

**NEW YORK STATE  
OFFICE OF MENTAL HEALTH  
RESPONSE TO THE COMMISSION ON QUALITY OF CARE AND  
ADVOCACY FOR PERSONS WITH DISABILITIES 7/18/06 DRAFT  
CONTINUING DAY TREATMENT REPORT**

In 2004, the Commission on Quality of Care and Advocacy for Persons with Disabilities (the Commission) conducted a review of the programmatic and financial practices of continuing day treatment (CDT) programs in New York State. On July 18, 2006, the Commission forwarded a draft report of their findings and related recommendations to the Office of Mental Health (OMH). This document represents OMH's response to those findings.

**PROGRAMMATIC COMPONENT**

The Commission's stated objectives of the programmatic review were to: 1) review the extent to which program activities reflected a rehabilitation and recovery model and advanced the independence of the participants; 2) assess the quality and relevance of treatment planning; and 3) assess participant satisfaction. In general, the Commission found: 1) variability in the quality of programming; 2) that treatment planning was deficient in several respects; and 3) that individuals like the programs they attended. As a result, the Commission recommends that OMH provide written guidelines to supplement current certification standards, directing CDT providers' attention to treatment planning and treatment strategies that promote a recipient's integration into everyday life activities.

As stated in the Commission's draft report, 17 CDT providers "situated throughout the State" were selected for review. Most of these providers operate multiple CDT programs and therefore, a total of 36 programs were visited. From within the selected 36 programs, case records of 87 recipients were requested and reviewed. One hundred and twenty six CDT providers who operate 178 programs are licensed by the NYS Office of Mental Health.

### **Variability in Quality of Programming**

In this section of the draft report, the Commission describes numerous examples of services, group sessions, and weekly schedules provided within the 17 CDT providers that were visited. Judgments of the quality of the programming were reached based on direct observation of group sessions and other activities, interviews with program administrators, and discussions with recipients.

Generally, the Commission concluded (without quantification) that the quality of programming was widely variable among programs. While OMH recognizes that the draft report represents a summary of the findings from the Commission's review, the lack of specific data and program-specific details, makes it difficult to know how the context of the program itself, and the goals of the recipient's treatment plan, impact the examples cited in the draft report. For example, the draft report mentions in various sections that some individuals used the CDT program primarily as a "drop-in" center, with little active interaction in CDT services. The presumption is that CDT staff failed to engage the individual in these cases. However, with more assertive staff, attempts to actively engage an individual could be viewed more positively and even be appropriate as an

initial engagement step. In a number of instances, the draft report illustrates findings that could be viewed as positive or negative, depending upon the context of the particular program in which it was provided.

The Commission's recommendations include an expectation that CDT programs will address rehabilitation and recovery goals. As acknowledged in the Commission's draft report, the inclusion of a review of the availability of rehabilitation and recovery services within the CDT programs was done so at OMH's request. Over the past several years, OMH has included in its mission, vision and values an emphasis on recovery. Furthermore, OMH has recently implemented a new model of outpatient care, known as Personalized Recovery Oriented Services (PROS), which incorporates an emphasis on rehabilitation and recovery. As part of the person-centered planning focus of this initiative, it is the intent of this program to address each of the recipient's stated life goals and to provide services to overcome the identified mental health barriers to achievement of such goals.

OMH agrees with the Commission that rehabilitation and recovery goals need greater emphasis within CDT programs and we look forward to working with the Commission in achieving that objective. However, it should be noted that it is OMH's expectation that, over time, the majority of the CDT programs will convert to the PROS model, thereby advancing the rehabilitation and recovery agenda through such licensure conversion. In fact, the Commission's draft report states that "the PROS program should be better able to meet the real-life needs of the participants as they (the consumers) see them."

## **Quality of Treatment Planning**

This section of the draft report included a summary of the Commission's case record review. While some positive findings were noted (e.g., timeliness of progress notes, and congruence between assessments and treatment plans), several deficiencies in treatment plans and progress notes were identified. The noted deficiencies included lack of individualization of plans, lack of meaningful review and revision of treatment plans, and lack of congruence between the progress notes and treatment plans.

