

Commission on Quality of Care and Advocacy
for Persons with Disabilities
Continuing Day Treatment Review
December 2006

Executive Summary

The New York State Office of Mental Health (OMH) oversees a network of programs and services which provide critical support for 600,000 New Yorkers who have a diagnosis of mental illness. With annual expenditures of close to \$3.0 billion, OMH regulates and licenses more than 2,500 mental health programs operated by local governments and private agencies which include inpatient, outpatient, emergency, residential and community support services. The programs available through this network provide a safety net to protect vulnerable individuals and their families and a framework to support those same individuals as they seek greater independence and dignity through rehabilitation and recovery.

One of the core community treatment programs in this system is the Continuing Day Treatment (CDT) program, which provides a comprehensive array of services for persons with a diagnosis of mental illness on a relatively long-term basis. By regulation, CDTs are designed to maintain or enhance a participant's current level of functioning and skills, ability to maintain community living, and develop self-awareness and self-esteem. CDTs provided services to more than 23,000 individuals in 2003 at a total cost of approximately \$175 million.

In 2004, the Commission undertook a statewide review of CDT programs following reviews that revealed instances of questionable services being provided and a lack of accountability for some services being billed to the Medicaid program.

The Commission's current review found wide variability in the quality of services provided, not only throughout the state but also within individual programs. Services ranged from those which were creative, individualized and beneficial to recipients to those which engaged recipients in meaningless activities providing little therapeutic value. Some programs even allowed recipients to wander halls or sleep throughout the day. Perhaps most disturbing was the poor quality of treatment planning evident in many of the programs visited. The quarterly revisions of these plans often demonstrated no meaningful consideration of treatment needs, but rather were rewordings of previous plans, with the same objectives or the same objective with changed attainment criteria. Commonly, treatment plans failed to address significant life events that consumers were wrestling with, such as the death of a loved one, divorce, or the loss or regaining of custody of a child.

Equally disturbing was the lack of fiscal accountability throughout the programs reviewed. The Commission examined 1,100 claims billed to Medicaid and found that a significant number of the claims reviewed did not have the proper documentation to support the billing to Medicaid.

This lack of accountability appears to be the result of two factors.

First, most of the CDTs reviewed by the Commission billed Medicaid based on an individual's hours of attendance at the program, without regard to the extent to which the individual actually participated in Medicaid-reimbursed activities. Programs justify this practice as consistent with "milieu therapy," believing that the program itself is a therapeutic environment, even if a participant is not engaged in groups or activities during the day. The Commission believes this acceptance of lack of participation additionally risks undermining a person's belief in his or her own recovery.

Second, OMH regulations base the reimbursement system for CDT programs on a "visit," which is, in turn, based on service hours; i.e., Medicaid reimburses a provider for every hour a recipient receives a service. However, OMH does not require that a provider document that a service was provided for each billable hour. Instead, the total time each day an individual attends the program dictates what is billed as long as the requirements for a "visit" – a face-to-face interaction between a recipient and clinical staff for the provision of a service – are met. For example, if a person is physically at the program for five hours, but only receives one service constituting a "visit" during this time, the full five hours would be billed.

Given the recent and increased attention to combating Medicaid fraud, waste and abuse and with the introduction of PROS (Personalized Recovery Oriented Services) - - a program that expands the availability of Medicaid funding to support a broader range of rehabilitation and recovery services - - it is imperative that OMH assure accountability in the use of Medicaid funds, not only in the CDT program, but also in any program, including PROS, that is reimbursed by Medicaid on the basis of hours of service rendered. More importantly, given the substantial investment which is being made by the state, local and federal governments, increased attention must be given to the process of developing treatment plans to ensure that services are effective, of the highest quality and promote rehabilitation and recovery.

The Commission shared this report with the Office of Mental Health and welcomes the Office's response, which is attached. The response describes in some detail the recent and ongoing OMH initiatives to improve the quality of treatment planning and service delivery in CDTs and the revitalized OMH licensing reviews.

OMH addressed the Commission's finding that documentation of many CDT services was insufficient to support the Medicaid billing, stating that it is awaiting further guidance from the Federal Centers for Medicare and Medicaid Services. The Commission continues to be concerned that programs remain at risk without clear guidelines from OMH to providers on proper documentation and billing of Medicaid services.

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Introduction

The Commission's 2002 study on services provided to adult home residents¹ and other financial reviews of Continuing Day Treatment (CDT) programs have raised serious concerns about both the programmatic and financial practices of CDTs in general. Those reviews found that CDTs provided a questionable mix of services, as well as services of variable quality. Often programs emphasized socialization and activity groups rather than the more clinically-oriented services mandated by OMH, such as medication therapy or symptom management. At the programs visited, it was not uncommon to find recipients attending activity sessions, such as movies and bingo, almost exclusively.

In addition to the programmatic deficiencies, the Commission's reviews raised concerns about the systemic practice of billing Medicaid for more hours of therapeutic activity than what was actually provided. For instance, at many programs the first hour of the day was spent with donuts and coffee. Yet, this hour was billed to Medicaid as part of a "community meeting," although the hour was spent socializing.

When the Commission first discussed a broader study of CDTs with OMH, officials suggested that we not only look at the current services and financial practices, but also include a review of the availability of rehabilitation/recovery services within the CDT model. OMH officials were particularly interested in this aspect of CDT programs, given that they were in the process of implementing a new service model – Personalized Recovery Oriented Services (PROS) - which was designed to assure both greater flexibility and accountability in the delivery of rehabilitation and recovery services.

