agency did not ensure that TCM services claimed under the Medicaid program met the documentation requirements. As a result, we estimate that during calendar years 2003 through 2005, the State agency claimed $16,022,866 ($8,810,404 Federal share) in unallowable TCM costs. The remaining 326 claims included in 84 sampled beneficiary-months complied with Federal and State requirements.



DPW OMHSAS Response: The DPW OMHSAS concurs only in part with this draft finding. A response specific to each OMHSAS sample is included below. Additional documentation is included for some of the samples which, when reviewed, should eliminate the finding, in full or at least in part.

Unsupported Claims

DPW concurs with the finding for Sample #83. The Case Management agency was not able to identify or submit documentation to support the claims submitted for Mental Health Intensive Case Management (ICM) services. OMHSAS will require the Erie County Mental Health/Mental Retardation program to obtain training schedules from ICM provider agencies. These schedules must identify training sessions on service documentation in compliance with the CMS "State Medicaid Manual," State Plan Amendment (SPA) 92-13, and ICM regulations (55 PA Code § 5221.33(4)). In addition, OMHSAS will request documentation of attendance at said training as part of the annual review process for the ICM provider agency.

DPW does not concur with the finding for Sample #61. DPW did submit the Encounter Form, signed by the service recipient's parent (recipient is a child) to support receipt of services for claims submitted. In addition, while "case notes" were not available for submission (due to a computer system failure in 2003), the ICM was able to document the date and purpose for 9 of the 15 claims identified in the audit sample. This document is submitted as Attachment #1. DPW requests that the amount determined as unsupported be reduced to reflect only those claims for which the Case Manager did not account.

Insufficiently Documented Claims

DPW concurs with the finding for Sample #60. The ICM provider submitted a claim for attempting to contact a recipient, but the documentation supports the finding that the recipient was not at home. DPW will require the Centre County MH-MR Program to submit a training schedule from the ICM Provider agency. This schedule must identify a training session on Record and Payment Requirements as outlined in ICM regulations (55 PA Code § 5221.42.f). In addition, OMHSAS will request documentation of attendance at the training as part of the annual review process for the ICM provider agency.

DPW does not concur with the finding for Sample #23. Case notes were obtained from Northwest Human Development, Inc., for the claim submitted for ICM services on 2/14/05. Contact with the recipient is documented. A copy of this case note is included as Attachment #2.

DPW does not concur with the finding for Sample #55. The finding indicates that the Resource Coordination (RC) services billed were documented in the case notes as attempts to resolve bench warrants and did not reflect access to mental health services (page 5). The RC Case Manager discovered the bench warrants during her efforts to

assist the consumer in applying for Supplemental Security Income (SSI) benefits. The consumer's application for SSI could not be processed until the bench warrants were resolved. Obtaining SSI resulted in the consumer receiving more income to obtain housing and a more stable medical benefit. Therefore it is DPW's position that the RC Case Manager's efforts to assist this person were clearly within the scope of targeted case management services, "…to assist persons in gaining access to needed benefits and supports."

DPW ODP response: The DPW ODP also concurs only in part with the OIG draft finding. In the response time given, ODP staff has done research of the "unsupported" samples. Additional documentation has been found for six of these cases; see Attachments #3 through #8 regarding sample items numbered 12, 20, 69, 82, 92, and 95. ODP believes service notes for other sample cases identified may have been archived, and, with sufficient time, the materials could be retrieved.

With regard to the other OIG recommendations, ODP will strive to ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with Federal and State requirements. ODP is in the process of issuing bulletins on Supports Coordination services which will contain standards for documentation of service notes. As per normal practice, ODP will be offering Supports Coordination Training on this issue. In addition, ODP is now using an automated billing system which captures units of service billed through the service notes. If no service notes are entered, no units of service are recorded. ODP will make examples of this training available for review as it is developed.

Thank you again for the opportunity to respond to the draft report. If you need any further information, please contact Linda Swick, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7218, or via e-mail at lswick@state.pa.us.

Sincerely,

Theodore Dallas

Enclosures