

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE DISTRICT OF COLUMBIA CLAIMED  
SOME DAY TREATMENT PROGRAM  
SERVICES THAT WERE NOT IN  
COMPLIANCE WITH FEDERAL OR  
DISTRICT REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Gloria L. Jarmon  
Deputy Inspector General  
for Audit Services

October 2017  
A-03-16-00201

# *Office of Inspector General*

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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.

## Report in Brief

Date: October 2017

Report No. A-03-16-00201

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



### Why OIG Did This Review

A 2010 OIG report found that the District of Columbia's Medicaid Management Information System did not prevent some unallowable Medicaid claims from being paid. The report included claims for services for the District's Day Treatment Program (DTP). District regulations defined the the DTP as "a nonresidential program operated for the purpose of providing medically supervised day treatment services for elderly persons, children from birth through age three (3), or adults with a developmental disability, and adults with mental disorders." The District's DTP began in 1984 and was repealed in January 2016. Other OIG reviews showed that States' Medicaid claims for day treatment services did not always comply with Federal and State requirements.

Our objective was to determine whether the District's DTP claims were made in accordance with Federal and District requirements.

### How OIG Did This Review

We reviewed Federal and District requirements regarding day treatment services and also reviewed a random sample of 100 DTP claims paid to 13 providers. Our review covered 185,597 claims totaling \$59,486,030 (\$42,250,794 Federal share) that the District claimed for DTP services from 2011 through 2015. These claims were submitted by 27 providers for 2,428 beneficiaries.

## The District of Columbia Claimed Some Day Treatment Program Services That Were Not in Compliance With Federal or District Requirements

### What OIG Found

While 80 of the 100 claims in our sample complied with Federal and District requirements, 20 of the sampled claims did not comply with either Federal requirements that claims have adequate supporting documentation or District requirements that claims include a physician's order, a participant plan of care, the beneficiary's attendance record, and daily progress notes. Specifically, 11 claims did not include any documentation to support that the beneficiaries received services on the claimed dates of service, 8 claims were submitted for beneficiaries who did not have a plan of care, and 1 claim was submitted for a beneficiary who was absent on the claimed date of service according to the attendance log.

On the basis of our sample results, we estimated that this resulted in the District claiming at least \$4,588,756 in Federal reimbursement for unsupported and, therefore, unallowable DTP services.

### What OIG Recommends and District Comments

We recommend that the District refund to the Federal Government \$4,588,756 for DTP services that were not claimed in accordance with Federal and District requirements.

In written comments on our draft report, the District agreed to refund the full amount of questioned costs. In addition, the District noted that throughout our audit period, the District was operating under a Plan of Correction approved by the Centers for Medicare & Medicaid Services "to effectuate the orderly shutdown of this troubled program and to transition the beneficiaries safely to clinically appropriate alternative services."

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## INTRODUCTION

### WHY WE DID THIS REVIEW

A 2010 Office of Inspector General (OIG) report found that the District of Columbia's (the District) Medicaid Management Information System (MMIS) did not prevent some unallowable Medicaid claims from being paid.<sup>1</sup> The report included claims for services for the District's Day Treatment Program (DTP). Other OIG reviews showed that States' Medicaid claims for day treatment services did not always comply with Federal and State requirements.

We conducted this audit to determine whether the District's claims for day treatment services complied with Federal and District requirements.

See Appendix A for related OIG reports.

### OBJECTIVE

The objective of our review was to determine whether the District's DTP claims were made in accordance with Federal and District requirements.

### BACKGROUND

#### The 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 Medicaid State plan. States report their Medicaid expenditures quarterly to CMS on Form CMS-64. Expenditures are allowable only to the extent there is adequate supporting documentation. The supporting documentation should be sufficient to determine if the Medicaid service was provided according to Federal and State payment requirements. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements. In the District, the Department of Health Care Finance (State agency) administers the Medicaid program.

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<sup>1</sup> *Review of Medicaid Management Information System Prepayment Edit In The District of Columbia* (A-03-08-00208), published June 16, 2010.