Scope of Review

To conduct a programmatic and fiscal study of Medicaid-funded services at CDT programs, the Commission selected 17 providers licensed by OMH to review. The 17 providers were situated throughout the state and included five hospital-based programs, one county-operated program, and 11 programs operated by private nonprofit corporations. Because most providers operate more than one CDT program, a total of 36 programs were visited – 17 programs were located in the NYC and Long Island region, seven in the lower Hudson Valley region, and the remaining twelve programs were located in other areas of the state. Programs ranged in size from approximately 80 to an enrollment of 600.

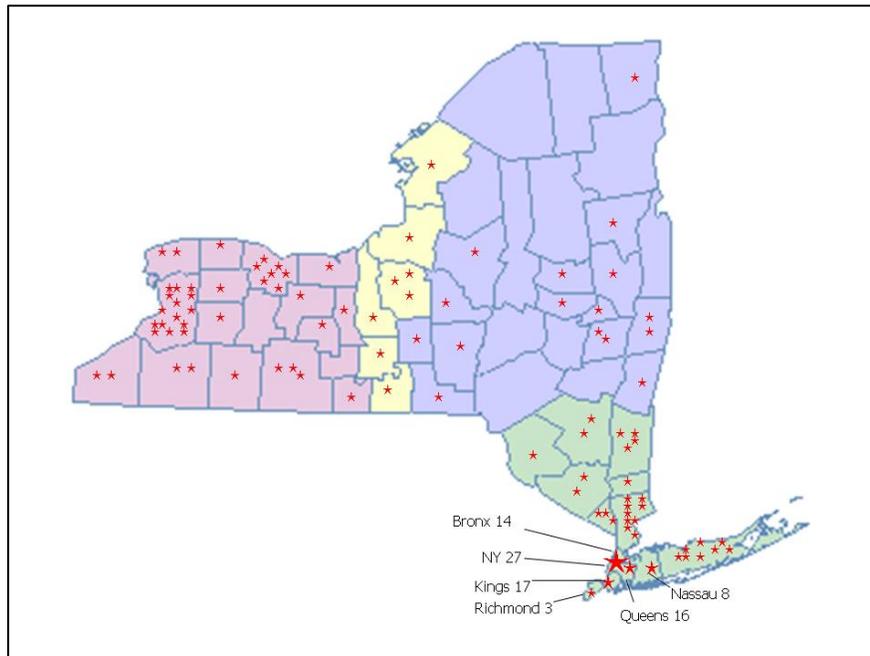
¹ *Adult Homes Serving Residents with Mental Illness: A Study on Layering of Services*, New York State Commission on Quality of Care for the Mentally Disabled, August 2002

To conduct the programmatic portion of the review, the complete case records of 87 recipients from across the 17 sampled programs were requested and reviewed. Commission staff spent one or two days at each CDT site, talking with participants and interviewing administrators, reviewing records, observing formal groups, meals, and recreational activities. In addition, a written consumer satisfaction survey was distributed to recipients, with approximately 1,300 people responding.

The fiscal review attempted to determine the profitability of the nonprofit programs. A review of 1,100 Medicaid claims for the period January 1, 2003 to April 30, 2004 was also conducted to determine compliance with Medicaid billing requirements established by both OMH and the Department of Health (DOH), the state agency responsible for administration of the Medicaid program. Agency records were reviewed to ensure that claims were made for services which were consistent with recipient treatment plans, that billing criteria were met, that records documented a definable medical service was provided, and that the nature and extent of services was fully disclosed.

Programmatic Findings

There are approximately 130 agencies in New York State certified to operate CDT programs. These agencies provided services to about 23,000 individuals, costing the Medicaid program close to \$175 million in 2003.



The Commission's sample of 87 persons, which was almost evenly divided between men and women, ranged from 21 to 72 years of age, with 59 percent between 30 and 45 years old. Statewide, according to 2003 data, approximately 50 percent of the program participants were in this age range. One third of the Commission's sample had been attending the program for four years or more, and approximately 10 percent had been attending for 10 or more years. Sixteen percent were the parents of minor children. In some cases, the program participant was raising his/her child at home; in other cases the child was living with a relative or in a foster family. Fourteen programs were providing services to approximately 110 individuals receiving Assisted Outpatient Treatment.² Twenty percent of the sample individuals had been hospitalized for mental health treatment in the preceding 12 months.

A sizeable number of the persons in the Commission's sample were or had been involved in drug/alcohol abuse. Records indicated that 37 individuals (43 percent) either currently or by history had abused drugs or alcohol. Over two-thirds of these individuals (25) were receiving drug/alcohol treatment at the time of the review. Sixteen percent of the sample had a criminal

² Kendra's Law establishes a procedure for obtaining court orders for certain mentally ill individuals to receive and accept outpatient treatment for their illness. If the court determines that the individual meets the criteria for assisted outpatient treatment, an order is issued by the court to the Director of the AOT program, requiring the director to provide those services described in the written treatment plan.

justice history, some, but not all, related to drug charges. Four individuals were currently on probation.

The programmatic review was guided by three objectives:

- to review the extent to which program activities reflected a rehabilitation and recovery model and advanced the independence of the participants;
- to assess the quality and relevance of treatment planning; and,
- to assess participant satisfaction.

Our study activities yielded substantive findings related to the quality and quantity of programming and to the caliber of treatment planning, as well as to program participant satisfaction.