OMH agrees with the Commission's recommendation that CDT providers must conduct meaningful reviews and revisions of treatment plans, and that written guidelines are necessary to supplement current certification standards. To that end, OMH plans to develop and distribute guidance materials that are focused on the topics of medical necessity, person-centered planning, and related documentation. However, it is OMH's belief that written guidance alone is not sufficient, and will therefore be planning a more proactive technical assistance and training approach for providers. OMH welcomes the participation of the Commission in the design and conduct of such sessions. It should also be noted that in June 2006, OMH conducted a two-day statewide training for all Field Office and Central Office licensing staff. A prominent session early on the first day consisted of a panel presentation on the changing environment for CDT programs. The purpose of the session was to reinforce how the role of licensing can be used to improve the quality of CDT programs. The collaborative and complementary panel included a representative from the Commission who

presented on the programmatic findings from their CDT study; the director of licensing from the NYC Field Office who presented actual inspection results as case studies on how licensing moved two CDT programs toward improvements; a representative from OMH Recipient Affairs who gave a powerful presentation of a recipient's perspective on the role licensing can play in CDT programs; and a representative from St. Mary's Hospital in Amsterdam (a CDT provider positively recommended by the Commission) who presented on how a CDT provider can deliver quality services. The subsequent evaluations of the training session indicated that licensing staff appreciated the comprehensive way in which licensing can intersect on various dimensions to improve the overall quality in CDT programs.

One of the recommendations included in the Commission's draft report was that persons whose CDT participation is billed to Medicaid must, at a minimum, accept some CDT core services. To the extent that "core services" are intended to mean those services that a provider is authorized to offer, by virtue of its OMH operating certificate, OMH agrees with this recommendation. All services implied by, or identified on, a provider's operating certificate are considered to be appropriate for inclusion in the CDT program. The provision of any such service to an individual must, of course, be consistent with, and identified in, the individual's treatment plan.

All CDTs are required to offer the following services, and are therefore implied by the issuance of a CDT operating certificate: assessment; health screening; treatment planning; discharge planning; medication therapy;

medication education; case management; health referral; rehabilitation readiness development; psychiatric rehabilitation readiness determination and referral; and symptom management. In addition, CDT providers may elect to offer the following services: supportive skills training; activity therapy; verbal therapy; crisis intervention; and clinical support. This category of services is commonly referred to as "additional services." Lastly, providers may offer other services upon the prior review and written approval of OMH. This category of services is referred to as "optional services." Any "additional" or "optional" services to be offered by a provider must specifically be identified on the provider's operating certificate.

The Commission's recommendation is consistent with an existing requirement within OMH's regulations. Specifically, the definition of "visit" includes the statement that "a visit shall involve one or more required or additional services or any optional services approved by the Office of Mental Health" (14 NYCRR § 588.4(a)). The regulatory requirements concerning the required and additional or optional services will be highlighted in guidance and training materials to be developed by OMH.

Beyond the steps noted above that OMH plans to take in the future as part of its ongoing effort to improve program quality, it must be noted that in 2004, OMH began an aggressive review and revision of its licensing process to enhance its effectiveness in ensuring quality care and fostering quality improvement. A plan for revitalizing the licensing process was developed and initiatives were undertaken in the four key areas detailed below.

*1) Identifying programs at risk as a basis for early intervention.*

An important first step in OMH's renewed commitment to improving the quality of services provided in the public mental health system was to begin looking more carefully at licensed programs that have failed to adhere to established standards and requirements for the delivery of mental health services. In the interest of providing an early opportunity to intervene in such programs, to correct the deficiencies, and thus to minimize their impact on the consumers they serve, OMH has strengthened the protocol for monitoring programs that have performed poorly on renewal-of-certification surveys and has developed an early warning system to identify programs at risk.