## The District of Columbia's Day Treatment Program

The District's DTP began in 1984. District regulations<sup>2</sup> defined the DTP as "a nonresidential program operated for the purpose of providing medically supervised day treatment services for elderly persons, children from birth through age three (3), or adults with a developmental disability, and adults with mental disorders."<sup>3</sup> All DTP services are billed under procedure code G0176, activity therapy services. In its Medicaid State plan (State plan), the District identified DTP services as clinic services.<sup>4</sup> However, in its regulations, the District permitted the DTP to "be operated in free standing facilities or part of existing facilities such as nursing homes, senior centers, hospitals, or churches."<sup>5</sup>

In April 2010, CMS sent a letter to the State agency, reminding the District that approval of the State plan was contingent upon the submission of an amended State plan that would remove DTP services as a clinic service and reclassify them as a rehabilitative service. The District did not respond to CMS's 2010 letter. CMS sent another letter in August 2012 that repeated its directive to amend the State plan. Specifically, CMS stated that because DTP services were being furnished "outside the four walls of the clinic" and because "there are no provisions in DC's state plan that describe day treatment services outside of a clinic setting, we want DC to correct the issue by submitting a State plan amendment to move these day treatment services from the clinic section of your state plan and place them in the rehabilitation section of your state plan."

The District responded to CMS in September 2012 stating that "most of the providers and the services they deliver would not fit within the rehabilitative option." The District instructed DTP providers not to admit new beneficiaries to the DTP program after January 1, 2013. The District stated that it would deny all claims submitted for DTP services rendered for any new admission on or after that date, but continue to pay for services of beneficiaries who were active before January 1, 2013.<sup>6</sup> The District then performed an assessment of DTP beneficiaries to determine their needs and move them into an existing District program that would meet those needs.

The DTP program transitioned to the adult day health program 40 beneficiaries with developmental disabilities and 70 beneficiaries with mental health issues. In addition, the District transitioned 1,158 DTP beneficiaries to providers of mental health rehabilitation services and 64 children in the DTP to providers of early intervention services. The District subsequently amended its State plan under section 1915(i) of the Act to establish an adult day health program specifically for beneficiaries age 55 and over. This new program, distinct from

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<sup>2</sup> Title 29, Chapter 7 of the District of Columbia Municipal Regulations (DCMR).

<sup>3</sup> 29 DCMR § 799.1.

<sup>4</sup> State Plan Amendment, TN No. 09-006 (effective date October 1, 2009).

<sup>5</sup> 29 DCMR § 706.8.

<sup>6</sup> 61/5 D.C. Reg. 000851-000852 (January 31, 2014).

the DTP, was effective April 1, 2015,<sup>7</sup> and was projected to initially serve approximately 569 beneficiaries. The 1915(i) program is still active. However, on January 22, 2016, the District repealed the DTP.<sup>8</sup> Claims for 1915(i) program services are not included in this review.

Appendix B contains Federal and District requirements related to DTP services.

## **HOW WE CONDUCTED THIS REVIEW**

Our review covered 185,597 claims totaling \$59,486,030 (\$42,250,794 Federal share) that the State agency claimed for DTP services between January 1, 2011, and December 31, 2015. The claims were submitted by 27 providers for 2,428 beneficiaries. We selected a random sample of 100 claims paid to 13 providers and representing 1 to 5 days of activity therapy services. We reviewed DTP beneficiary records, including physician's orders, participant plans of care, beneficiary attendance records, and daily progress notes, to determine if each sample claim was properly supported.

We did not review the overall internal control structure of the State agency. We limited our review to those controls related to the State agency's methodology for claiming DTP services. We performed our fieldwork at the State agency and DTP program providers in the District and Maryland.

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 C contains the details of our audit scope and methodology.

## **FINDING**

While 80 of the 100 claims in our sample complied with Federal and District requirements, 20 of the sampled claims did not comply with either Federal requirements that claims have adequate supporting documentation or District requirements that claims include a physician's order, a participant plan of care, the beneficiary's attendance record, and daily progress notes. On the basis of our sample results, we estimate that this resulted in the State agency claiming at least \$4,588,756 in Federal reimbursement for unsupported and, therefore, unallowable DTP services.

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<sup>7</sup> State Plan Amendment, TN No. 14-004 (effective April 1, 2015).

<sup>8</sup> 63/4 D.C. Reg. 000889 (January 22, 2016).