- We found wide variability in the quality of programming both among and within the sample sites and, not surprisingly, wide variability in tolerance for program participants using the CDT as a “drop in” center for meals and a place to rest. Tolerance for inappropriate (including highly sexualized) dress and failure to maintain minimum grooming standards also differed between programs.
- Treatment planning was deficient in several respects. Many treatment plans showed no insight into an individual’s unique circumstances, failing to address critical life events, such as death of a close family member or the regaining of custody of one’s child. Some plans lacked meaningful review and revision, often repeating the same goals year after year, tinkering only with the wording or changing the performance criteria. A few treatment plans were written as instructions to staff. For example, [Staff shall] “continue to stay attuned for conflict in [Mr. X’s] relationships. Continue to point out pattern of acting out and define as dangerous.” In many instances, treatment plan reviews did not provide specific information on the attainment or lack of progress on treatment objectives.
- Notwithstanding the problems, individuals liked the programs they attended. While most participants stated that their treatment goals made sense for them, half of the persons responding to the write-in portion of the survey identified finding employment and securing a more independent housing arrangement as goals they wanted additional help in achieving.

Variability in Quality of Programming

Regulations governing CDT programs (14 NYCRR §587) describe the program as providing active treatment through required services that include medication therapy, medication education, case management, health referral, rehabilitation readiness development and referral, and symptom management, provided in a manner consistent with the individual’s condition and needs. Supportive skills training, activity and verbal therapy, crisis and clinical support services also may be provided.

Typically, programs afforded individuals the opportunity to attend three group sessions each day (two in the morning and one in the afternoon), plus a community meeting or day planning session in the morning where, in many programs, breakfast was served. All of the CDT programs in the Commission's sample provided at least one opportunity a week to participate in medication education and symptom management groups, should the individual so choose. Participants saw a psychiatrist monthly for medication therapy, if this was a needed service.

The mix of therapies and activities varied among the programs, and the quality of the group sessions varied substantially both within and among programs as illustrated below:

- Attention to health issues of consumers varied substantially. In some records, therapists kept running notes about significant health issues affecting the persons they were counseling. In other programs, we found little evidence of health referrals for consumers. This included several women in the study sample whose counselors did not engage them in a discussion of the potential benefit of a health referral to family planning education/services.
- A Symptom Management group, where individuals were called upon to discuss not only their symptoms but to recount actual circumstances where they used techniques to manage the symptom, contrasted with a group where participants discussed what they did over the weekend (including descriptions of the television shows they watched), but made no reference to how this related to their success in using coping skills.
- Individuals in some programs were producing imaginative and moving art work under the direction of art therapists. Some of this work clearly depicted the suffering and loneliness that often accompanies mental illness; other work was colorful and joyful. Framed pictures, along with collages and patch quilts, decorated the walls. In contrast, other programs offered individuals crayons, markers and coloring books, and called the activity an "art group."
- Lively discussions of current events, with the group facilitator asking thought-provoking questions about the ethics and personal, national or global impact of the issue under discussion, provided food for thought in some programs observed. This contrasted sharply to the silence of one facilitator when a program participant took over leadership and fired up the group to agree that isolating and locking up gay people was best for society.
- Groups following the Dialectic Behavioral Therapy model, with expectations for engagement and the completion of assignments; budgeting groups; groups devoted to the understanding of a specific disease or disorder (e.g., diabetes); and health maintenance groups, with diet and exercise components, challenged and rewarded individual participants. Similarly, a Leadership Program in an upstate CDT required a commitment to active participation and completion of the curriculum that provided some participants the skills and confidence to move out of the CDT. These program tracks contrasted with groups where facilitators let the discussion roam so far afield

on matters of no import that it was hard to remember what the topic was supposed to be, and to those groups where the facilitator made no effort to engage the participants, who slouched in chairs, did not contribute to the discussion, and never visually focused on the speaker.

- Group TV watching--on the day of our visit, a History Channel biography of Andy Griffith--and movie watching with no discussion of the content, stood in contrast to drama and role-playing groups where every individual was actively engaged.
- The records of some individuals referenced their being sent home when their lack of personal hygiene was no longer tolerable or when their dress was too provocative. In other instances consumers were asked to sign a contract stating their understanding that they must shower and dress appropriately if they wanted to continue attending. On-site observations revealed a small minority of people whose bizarre dress and offensive personal hygiene were not addressed.

Participant and Administrator-Identified Programs That Work

Our study identified positive program offerings which deserve note. Program directors spoke to us about their efforts to include more activities related to health maintenance in the schedule. These included exercise and diet workshops, where participants actually exercised and weighed-in weekly, separate groups for men and women addressing health issues related to each, and workshops where guest speakers addressed health issues of particular relevance to the audience. In the Commission sample, 37 percent of the individuals either were engaged in health-related activities or had a treatment goal related to physical health maintenance. One program offered a full-morning or full-day outdoor physically challenging activity nearly weekly, e.g., a hike in the woods, and other programs offered Yoga and Tai Chi. Two programs visited provided services for persons with severe hearing impairments by staff members who signed.

Parenting groups, cooking groups and what might be described as “work-study” groups were engaging participants in daily living tasks and preparing them for more independent living with the commensurate increasing responsibilities. In several programs, individuals assisted in preparing and serving lunch, worked on clerical tasks, produced a newsletter or engaged in other activities that required a sustained commitment of time and attention. In some programs individuals were paid for their services; in other programs they were not paid.