Licensing staff were provided intensive training related to regulatory requirements and the identification and monitoring of programs at risk. OMH developed an enhanced tracking system to identify programs found in substantial non-compliance, initiated monthly reports of programs at risk, and generated the Executive Information System for sharing key information about such programs with senior administrative staff. Approximately 70 licensed mental health programs are currently on OMH's high risk list and an additional 170 are receiving increased scrutiny on the watch list. In terms of CDTs, as of 11/1/06, four are currently identified as being at high risk and 18 are included in the watch category. In addition, OMH developed protocols for the certification staff to ensure consistent, rapid responses to problem providers, including a schedule of visits by Field Office and/or Central Office staff, technical assistance, clinical review as appropriate, plans of correction, meetings with members of the

program's board, and potential sanctions. Such sanctions may include fines, revocation or suspension of operating certificates, issuance of operating certificates for less than a year, and termination of special funding arrangements (e.g., COPS supplemental payments). A standardized protocol for the follow up of high-risk programs was developed, which includes conducting additional site visits to ensure adequate implementation of approved corrective action plans.

*2) Strengthening the licensing review process.*

The Office of Mental Health currently licenses over 1700 mental health programs in New York State. Over nine hundred and fifty of these programs serve individuals in an outpatient setting. Of these, 178 are CDT programs. Licensing of CDTs is accomplished via a tiered certification process which covers five key areas (life safety, recipient rights, treatment outcomes, accessibility and linkages, and program operations).

For tiered certification, the five licensing compliance categories are composed of 36 specific performance indicators or standards. Over the past year, the survey process has been enhanced by the consistent inclusion of recipient interviews, observation of group sessions, review of program schedules, and attention to repeat citations. This has resulted in an increase in the total number of deficiencies cited from 168 between 2/1/03 and 1/31/04 to 221 between 2/1/04 and 1/31/05 to 246 between 2/1/05 and 1/31/06. Further, although some of the most frequent types of citations have remained constant (discharge planning, treatment outcomes, service plans, governing body oversight), new types of deficiencies relating to medication education,



documenting progress, the assessment process, incident management, and program furnishings have become more prevalent. More importantly, the nature of these citations has become more meaningful and data driven. For example, recent citations have noted that “19/38 weekly scheduled groups are recreational or leisure oriented” or “protocols for groups have not been developed.”

To further improve the overall effectiveness of the certification process, the framework of certification visits was modified to include standardized protocols, training to enhance the quality and consistency of licensing findings, a renewed commitment to conducting licensing renewal visits before current licenses expire, and benchmarking of visit outcomes. A clearer set of standards has been generated regarding the credentials, qualifications and level of competency of licensing staff, and a standardized inpatient survey instrument was developed to ensure uniformity in the format and focus of inpatient surveys.

Increased attention was given to the standards of other external review agencies, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS), to ensure that OMH's licensing determinations and recommendations are consistent with national standards. In addition, to reaffirm the importance of the licensing process, licensing staff were alerted to the statutory authority that drives the certification process and the implications of that authority for mental health care delivery. Finally, consistent with the readiness model implemented by JCAHO, CMS and other national review bodies, OMH developed an unannounced survey approach. This approach is designed to ensure that mental

health providers are survey-ready, and thus in compliance with OMH standards and regulations, at all times as a result of normal operating activities.

*3) Ensuring consistency of the certification process.*

Several steps have been taken to enhance consistency among the certification staff in the Field Offices in their application of licensing standards. Discussion of licensing and certification issues, including revised licensing protocols and policies, was established as a standing agenda item at Field Office Directors' meetings. To improve communication, minutes of Field Office Licensing Unit Directors' meetings are maintained and shared with Field Office Directors. Joint Central Office/Field Office licensing reviews were scheduled to provide role modeling and support for Field Office licensing staff.

Criteria were established for the conduct of clinical record reviews, and a reduced number of appropriately qualified individuals were assigned to conduct these reviews. A template was developed and instituted to guide the submission of an acceptable action plan that includes timeframes for completion and identified persons responsible for implementation. Uniform expectations were established regarding the inclusion of satellite programs and family-based treatment sites in licensing visits. Finally, on an ongoing basis, Field Offices are provided with benchmarking reports that demonstrate regional surveying habits and findings.

*4) Improving training for licensing staff.*

To enhance the competency of licensing surveyors, to assist them in remaining current with changing practices and OMH priorities, and to ensure

accurate determinations in all areas of licensing reviews, a number of training initiatives were developed. The needs of each Field Office were assessed and a list of surveyor training needs was generated. All licensing staff were trained in standards and protocols to ensure a standardized level of licensing staff competency and consistent application of standards across the State. OMH will continue this training annually and on an as-needed basis.