## **SOME DAY TREATMENT PROGRAM SERVICES WERE NOT PROPERLY DOCUMENTED**

To be eligible for reimbursement, day treatment service claims must include adequate documentation to determine whether the Medicaid service was provided according to Federal and District payment requirements. Federal requirements are found in CMS's State Medicaid Manual, which states that "expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met."<sup>9</sup> District documentation requirements include a physician's order, a participant plan of care, the beneficiary's attendance record, and daily progress notes. For the 20 claims in our sample that were not properly documented, we found that:

- 11 claims did not include any documentation to support that the beneficiaries received services on the claimed dates of service,
- 8 claims were submitted for beneficiaries who did not have a plan of care, and
- 1 claim was submitted for a beneficiary who was absent on the claimed date of service according to the attendance log.

On the basis of our sample results, we estimated that the State agency claimed at least \$4,588,756 in Federal reimbursement for unallowable DTP services.<sup>10</sup> See Appendix D for our statistical sampling methodology and Appendix E for our sample results and estimates.

### **RECOMMENDATION**

We recommend that the State agency refund to the Federal Government \$4,588,756 for DTP services that were not claimed in accordance with Federal and District requirements.

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

In written comments on our draft report, the District agreed to refund the full amount of questioned costs. In addition, the District noted that throughout our audit period, the District was operating under a CMS-approved Plan of Correction "to effectuate the orderly shutdown of this troubled program and to transition the beneficiaries safely to clinically appropriate alternative services." We are pleased that the District has taken action to address the treatment of these most needy individuals. The State agency's comments are included as Appendix F.

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<sup>9</sup> CMS, State Medicaid Manual § 2497.1.

<sup>10</sup> To be conservative, we recommend recovery of overpayments 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 A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>New Jersey Claimed Medicaid Adult Mental Health Partial Care Services That Were Not in Compliance With Federal and State Requirements</i>	<a href="#"><u>A-02-13-01029</u></a>	12/27/2016
<i>New York Claimed Nonhospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements</i>	<a href="#"><u>A-02-12-01011</u></a>	7/3/2014
<i>New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements</i>	<a href="#"><u>A-02-11-01038</u></a>	9/5/2013
<i>Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State</i>	<a href="#"><u>A-02-09-01023</u></a>	10/12/2011
<i>Medicaid Services Provided in an Adult Day Health Setting</i>	<a href="#"><u>OEI-09-07-00500</u></a>	7/12/2011
<i>Review of Medicaid Management Information System Prepayment Edit in the District of Columbia</i>	<a href="#"><u>A-03-08-00208</u></a>	6/16/2010

## APPENDIX B: FEDERAL AND DISTRICT REQUIREMENTS

Section 1905(a)(9) of the Act authorizes clinic services furnished by or under the direction of a physician. Federal regulations define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(a) Services furnished at the clinic by or under the direction of a physician or dentist.

(b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.<sup>11</sup>

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR § 225), establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards.<sup>12</sup> Pursuant to 2 CFR part 225, App. A, C.1.c, to be allowable, costs must be authorized or not prohibited by State or local laws and regulations.

Under the District's State plan, the State agency identified day treatment services as clinic services.<sup>13</sup> According to the State plan, day treatment providers were reimbursed a provider-specific per-diem rate.

DTP services must be provided in accordance with the beneficiary's plan of care.<sup>14</sup> The District required the plan of care to be based on the beneficiary's physician order after that physician had conducted a thorough needs assessment. The plan of care was to be developed using an interdisciplinary approach, designed to maintain the beneficiary at, or to restore him or her to, optimal capability for self-care in a less restrictive environment.<sup>15</sup> All DTP beneficiary records

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<sup>11</sup> 42 CFR § 440.90.

<sup>12</sup> On December 26, 2013, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. The Department of Health and Human Services has codified the guidance in regulations at 45 CFR part 75, which became effective on December 26, 2014.

<sup>13</sup> State Plan Amendment, TN No. 09-06 (effective October 1, 2009).

<sup>14</sup> 29 DCMR § 715.