As noted, 25 participants were receiving treatment for drug/alcohol abuse as a component of the CDT in many cases. These programs generally required regular attendance, monitored drug and alcohol use through self-reporting and urine testing, and suspended participation when individuals were actively using. Second and third chances were common. In interviews, participants talked about the program requirements and the challenge these presented to them. When meeting these challenges, they expressed pride; when having trouble, they generally acknowledged this to Commission staff. Participants also identified groups/activities which helped them develop crisis plans as important to them. This was illustrated by a woman who explained that she sometimes felt the need to cut herself. With the crisis plan in hand, she was

able to contact her supports, did not cut herself, and avoided the use of the psychiatric emergency room.

In summary, a set of common characteristics emerged when reviewing the program tracks which individuals said were particularly helpful to them and those which program directors singled out and spoke of with pride. As a rule, these programs required participants to attend regularly and comply with expectations regarding conduct and engagement, applied consequences for not meeting expectations, provided some 1:1 time with an attentive staff member, and often had a “safety net” component. In short, these programs set high, but attainable, expectations, and participants gained confidence in their own abilities as they strove to meet them.

Choosing How to Spend the Day

The mix of active therapy groups and recreational groups offered at the program, together with consumer choice, determined how an individual spent his/her time at the CDT. Program schedules varied with the size of the program, with the expertise of the staff members, and with the philosophy of the program. Larger programs were able to offer four or more options for each time slot; smaller programs generally offered two or three. In some programs, an individual’s schedule was determined during a conference between the participant and a staff person. In other programs, participants created their schedule each day by selecting from the groups offered. The master schedule of program options was revised at least semi-annually in most programs.

In some programs, there was at least one group session each week where attendance was mandatory. This was often a group therapy session, where membership was defined and confidentiality was stressed. In other programs, morning check-in time was considered essential. Some master schedules permitted participants to choose a personal daily schedule heavily weighted with recreational groups, as illustrated below.

Monday	Tuesday	Wednesday	Thursday	Friday
9:30-noon <u>Swimming or Bowling</u>	9:00-9:45 Newspaper Group	9:30-11:30 <u>Bowling or Volleyball</u>	9:30-10:00 <u>Wake Up</u>	9:30-12:30 <u>Video Group</u>
11:30-12:30 Drama or Art	10:30-12:30 <u>Crafts & Recreation</u>	11:30-12:30 Art Experience	10:00-10:30 Newspaper Group	12:30-1:00 Lunch
1:00-2:30 <u>Games Group</u>	12:30-1:00 Lunch	12:30-1:00 Lunch	10:30-12:30 <u>Crafts & Recreation</u>	1:00-2:30 <u>Games Group</u>
	1:00-2:30 Community Meeting	1:00-2:30 <u>Games Group</u>	12:30-1:00 Lunch	
			1:00-2:30 <u>Games Group</u>	

In another program visited, art therapy and crafts so dominated the schedule that a participant could choose 12 hours of these activities from a possible 20 hours of programming each week.

The variety of programming options also reflected the program's definition of itself. Some programs provided and scheduled for each participant to have 1:1 time with a counselor, usually one-half hour every week or two. Other programs were entirely group-focused and provided no scheduled 1:1 time. Significantly, in response to our consumer satisfaction survey, participants ranked meeting privately with a counselor as the most preferred activity. With many participants having limited families and friends engaged in their lives, the counselor at the CDT program serves the role of "trusted other" at least temporarily and provides a much appreciated service.

The location and physical plant also reflected the program's view of its purpose and relationship to the community. Many CDT participants have treatment goals to reduce isolation and work on building personal and community relationships. Thus, one measure of a program's success is its ability to facilitate common daily interactions in the community. Most, but not all, programs visited had an attractive or at least neutral façade. Programs situated in industrial sites where community services (libraries, stores, and recreational sites, for example) are scarce and programs far from the neighborhood where people live (and to which they are bussed in vans) limit the program's ability to help participants use and enjoy local community resources. When program buildings look like fortresses, as at the program whose outside space is surrounded by a fence topped in barbed wire, they may inadvertently stigmatize participants by conveying the impression that dangerous people spend their day there. Those programs with very limited outdoor space, where participants congregate on the street to smoke, make them less than desirable neighbors.

The Non-participating Participant

Tolerance for using the CDT as a "drop in" center varied across the programs studied. Some programs engaged hall monitors to ensure that all participants at least walked into a group session and did not leave to wander the halls or rest in the lounge. Other programs allowed participants to wander the halls and/or doze on couches during group activity, attend the program only to eat meals, or attend groups sporadically. This was the case with an articulate 40 year-old man who came to a CDT in the western part of the state every weekday for morning "check in" and attended one group on Tuesday afternoons. The rest of his time in the CDT was spent reading the paper and listening to music. He had previously attended college and held part-time service jobs. Similarly, a man in a Long Island program typically spent two hours of each Tuesday afternoon playing UNO and doing Word Search puzzles.

In response to questions asked of the "permissive" CDTs about these practices, programs cited several reasons for permitting these behaviors: some individuals may have recently been discharged from the hospital and were still adjusting to a change in medication that was making them sleepy; some participants would leave the program if not allowed to simply rest and eat and would wander the streets and engage in activities that could result in law enforcement

involvement; others were simply very difficult to engage and could not tolerate the stress associated with group attendance.

