HARBOR
LUCAS COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2013 THROUGH DECEMBER 31, 2015

Dave Yost · Auditor of State

HARBOR
LUCAS COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH MEDICAID REQUIREMENTS APPLICABLE TO PARTIAL HOSPITALIZATION SERVICES

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Harbor
Ohio Medicaid # 2341639

We have examined Harbor's (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization for partial hospitalization services during the period of January 1, 2013 through December 31, 2015.

The Provider entered into an agreement (the Provider Agreement) with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients and to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. The Provider is responsible for its compliance with the specified requirements. Our responsibility is to express an opinion on the Provider's compliance with the specified Medicaid requirements based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Provider complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the Provider complied with the specified requirements. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our modified opinion. Our examination does not provide a legal determination on the Provider's compliance with the specified requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Qualified Opinion

Our examination disclosed material non-compliance with the requirements for practitioners rendering partial hospitalization services.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider has complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation and service authorization for partial hospitalization services for the period of January 1, 2013 through December 31, 2015.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We found improper payments in the amount of $806,336. This finding plus interest in the amount of $83,422.64 totaling $889,758.64 is due and payable to the ODM upon it's adjudication of this examination report. Services billed to and reimbursed by the ODM, which are not validated in the records, are subject to recoupment through the audit process. *See* Ohio Admin. Code § 5160-1-27 In addition, if waste and abuse[1] are suspected or apparent, the ODM and/or the office of the attorney general will take action to gain compliance and recoup inappropriate or excess payments in accordance with rule 5160-1-27 or 5160-26-06 of the Administrative Code.

This report is intended solely for the information and use of the Provider, the ODM, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties.

Dave Yost
Auditor of State

July 23, 2018

[1] "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01

Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin Code § 5160-1-17.2(D)

Ohio Medicaid recipients may be eligible to receive mental health services. The only provider of mental health services is an Ohio Department of Mental Health Facility that meets the requirements in accordance with Ohio Admin. Code § 5160-27-01.

During the examination period, the Provider received reimbursement of $65,636,940 for 460,339 mental health services. These mental health services included the following:

- $16,673 for crisis intervention mental health services (procedure code S9484);
- $830,176 for psychiatric diagnostic evaluation with medical services (procedure code 90792);
- $1,888,836 for community psychology support treatment (procedure code H0036);
- $3,670,014 for mental health assessment by a non-physician (procedure code H0031);
- $7,963,914 for pharmacologic management with psychotherapy (procedure code 90863);
- $10,932,399 for behavior health counseling and treatment (procedure code H0004);
- $11,673,112 for partial hospitalization services (procedure code S0201); and
- $28,661,816 for medical home program comprehensive care coordination and planning maintenance (procedure code S0281).

The Provider had two additional Medicaid provider numbers; 2684331 is active and 0265565 is inactive. The active number is associated with Ohio Department of Developmental Disabilities waiver services and both of these numbers are listed under the name Harbor Behavioral Healthcare.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's claims for reimbursement complied with Ohio Medicaid regulations. The scope of the engagement was limited to an examination of partial hospitalization services (procedure code S0201) that the Provider rendered during the period of January 1, 2013 through December 31, 2015 and received payment from Ohio's Medicaid program.

We received the Provider's claims history from the Medicaid database and removed all services with third party payments, co-pays, and a paid amount of zero. We extracted partial hospitalization from the population, and used a sampling approach to facilitate a timely and efficient examination of the services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

Purpose, Scope, and Methodology (Continued)

Specifically, a combination of an acceptance test using both tolerable error rate (Beta Risk) and threshold rate (Alpha Risk) values and a simple random sampling approach was used due to the extremely low variability in the amount paid and the number of services provided.

We first determined with a 95 percent level of confidence whether the population error rate is less than or equal to five percent. To calculate the sample size for this, the IDEA Attribute Sample planning tool was employed using a tolerable error rate of five percent while allowing for a threshold error rate of two percent to estimate the sample size needed and the maximum number of errors that could be found (critical value) and still allow an achieved Beta Risk of 95 percent or better that the error rate was not higher than five percent.

We then determined an estimate of Medicaid overpayments with a precision of +/- 10 percent or better at the 95 percent confidence level. An estimate of the population overpayment standard deviation was made using the standard deviation of the actual amount paid per claim and a 50 percent error rate. A 50 percent error rate was used as a conservative estimate. The estimated error mean and standard deviation were calculated using the U.S. Department of Health and Human Services/Office of Inspector General's (HHS/OIG) RATSTATS[2] statistical program.

RATSTATS was also used to calculate the required sample sizes using the calculated estimates which resulted in a sample size of 383 services for the variable sample and 385 services for the acceptance sample. The greater of the two sample size estimates (385) was used as the final sample size.

Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect[3].

A notification letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference, the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. During fieldwork we reviewed service documentation and personnel records. The Provider was given opportunities to submit additional documentation and we reviewed all documents received for compliance.