<sup>15</sup> 29 DCMR § 715.

were required to contain functional assessments, including an original and revised version indicating the participant's progress.<sup>16</sup> DTP services may include:

- nursing, nutrition, and personal care services,<sup>17</sup>
- individual and group social, educational, and recreational activities,<sup>18</sup>
- individual or group counseling to beneficiaries and their families,<sup>19</sup> and
- restorative, habilitative, or maintenance therapy services for adults with developmental disabilities or mental disorders.<sup>20</sup>

DTP providers were required to have a professional staff qualified to meet the needs of beneficiaries and under the supervision of a program director.<sup>21</sup> Staff members included an activities coordinator, registered nurses, social workers, and therapists.<sup>22</sup>

Providers generally must keep records necessary to fully disclose the extent of the services provided to Medicaid beneficiaries (the Act § 1902(a)(27)(A)). Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (CMS, State Medicaid Manual § 2497.1).

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<sup>16</sup> 29 DCMR § 717.2.

<sup>17</sup> 29 DCMR §§ 710.2, 710.3, and 710.6.

<sup>18</sup> 29 DCMR § 710.5.

<sup>19</sup> 29 DCMR § 710.7.

<sup>20</sup> 29 DCMR § 710.11.

<sup>21</sup> 29 DCMR § 702.6.

<sup>22</sup> 29 DCMR §§ 703, 704.1, and 705.

## APPENDIX C: AUDIT SCOPE AND METHODOLOGY

### SCOPE

From January 1, 2011, through December 31, 2015, the State agency claimed \$67,173,465 (\$47,705,635 Federal share), representing 191,390 claims submitted under procedure code G0176 (activity therapy services) by DTP providers. We removed 5,793 claims that contained either less than 1 day or greater than 5 days of activity therapy. The removed claims totaled \$7,687,435 (\$5,454,842 Federal share). These claims were removed in order to decrease the variability of the frame and the time required to review the sample.

Our review covered 185,597 claims for services representing 1 to 5 days of activity therapy<sup>23</sup> valued at \$59,486,030 (\$42,250,794 Federal share), representing payments to 27 providers. We based our review on a random sample of 100 claims paid to 13 providers.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the District's DTP claims were made in accordance with Federal and District requirements. Our review did not assess the quality of the services or whether the services provided to the beneficiaries were medically necessary.

We conducted our audit from February to November 2016 and performed our fieldwork at the State agency's office in the District and at provider locations throughout the District and Maryland.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and District laws, regulations, and guidance;
- held discussions with State agency officials and DTP providers to gain an understanding of the operation of the DTP program;
- reconciled claimed DTP program services to the State agency's accounting records;
- obtained a database of DTP service claims during the audit period from the State agency's MMIS, which recorded 191,390 claims for activity therapy services (procedure code G0176) totaling \$67,173,465 (\$47,705,635 Federal share);

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<sup>23</sup> Activity therapy was billed under procedure code G0176, which represented 1 day of DTP service. Neither the State agency nor any DTP provider could determine why this code was used, when DTP providers were first instructed to use it, or how many hours constituted 1 day of service.

- removed 5,793 claims totaling \$7,687,435 (\$5,454,842 Federal share) that contained either less than 1 day or greater than 5 days of activity therapy;
- selected a simple random sample of 100 claims from our sampling frame of 185,597 claims totaling \$59,486,030 (\$42,250,794 Federal share);
- reviewed DTP beneficiary records to determine if DTP claims were properly supported to include a physician's order, a participant plan of care, the beneficiary's attendance record, and daily progress notes;
- calculated the overpayments for each sampled claim;
- estimated the unallowable costs based on the sample results; and
- discussed our findings with CMS and 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 D: SAMPLING METHODOLOGY**

### **POPULATION**

The population consisted of Medicaid claims paid from January 1, 2011, through December 31, 2015, for activity therapy services (procedure code G0176) under the DTP program.

### **SAMPLING FRAME**

From the population of 191,390 claims for procedure code G0176, activity therapy, totaling \$67,173,465 (\$47,705,635 Federal share), we removed 5,793 claims that contained either less than 1 day or greater than 5 days of activity therapy.<sup>24</sup> These claims totaled \$7,687,435 (\$5,454,842 Federal share). After we removed these claims, the sampling frame consisted of a Microsoft Excel spreadsheet that contained 185,597 claims for activity therapy services submitted by 27 providers that the District paid during the audit period. The total Medicaid reimbursement for the 185,597 claims was \$59,486,030 (\$42,250,794 Federal share).