Over-arching these individual-specific concerns, most CDT programs in the Commission's sample held the belief that the programs were providing a definable service in maintaining a milieu which was therapeutic. While the Commission is sympathetic to the needs of persons too symptomatic to actively engage in CDT programming and acknowledges the good intentions of the programs in providing meals and a comfortable environment, the Commission questions the appropriateness of using Medicaid funds to pay for maintenance of a therapeutic milieu. This issue is further discussed in the fiscal section of this report.

Treatment Plans

The regulations governing OMH outpatient programs (14 NYCRR §587) require staff and participants (to the degree they are able and willing) to engage in an ongoing assessment process which results in a treatment plan. This plan should identify treatment goals and objectives and should be "updated or revised as necessary to document changes in the recipient's condition or needs and the services and treatment provided." Progress notes, written at least every two weeks, should "identify the particular services provided and the changes in goals, objectives and services, as appropriate." Objectives are expected to be specific, measurable and attainable.

Reporting Progress

With rare exception, programs met the regulatory requirement for a progress note every two weeks; however, these notes often did not report progress, i.e., they did not address advancement of the treatment plan goals or reported only attendance and sometimes level of participation. As an example, Mr. B's treatment objective was to "note 10 ways that I have stabilized my mood weekly." The progress note states, "Pt. utilizes groups and CDT to assist with stabilizing his moods." This same man had an objective to "have an increased ability to manage symptoms and increased knowledge of my illness." The progress note read, "Attended numerous groups to increase knowledge of illness." Similarly, rather than address whether the individual did or did not work on a goal and the progress or lack of it, this progress note appeared with regularity over several months for a downstate participant:

Client attendance as usual. Reports (illegible word) stability and med compliance. Continues to miss SW appointments. Denies SI/HI. Reports no problems in the neighborhood.

The notes in all programs were not as terse, repetitive, or unfocused. One CDT used a computer program that provided a very short description of the discussion topic or activity of the group, the length of the group, and the level of the individual's participation. Several programs with computerized record keeping systems maintained a list of the individual's problems (as identified through the treatment planning process) with a scoring system (e.g., 1=not a problem, 5=severe problem) that allowed a counselor to evaluate the individual's status every two weeks.

Other programs used a scoring system to evaluate progress on a quarterly basis. Another system showed baseline and current status scores on three broad variables for all attendees: participation, skill development activities and social functioning.

Selecting Objectives

In general, treatment objectives were based on assessments that identified skills the individual needed to acquire and maladaptive behaviors the individual needed to reduce. In short, assessments and treatment plans were congruent. The problems evident in the Commission's review of records related to the failure to meaningfully change, add or delete treatment objectives when necessary and appropriate. Some treatment plan objectives were continued forward or revised with no reference to the degree of progress. Often when a treatment plan indicated that a participant had attained a goal, there was no documentation in the progress notes to support this determination. Alternately, some objectives, as with Mr. L, were documented as attained in July, but nonetheless carried forward with a new target date of December 29, with no explanation.

Similarly, treatment plan objectives were discontinued with no rationale. As an illustration, objectives concerning maintaining long-term sobriety and practicing relapse prevention skills were dropped from one individual's treatment plan in December 2003 with no documentation that the objective had been attained and no rationale provided for the deletion. At the time of our visit in the fall of 2004, the individual was noted as recently stating that he still has the urge to drink. Alternately, in some cases, the criteria for success was changed (e.g., an objective for an individual to be able to state three coping strategies would be changed to two or four) with no explanation.

In other instances, the same objectives were repeated over long periods of time without revision. Perhaps the most extreme example concerns a man who had been in a downstate CDT program for ten years. Two of the objectives for this man, "maintain stability by attending CDT regularly" and "continue to speak up in groups and maintain friendships to decrease isolation," were initiated nine years earlier and were still active at the time of our review. A goal to "reduce sadness and paranoid symptoms and have more relaxed, trusting interpersonal interactions, be less guarded, reduce poverty of speech" was established for a woman in a downstate CDT program in June 2002. Objectives for her to "talk with other members every day, improve ability to participate in conversation and initiate interactions and spontaneous verbal responses" had been carried forward unchanged for 27 months, through the time of our review.

Objectives that provided no challenge to the individual and treatment plans in which all of the objectives involved only maintaining attendance at various groups, with no indication of the expected outcome, also raised concern. For example, one individual in the sample worked part-time three days a week, had attended college and hoped to return on a part-time basis, and wanted to leave the CDT program. Yet, his treatment plan goals were to "attend medication education groups and increase his over-all attendance at the CDT." His schedules for the two days he attended both ignored his aspirations and did not address his need for medication education.

Monday	Wednesday
Sing-a-long	Jewelry Making
Relaxation Movement	Eating Problems & Solutions
Karaoke	Games

Finally, some treatment plans were developed from canned programs where the therapist chose from a selection of symptoms, goals and objectives and treatment services. In one program two of the five individuals in the Commission sample had the same treatment objective: “Achieve greater success/satisfaction in community living and through the development of new skills and supports will improve functional deficits.” The method for attaining the goal was attendance at groups. The only element that differed was which groups the individual was supposed to attend.

Moving the Focus to the Individual

Dr. Mark Ragins, affiliated with MHA Village Integrated Service Agency³ and a leading advocate and writer on recovery-based mental health care and treatment, writes in his article “The Four Walls,” “If we ask people what was most helpful to them they rarely describe our clever diagnosis and elaborate combinations of medications. They describe moments of human kindness and caring, of believing in them and inspiring hope, of listening to them and making them feel precious.” Whatever other problems with treatment planning the study revealed, the one most likely to have the greatest negative impact on the people served was the failure of the plans to acknowledge and address significant life-changing events they were experiencing. In those programs where participants had some 1:1 time with a counselor, these issues may have been discussed during these sessions. In other programs, the issues came to light largely because they impacted on the individual’s attendance at the CDT.