Results

We examined 385 partial hospitalization services and found 37 errors. The overpayments identified for 36 of 385 services from our statistical random sample were projected across the Provider's population of paid partial hospitalization services. This resulted in a projected overpayment amount of $1,091,823 with a 95 percent certainty that the true population overpayment fell within the range of $751,392 to $1,432,255, a precision of plus or minus $340,431 (31.18 percent.) Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment amount is at least $806,336. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

[2] RAT-STATS is a free statistical software package that providers can download to assist in a claims review. The package, created by OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services.

[3] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

Rule References

Ohio Admin. Code §§ 5160-27-01, 5160-27-02, and 5160-27-05, in effect during this examination period, contain the requirements to be an eligible provider, coverage and limitation policies, and reimbursement requirements for Medicaid community mental health services. These Medicaid rules reference specific sections of Ohio Admin. Code § 5122 related to behavioral health programs delivered by Ohio Department of Mental Health and Addiction Services certified/licensed programs as requirements for services billed to Ohio's Medicaid program.

A. Provider Qualifications

Ohio Admin. Code § 5122-29-30, Appendix B identifies the practitioners who may render partial hospitalization which includes, but is not limited to, social workers (including independent and temporary licenses) and qualified mental health specialists (QMHS).

We compiled the names and professional credentials for the 58 practitioners who rendered services in the sample. Except for QMHSs, we searched the Ohio e-License Center website for the professional license of each practitioner to ensure that it was current and valid on the first date of service in our testing and was active during remainder of examination period, or for the duration of time the practitioner rendered services. We found no errors with licensure verification.

Ohio Admin. Code § 5122-29-30, Appendix A states that a QMHS is an individual who has received training for or education in mental health competencies and has demonstrated, prior to or within 90 days of hire, competencies in six basic mental health skills.

The Provider stated it requires a training module for partial hospitalization staff and a 120 day introductory evaluation to meet this requirement. The Provider used a new employee checklist to document completion of the partial hospitalization training module. When there was no date on the checklist indicating when the training module was completed, we used the date of the introductory evaluation to determine when compliance was met.

In addition, we compared the six competency requirements per the rule to the 14 different introductory evaluation forms used by the Provider. We found:

- 6 of the forms included demonstration of 5 of the required 6 competencies;
- 3 of the forms included demonstration of 2 of the required 6 competencies; and
- 1 of the forms included demonstration of 1 of the required 6 competencies.

We applied an 80 percent threshold for material non-compliance to the introductory evaluation forms which resulted in evaluations that demonstrated less than five of the required six competencies being identified as materially non-compliant.

For employees hired during our examination period, we determined if the partial hospitalization training module and an introductory evaluation that included demonstration of at least five of the required competencies were completed within 90 days of hire. For employees who did not complete both within 90 days, we identified services rendered after day 90 and before completion of both as non-compliant and associated an overpayment with the service.

For employees hired prior to our examination period, we determined if the partial hospitalization training module and an evaluation that included demonstration of five required competencies were completed prior to the first service in our sample. For employees who did not complete both prior to the first date of service in our sample, we determined services rendered prior to completion as non-compliant and associated an overpayment with the service.

A. Provider Qualifications (Continued)

We examined 385 services and found 33 services rendered by a practitioner that did not materially meet the required qualifications on the date of service delivery. These 33 errors were used in the overall projection of $806,336.

Recommendations:

The Provider should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services and maintain appropriate documentation to demonstrate that all requirements have been met. In addition, the Provider should review the applicable requirements for a QMHS and ensure its training program is compliant. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Providers must maintain documentation of mental health services which includes, but is not limited to clinical records for a covered service, time keeping that indicate time span of the service, the type of service provided, location the service was rendered, description of the services rendered, assessment and description of progress made, or lack thereof, as well as the signature of the rendering provider and supervisory signature, if applicable. *See* Ohio Admin. Code § 5122-27-06(C)
In addition, Ohio Admin. Code § 5122-29-06 (E) states that a partial hospitalization program day shall consist of a minimum of two hours.

We found no errors.

C. Authorization to Provide Services

Per Ohio Admin. Code § 5122:27-05(A), providers of mental health services must create an individual service plan that identifies specific mental health needs and the name and/or description of all services being provided. The plan must contain the signature of the staff member that developed the plan, the date of development and evidence of supervision, as applicable.

We examined 385 services and found two instances in which the individual service plan was not signed by a qualified practitioner and two services in which partial hospitalization was not authorized on the individual service plan.

These four errors were used in the overall projection of $806,336.

Recommendation:

The Provider should ensure that individual service plans are prepared as required and contain the signature of a qualified practitioner and supervisor when required. The identified issues should be addressed to ensure compliance with Medicaid rules and avoid future finding.

Official Response

The Provider submitted an official response to the results of this examination which is presented in **Appendix II**. The Provider disputes the criteria used in the examination and the determination that affidavits prepared during the examination were not treated as appropriate evidence of provider qualifications. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Conclusion

The scope of this examination was to determine compliance with the Ohio Medicaid rules for services that were billed to and paid by the Ohio Medicaid program. Language was added to the report to further clarify the criteria used in the examination; however, no change was made to the criteria used as they appropriately reflect the requirements of the Medicaid program.