To ensure appropriate, consistent citations and recommendations, licensing staff were provided with a better understanding of how JCAHO and CMS standards intersect with OMH regulations. Licensing staff were trained in the legal ramifications of certification; their rights, duties, and powers as licensing representatives; and the actions that they are authorized to take as delegates of the Commissioner. In addition, staff was trained to distinguish between the technical assistance and the licensing functions within the Field Offices to ensure that each function is provided consistently and effectively. Finally, joint Central Office/Field Office visits were conducted as an educative tool for licensing staff on how to conduct reviews.

Consistent with the overall approach to strengthening the OMH licensing process, OMH has taken a more aggressive stance specifically in review of CDT programs. Considering the duration of the license as an indicator of the quality of the program (based on the extent of compliance with regulatory standards and the Tiered Certification process), a comparison of the Tiered Certification status of CDT programs is provided below. This analysis compares a 3-year snapshot with the most recent 12-month period as follows:

Tier Level	3 year snapshot		12 month 2/05 – 1/06	
	# CDTs	%	# CDTs	%
I (36 months)	74	41.6%	13	19.1%
II (12-30 months)	101	56.7%	46	67.6%
III (0-9 months)	3	1.7%	9	13.2%
Total	178		68	

As depicted in the chart above, the shift from Tier I to Tier II status is a result of more in-depth programmatic findings during the license renewal inspections. This has resulted in an increased number of plans of corrective action to improve the quality of the CDT program, as well as an increase in the review and monitoring of these plans by OMH licensing staff.

The increased percentage of CDT programs in Tier III status has resulted in intensive monitoring of the programs by licensing staff consistent with Tier III protocols. In some cases, providers in Tier III status have received OMH sanctions, which further leverage quality improvements.

Focusing specifically on the 13 CDT programs originally communicated to OMH as being in the Commission's review sample, OMH analyzed the Commission's findings against the OMH findings from the most recent licensing report. In nearly every program, OMH not only concurred with the Commission, but also identified additional findings requiring a plan of corrective action. Specifically, in nine of the 13 CDT programs, OMH concurred with the Commission's findings. In the remaining four CDTs, the Commission focused on the fact that treatment plans did not reflect major life events or were not modified in a meaningful fashion while OMH reports included: program should offer more groups on recovery to enhance recipient's functioning; groups should be

developed and revised to meet the needs of the population; groups are too large; in 8/10 records reviewed, the program identified collaterals but does not incorporate their input into service plans; injectable medications were not consistently tracked; discharge summaries and other appropriate information are not transmitted to the receiving program; and use of staff from another agency's case management program to co-facilitate groups in violation of billing and confidentiality requirements.

### **Recipient Satisfaction**

For purposes of this portion of its review, the Commission developed a written consumer satisfaction survey, which was distributed within the 36 programs that were visited. Approximately 1300 individuals responded. In order to elicit more expansive answers to the survey questions, Commission staff interviewed respondents who were available and willing. (Note: The number of interviews conducted is not clear from reading the draft report.) Based on the results of the survey, the Commission concluded that the vast majority of the individuals enjoyed attending the CDT program most of the time (80%), and were treated respectfully all or most of the time (97%).

The survey instrument included a write-in question that asked individuals if they wanted assistance that was not presently being addressed by the CDT program. Eleven percent of the individuals who participated in the survey indicated that they had personal concerns that they would like addressed. Among those individuals, the largest percentage indicated a desire related to work.

As a result of the above finding, the Commission has recommended that the goals of the treatment plan review process should include identification of persons who wish to work, and programs should provide services accordingly. While OMH agrees that recipients' goals related to work should be addressed by CDT programs, it is the agency's position that each of the recipient's stated life goals, not just those pertaining to employment, should be incorporated into recipient's treatment plans. It is anticipated that the planned training and technical assistance initiative regarding person-centered planning that is described above in the treatment planning section will have a positive impact on this area.