- Five individuals in the Commission sample were surrendering custody or regaining custody of their children. The examples below are representative of that group.
 - Ms. D, whose objective to talk to other CDT members had not changed in 27 months was soon to move into a new two-bedroom apartment because her 13 year-old son was being returned to her custody after having been in foster care for several years. The CDT program accommodated her request not to be discharged because she was feeling extremely stressed, but there was no change in her treatment plan and no additional 1:1 counseling provided to assist her.
 - 30 year-old Ms. S regained custody of the youngest of her five children in the spring, but the child was returned to respite care in the fall when Ms. S was hospitalized. Occasional visits were occurring again at the time of our review. Progress notes indicated that the treatment team recognized that mom (and other women in the program) would benefit from a parenting group. Five months later

³ A program of the National Mental Health Association of Greater Los Angeles

when Commission staff reviewed the record, this group had not begun, was not scheduled to begin, and there was no change in mom's treatment plan or schedule.

- 44 year-old Ms. G was in the midst of legal proceedings to regain custody of her daughter. Her treatment plan addressed her need to remain sober as she worked with lawyers to regain custody. It did not, however, provide parenting skill training or education on the effects of alcohol on parenting ability.

In contrast, one program obtained an Intensive Case Manager (ICM) for a woman who, within a three-month period, attempted suicide after she suffered a miscarriage and her two under-10-year-old children were returned to foster care. The ICM helped this young mother cope with the overwhelming circumstances.

- Participants were coping with loss from death and divorce, suicide attempts, and seriously harmful behaviors, but their treatment plans were not amended to address these issues.
 - Mr. Z, a forty year-old man, who shared an apartment with another man who also had a diagnosis of schizophrenia, returned to the apartment one fall evening to find his roommate unresponsive. He called 911 and was coached through CPR while waiting for EMS to arrive. The roommate was declared dead. Mr. Z was moved to another apartment. One note mentioned this traumatic event, but no counseling was offered and no adaptation in his treatment plan was made.
 - Mr. R was very upset when his apartment mate died. The friendship that the two men shared represented a great step for Mr. R, who was usually isolative and withdrawn. There was no change in Mr. R's treatment plan and only a short reference to the event in quarterly progress notes.
 - Mr. C and his foster brother spent many weekends together. When the foster brother died, there was no change in Mr. C's treatment plan and no additional counseling provided. Rather, the notes reflected that Mr. C was upset and not meeting his objective to attend the program regularly. Similarly when Mr. G's mother died, his grief was not addressed in his treatment plan.
 - One individual had continuing problems with anger. Thirteen notes describe his aggressive behavior between May and September 2004, including one instance when he went after another participant with a knife. Yet, no treatment objective addresses this problem.
 - Two suicide attempts within a month and a 23 day hospitalization did not warrant a change in Mr. B's treatment plan.

Finding A Recovery Focus

There was a disconnect between the life goals participants held for themselves and the goals and objectives they were working on in the CDT programs. Consumers told us in interviews and in their written comments on the satisfaction survey that the three leading areas where they wanted assistance were: finding employment, learning skills that would lead to employment, and living more independently. Yet, less than 20 percent of the sample had an objective addressing any aspect of finding employment and even fewer (14 percent) had an objective related to obtaining vocational training. Learning to handle money and budgeting were treatment objectives for only seven percent of the individuals in the sample.

Coping and dealing with symptoms dominated treatment plans. Ninety-five percent of the individuals in the sample had one or more goals related to symptom management, and thirteen people (15 percent) had goals exclusively related to symptom management. It was not surprising that a sizable number of consumers interviewed could not report their treatment goals and objectives other than to say they were working on getting better.

Some programs created opportunities for consumers to work within the program, providing services to their peers. Serving breakfast and lunch, working in the thrift shop and performing clerical duties were among the work tasks commonly performed. In some programs this was paid work, while in others the work was considered a voluntary training experience and was not compensated. Therapeutic groups that focused on job skills or which were specifically designed for the individuals working in these in-house positions often accompanied the on-the-job experience. In interviews, individuals clearly indicated that they took their assignment seriously and viewed it as a stepping-stone to compensated competitive employment. The recent introduction of PROS (Personalized Recovery-Oriented Services) provides programs the opportunity to substantially expand their rehabilitative services. Every program operating under a PROS license must offer intense rehabilitation⁴ and ongoing rehabilitation and support⁵-- services that consumers told us they were seeking.

Program Participants Speak

Four out of five individuals indicated they enjoyed coming to the CDT program most of the time. Fifteen percent said they enjoyed coming some time, and four percent did not like the program they were attending. Sixty-nine percent said they were always treated respectfully, twenty-eight percent said they were treated respectfully most of the time, and three percent reported respectful treatment almost never.

⁴ Intensive rehabilitation is defined in the PROS regulation (14 NYCRR §512) as a program component “designed to intensively assist individuals in attaining specific life roles such as those related to competitive employment, independent housing and school.”

⁵ Ongoing rehabilitation and support (ORS) is defined as a program component “designed to assist individuals in managing symptoms and overcoming functional impairments as they integrate into a competitive work place. ORS interventions shall focus on supporting individuals in maintaining competitive integrated employment.”