### **SAMPLE UNIT**

The sample unit was a DTP claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a sample of 100 claims.

### **SOURCE OF RANDOM NUMBERS**

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

### **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the sample units in the frame from 1 to 185,597. After generating 100 random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

We used the OAS statistical software to estimate the total amount and Federal share of the overpayments.

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<sup>24</sup> We determined the number of days by the DTP provider's per-diem payment rate.

**APPENDIX E: SAMPLE RESULTS AND ESTIMATES**

**Sample Results**

<b>Frame Size</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Claims Not Properly Supported</b>	<b>Value of Overpayments (Federal Share)</b>
185,597	\$42,250,794	100	\$21,247	20	\$4,319

**Estimated Value of Overpayments**

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

	<b>Federal Share</b>
Point estimate	\$8,016,732
Lower limit	\$4,588,756
Upper limit	\$11,444,709

## APPENDIX F: STATE AGENCY COMMENTS

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health Care Finance



Office of the Director

August 24, 2017

Jason C. Jelen  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region III  
150 South Independence Mall West, Suite 216  
Philadelphia, PA 19106

Re: Report Number: A-03016-00201

Dear Mr. Jelen:

The District of Columbia Department of Health Care Finance (DHCF) has reviewed the draft report entitled *The District of Columbia Claimed Some Day Treatment Program Services That Were Not in Compliance with Federal or District Requirements*. The report states that the Office of Inspector General (OIG) reviewed a random sample of 100 day treatment claims out of a total of 185,597 claims totaling \$59,486,030 during the period January 1, 2011 through December 31, 2015. At the outset of the audit period, there were 27 providers billing for day treatment services. Of the 100 claims, the OIG identified 20 claims among only four providers where there was inadequate documentation. Of the 20 claims identified as lacking adequate documentation, 11 (more than 50%) were from one provider; and another 25% were from another. Nineteen of the 20 claims were for dates of service prior to January 23, 2013. There was one claim with a date of service on April 17, 2015, and no claims in 2014. The amount of the claims lacking documentation totaled \$6,134.61. From this, the OIG extrapolated and determined that the District of Columbia owes \$4,588,756.

DHCF notes the following:

- Throughout the entire audit period, DHCF was operating under a Plan of Correction approved by the Centers for Medicare and Medicaid Services (CMS) designed to effectuate the orderly shutdown of this troubled program and to transition the beneficiaries safely to clinically appropriate alternative services.
- DHCF stopped new admissions to day treatment on January 1, 2013.
- By April 2013, we completed the transfer of approximately 1400, non-elderly, frail day treatment users to other Medicaid-funded home and community-based services and terminated the day treatment provider numbers for the providers that had served them.

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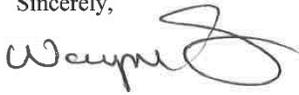
Letter to Jason C. Jelen, HHS/OIG  
RE: Report Number: A-03016-00201  
August 24, 2017  
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- DHCF worked with CMS to develop a new program for the remaining day treatment users – all of whom were frail and elderly. The new SPA was approved by CMS on February 10, 2015 with an effective date of April 1, 2015.
- On the effective date of the SPA approval, there were less than 150 remaining day treatment users in the program that needed to be transitioned.
- On October 23, 2015, we published rules repealing the day treatment program in its entirety with an effective date of December 31, 2015. All remaining beneficiaries were transitioned, and the provider numbers of the three remaining day treatment providers were also terminated.

In summary, DHCF worked diligently to effectuate the orderly shutdown of this program in a manner that ensured the safety and welfare of District residents. Throughout the process, we worked closely with CMS who monitored our progress at every stage.

Other than requesting a refund to the Federal Government in the amount of \$4,588,756, the HHS OIG has made no other findings and recommendations. Because we cannot dispute the findings made by the OIG regarding the lack of documentation for the 20 claims identified in the sample, DHCF will remit the full amount of the refund as requested.

Sincerely,



Wayne Turnage  
Director

cc: Francis McCullough, CMS Regional Administrator