## **FISCAL COMPONENT**

The Commission's stated objectives of the fiscal review were to determine: 1) the profitability of the nonprofit programs; and 2) compliance with Medicaid billing requirements. As part of this review, a random sample of 1,100 Medicaid claims was selected for the period of January 1, 2003 to April 30, 2004. In general, the Commission concluded that OMH should: 1) develop guidelines to address proper billing and documentation of Medicaid services; 2) ensure that billing guidelines are consistently applied across programs that offer similar services (e.g., CDT and PROS programs); and 3) review program billings to ensure that Medicaid is the payer of last resort (e.g., maximize Medicare).

### **Disconnect Between Practice and Regulations**

The Commission's draft report highlights a perceived inconsistency between the way in which CDT providers performed and the requirements of

State Medicaid regulatory requirements. The report correctly points out that OMH's regulations base the reimbursement system on a "visit", rather than as an hourly fee. The Commission's review does highlight variability in performance by providers that is consistent with reviews performed by OMH. In addition, OMH agrees that there has been increased attention paid to the Medicaid program, and that it is important to assure program accountability. OMH is also aware that the Federal Centers for Medicare and Medicaid Services (CMS) has indicated that it will be issuing regulations and guidance in the near future that are likely to be instructive with respect to the expectations of the Federal government regarding the provision and documentation of services under the Medicaid program. OMH will review these documents when they are issued, and will work with all stakeholders in ensuring that State program requirements are consistent with the Federal approach.

### **Medicare Maximization**

As part of the Commission's fiscal review of CDT programs, the issue of billing Medicare and Medicaid for persons who are dually eligible for such programs was examined. In two instances, the Commission found related billing to be problematic, wherein the providers misreported the amount approved and paid by Medicare, thereby resulting in significant Medicaid overpayments. The Commission noted that Medicaid system edits failed to identify and block the excessive Medicaid claims. As a result of the above findings, the Commission has recommended a review of program billings to ensure that all third-party revenues, such as Medicare, are maximized.

OMH agrees that billing for persons dually eligible for Medicaid and Medicare has, on limited occasions, been problematic. It is our understanding that a small group of hospitals that billed Medicare on a monthly basis for CDT services inadvertently handled the monthly bills as daily bills when they were re-submitted to Medicaid, resulting in significantly inflated claims. To our knowledge, this particular practice has been resolved. Furthermore, the Department of Health is currently working on the programming logic for the automated interface of Medicare with Medicaid, which will preclude the recurrence of past problems.

It is acknowledged that billing Medicaid and Medicare for dually eligible individuals is complicated, particularly in CDT programs. For example, Medicare will only pay for a small component of the services provided within a CDT program. Not only must the service being provided be either counseling, evaluation and monitoring, or medication management, but the practitioner providing the service must be a licensed physician, Ph.D. clinical psychologist, R.N. nurse practitioner, L.C.S.W. social worker, R.N. clinical nurse specialist, or physician's assistant. Due to this complexity, OMH will include information in its upcoming training sessions and guidance materials related to billing Medicaid and Medicare for dually eligible individuals to ensure that Medicare is maximized and that Medicaid is appropriately utilized as the payer of last resort. OMH will also monitor the Medicaid administrative files to ensure that patterns of Medicare billing are appropriate and will follow-up with providers when deficiencies seem apparent.



## **CDT Profitability**

In its fiscal review, the Commission attempted to determine the profitability of the CDT programs through an analysis of Consolidated Fiscal Reports for years 2001 - 2003. While the Commission found a significant range of surpluses among the providers, as well as one provider with a deficit, it concluded that any clear determination of profitability would require more detailed information due to the complexity of reporting revenues. Consequently, the Commission provided no related recommendation.

OMH appreciates that the Commission has noted in its draft report that any apparent CDT profits were, in reality, artifacts of supplemental payments (i.e., COPS and CSP) and other financial features unrelated to the costs of the CDT program. In late 2003, OMH substantially lowered the COPS payments to CDT programs; CSP payments will similarly be reduced with the implementation of PROS. It is believed that these measures will account for the perception of excess provider profits. The Commission may therefore wish to consider whether it is necessary to include this issue in its report.