These figures represent the responses on the first two multiple-choice questions in a written consumer satisfaction survey completed by 1,304 CDT program participants (survey attached as Appendix). Programs were provided the survey forms and asked to distribute them in a way that would disrupt programming the least. Some programs handed the survey out as people entered the program, some asked consumers to complete them at lunch time or during a community meeting, some programs provided staff to read the questions aloud while participants checked their responses, and other programs provided help when it was requested. In addition to the multiple choice questions, the survey concluded with a write-in question asking if there was anything the individual wanted assistance with that was not presently being addressed. Commission staff interviewed all of the individuals in the sample who were available and willing; in an effort to elicit more expansive answers to the survey questions. The procedures used to complete the forms may have influenced the responses.

Question	Yes %	No %
I determined how I spend my time here. I made my own schedule.	69	31
My goals make sense to me and I helped to choose them.	90	10
I am making progress in meeting my goals.	92	8
The medication I am taking is helpful.	92	8
The doctor listens to me when I talk about my medication.	92	8

In selecting from a list of options, consumers identified favorite activities in the rank order indicated. Each of the top four choices received at least 25 percent of the responses, with talking to therapist identified by 35 percent of the respondents.

- Talking with my counselor/therapist
- Breaks and lunch
- Groups related to feelings
- Current Events groups

One hundred forty-seven people responded to the write-in question on the survey with personal concerns they would like addressed, with the following results. As reported earlier, there was less emphasis on finding employment (18 percent) and securing education and training (14 percent) among the treatment goals in the study sample. Goals related to living more independently were rare, with a few persons receiving assistance in finding a different living arrangement.

Issue	% of responses
Finding employment	26
Living more independently	24
Education/Training	19
Improving relationships with people important to me	10
Dealing with a health problem	5
Dealing with sexual abuse trauma	5

Again, the PROS program should be better able to meet the real-life needs of the participants as they (the consumers) see them.

Fiscal Findings

Disconnect Between Practice and Regulations

The Commission selected 1,100 claims for the period January 1, 2003 to April 30, 2004 submitted by the 17 agencies in our study to review. Because CDT providers bill Medicaid based on service hours, the 1,100 Medicaid claims represented slightly more than 4,200 hours of attendance by recipients within the programs. The Commission's review found that a significant number of the services billed to Medicaid could not be substantiated by proper documentation.

A CDT provider bills Medicaid based on a "visit," which is defined by OMH as a face-to-face interaction between a recipient and clinical staff for the provision of a service (14 NYCRR §588.4(a)). CDT visits range from one hour to five hours in duration. Therefore, if a recipient attends a CDT program for one hour, the program would bill Medicaid for that hour utilizing the one-hour rate code; if the recipient attends for two hours, a separate two-hour rate code would be used, etc. Up to five hours per day can be billed.

Medicaid regulations require that a billing for a visit be supported by documentation indicating the nature and extent of services provided (18 NYCRR §504.3(a)). OMH regulations base the reimbursement system for CDT programs on a "visit," which is, in turn, based on service hours. The Commission looked for documentation describing the services the individual received during the hours billed. In a significant number of claims the Commission reviewed, however, the available documentation was not sufficient to provide that level of support.

OMH does not require that a provider document that a service was provided for each billable hour. Rather, the total time each day an individual attends the program dictates what is billed as long as the requirements for a "visit" (a face-to-face interaction between a recipient and clinical staff for the provision of service) are met. Providers document services as if they were reimbursed based on a "threshold rate."⁶ Using the threshold rate model, reimbursement does not depend on the number of hours of service provided; the program receives the same rate whether it provides one service or five. Therefore, documentation of each service provided is not necessary for Medicaid billing purposes, only documentation that at least one billable service was provided on each day billed. At most CDT programs in the Commission's review, programs billed Medicaid based solely on hours of attendance rather than the actual services provided.⁷ Often, the only documentation available was a sign-in sheet completed when the individual entered the program for the day and sometimes, but not always, when they left.⁸

⁶ A "threshold rate" is a reimbursement method where a provider will receive a set rate each time a patient crosses the threshold of a facility to receive medical services without regard to the number of services provided during that visit. Normally, only one threshold visit per patient per day is allowed. Most hospital-based clinics which are dually-certified by the Department of Health and Office of Mental Health receive reimbursement under this method.

⁷ The Commission is referring only to the nonprofit providers as the hospital-based CDT programs are reimbursed based on a threshold rate.

⁸ The Commission requested any and all documentation to support a providers' Medicaid billings and in most cases were provided only the daily attendance sheet. Treatment plans and bi-weekly progress notes also were reviewed; however, these records did not document the daily services provided to recipients.

The sign-in sheets simply record the times that a recipient entered and left the program – nothing more. Consequently, the nature and extent of services provided were unknown, as reflected in the sign-in sheet below.