The examination of provider qualifications focused on evidence that each practitioner who rendered a service in the sample was qualified at the time of service delivery. Lacking such documentation, we found no provision in the Medicaid rule to allow a practitioner to make a statement five years after the date of service to demonstrate compliance with the requirements. We reviewed all documentation received for compliance.

Appendix I

Summary of Partial Hospitalization Services Sample

POPULATION
The population is all paid partial hospitalization services (procedure code S0201) net of any adjustments, where the service was performed and payment was made by ODM.

SAMPLING FRAME
The sampling frame was paid and processed claims from MITS. These systems contain all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT
The sampling unit was paid Medicaid claims by service line. A service line is defined as an individual line on a claim.

SAMPLE DESIGN
We used a random variable sample.

Description	Results
Number of Population Services Provided	99,961
Number of Population Services Sampled	385
Number of Services Sampled with Errors	36
Total Medicaid Amount Paid for Population	$11,673,112.22
Actual Amount Paid for Population Services Sampled	$44,971.85
Estimated Overpayment	$1,091,823
Precision of Overpayment Estimate at 95% Confidence Level (two tailed)	$+/-$340,431 (31.18%)
Precision of Overpayment Estimate at 90% Confidence Level (two tailed)	$+/-$285,487 (26.15%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90% overpayment precision from the point estimate)(equivalent to method used for Medicare audits)	$806,336

Source: AOS analysis of MITS information and the Provider's medical records

Harbor

August 3, 2018

David Yost
Auditor of State

Re: Response to Compliance Examination Report

Dear Mr. Yost:

Harbor is a major non-profit community mental health center ("CMHC") that has served the Northwest Ohio community for over a century. Harbor's compassionate and competent staff provides services to over 20,000 members of our community annually. We take justified pride in being able to help individuals in their most difficult times work through issues and engage more successfully in their lives and the community. We also fully support the role of your office in assuring compliance with regulatory requirements in providing those services, which is why we cooperated fully and transparently with the auditors who conducted the examination.

Your office finalized a Compliance Examination of a sample of our partial hospitalization services on July 23, 2018. There appears to be no evidence of fraud or abuse, or that the services were not medically necessary and appropriate. In fact, in two of the three categories (service documentation and authorization to provide service) examined by your office, Harbor achieved 100% and 99% compliance, respectively.

The findings as to the third category (provider qualifications) were more problematic from our standpoint and stem from a fundamental disagreement with the Auditor as to (a) what set of standards are applicable and (b) how those standards should be applied for purposes of reimbursement. First, under OAC 5122-25-03 (Deemed Status and Reciprocity), if a CMHC attains national accreditation, the CMHC is required to maintain compliance with the national standards (which in our case include standards for partial hospitalization and human resources) in lieu of most Ohio Department of Mental Health ("ODMH") standards. During the time period in question, Harbor was nationally accredited and was fully compliant with the *national* accreditation standards for provider qualifications for all areas, including partial hospitalization. Your office ignored Harbor's compliance with the national accreditation standards and instead reviewed our records for compliance with ODMH standards from that time period. Secondly, having found noncompliance with one ODMH standard, specifically 5122-29-30 (rather than the national standards), your office assumed without justification that such noncompliance with this ODMH standard means Harbor was non-compliant with Medicaid reimbursement rules.

Harbor

Setting aside the standards issue, in the majority of cases where provider qualifications were questioned, your office acknowledged that appropriate training was provided but because the training documentation was not dated, it was found to be non-compliant. To address this concern, we provided sworn affidavits from current and former service providers that stated they received the appropriate training before providing services to patients. These affidavits were not new evidence that training occurred but merely confirmed that training occurred prior to staff rendering services. Your auditors refused to consider the affidavits citing the fact the affidavits did not exist at the time of the initial audit. While accurate, this fact is irrelevant for purposes of determining whether the training and evaluation actually occurred in the required time frame. This decision impacted forty percent of the ten staff members whose provider qualifications were questioned and acceptance of the affidavits would have resulted in a substantial reduction of the findings.

While we do not waive any of our objections set forth above, Harbor is a patient-centered organization and learning community and is always looking for opportunities to improve. New controls with respect to documentation of training and competency now include a single, centralized computer program that includes an entirely digitalized process, which is visible, actionable, and consistent at all levels of management to ensure 100% standardized compliance with documentation requirements. By centralizing our training process on an electronic learning management system for all teams and accelerating the timeliness of competency evaluations, all provider qualifications will not only continue to meet and exceed our national standards but will also meet the Ohio standards your office believes to be important for compliance.

We are very proud of the services we provide to our patients via our partial hospitalization services and look forward to continuously improving the services we provide to the community.

Sincerely,

Harbor

Steve Benjamin

Steve Benjamin
SVP, Quality Improvement, Government Relations and Training

Dave Yost • Auditor of State

HARBOR

LUCAS COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
AUGUST, 16 2018

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