LIST OF PRESENT CLIENTS FOR PROGRAM A -11/07/03				
CLIENT	NAME	11/07/03 TIME IN	2:35 PM TIME OUT	RON PAGE NO. 1 TIME SPENT
96003	, OLIVIA	8:49 AM	2:09 PM	5.33
18977	, BARRY	8:37 AM	2:08 PM	5.52
32121	, SALENA	10:01 AM	2:09 PM	4.12
1019	, DAVID	8:31 AM	2:01 PM	5.50
9900	, VALRICK	8:45 AM	2:02 PM	5.28
67107	, RONNIE	8:45 AM	2:01 PM	5.27
60922	, ROBERT	8:20 AM	2:07 PM	5.78
10681	, VICTOR	8:40 AM	2:00 PM	5.33
71871	, DAISY	9:14 AM	2:00 PM	4.77
60919	, KALIEK	8:34 AM	2:17 PM	5.72
14629	, EMMANUEL	9:17 AM	2:01 PM	4.73
2031	, JOSEPH	9:13 AM	2:16 PM	5.05
97429	, MORRIS	8:45 AM	2:00 PM	5.25
1339	, JULES	10:27 AM	2:16 PM	3.82
22256	, MARILYN	9:34 AM	2:11 PM	4.62
27843	, ANTONIO	8:59 AM	2:11 PM	5.20
5586	, JENNIFER	8:55 AM	2:07 PM	5.20
.....				

For example, “David” entered the CDT program at 8:31 am and left at 2:01 pm for a total of 5.50 hours. Because programs can only bill a maximum of five hours per day, the program billed for the full five hour day for David. However, what services, if any, were provided to David during this time were not documented. A significant number of the 1,100 claims reviewed by the Commission were supported only by a daily attendance sheet. As a result, the claims were unsupported as the services provided were unknown. In some cases, the daily attendance sheet did not even record the time the recipient was present at the program. Instead, the provider assumed that the recipient attended for the full five hours and billed Medicaid accordingly.

An actual case will illustrate an extreme example of the problem. Commission staff found one instance where a recipient attended the CDT program every day of the week for the full five hours each day or 25 hours for the week. However, he attended only one group session during the entire week - - a group therapy session mandated by the program. The recipient told Commission staff that the rest of the time he would “hang-out in the program,” either reading the newspaper or listening to music. The program billed Medicaid each day for the full five hours, even though the recipient only received one billable hour of service.

Regulations do not support this billing method. In addition to the OMH regulation (14 NYCRR §588.4) which requires that all visits be based on a face-to-face interaction between a

recipient and clinical staff, the Medicaid regulations (18 NYCRR §505.25(e)(5) and 18 NYCRR §504.3(a)) are equally clear that only a documented, definable medical service which discloses the nature and extent of services provided will be reimbursed. Yet, in the example noted above, even though there was no documentation of any service provided for 24 of the 25 hours billed, the provider still billed Medicaid each day for the full five hours.

As noted earlier, providers defend this practice, claiming that the program is a “therapeutic environment,” and just being in the environment is justification to bill Medicaid for the full time that someone is in attendance, regardless of whether or not services are provided.

Some providers documented an individual’s attendance at a particular group or individual therapy session by maintaining group notes. This documentation allowed the Commission to determine the amount of time actually spent receiving a service versus the time simply spent at the program. The providers keeping group notes could not support what services, if any, were provided to recipients in many of the claims reviewed.

Group notes were also deficient in many respects, but mainly in their failure to provide sufficient information about what therapeutic service occurred and the recipient’s response. For example, the group note below reflects that recipients attended a group titled “Anger Management Bingo.” Other than the cryptic title, the only description of what occurred was a scant note at the bottom - - “Clients participated in a game of bingo with anger management.” There was no other description of what occurred (what is anger management bingo?) and how any particular individual (on whose behalf Medicaid was billed) benefited. Even with these deficiencies, the Commission gave the program the benefit of the doubt and counted such documentation as sufficient when determining its overall error rate. Only one of the programs reviewed billed Medicaid based on group notes, thus avoiding the over-billing caused by lack of documentation.

CONTINUING DAY TREATMENT PROGRAM
SIGN-IN SHEET

GROUP: Anger Mgmt / 200 DATE: 8/22/03

LEADER: Thomas TIME: 1:00PM

1. <u>Vincent</u>	21. _____
2. <u>Charlotte</u>	22. _____
3. <u>Ken</u>	23. _____
4. <u>Steve</u>	24. _____
5. <u>Roger</u>	25. _____
6. <u>Richard</u>	26. _____
7. <u>James</u>	27. _____
8. <u>Clayton</u>	28. _____
9. <u>Julio</u>	29. _____
10. <u>Shannon</u>	30. _____
11. <u>Jennifer</u>	31. _____
12. <u>Ryan</u>	32. _____
13. <u>Joseph</u>	33. _____
14. <u>Kenny</u>	34. _____
15. <u>Bob</u>	35. _____
16. <u>Bob</u>	36. _____
17. <u>Tommy</u>	37. _____
18. <u>Chris</u>	38. _____
19. <u>Steve</u>	39. _____
20. _____	40. _____

Goals: Clients participated in a game of
baseball with Angel Management

Other notable group notes were:

Title of Group	Number in Attendance	Description
History of Rock & Roll	29	“Good Group”
Annual Picnic	103	“Social skills & community interaction within an alternative environment made the annual picnic a tremendous success. Participants developed, practiced and received reinforcement for involvement in sports, hikes and conversations as well as enjoyed tremendous amounts of barbequed beef.”
GED Science	9	“Group participants engaged in an activity from GED manual. Lecture was given and reviewed: genes and heredity.”
Video	34	“Clients viewed “The Little Rascals””

Finally, the Commission’s own observations during its site visits confirmed the findings of the claims review. In some programs it was not uncommon to enter a CDT program and witness recipients wandering the halls, or sitting in a lounge watching television or playing a variety of games for hours. Breakfast and lunch were provided at many programs and the time spent eating was calculated into the billed hours. Again, providers defended these practices by

stating that it is better that individuals attend the program rather than wander the streets or that it is hard to engage recipients in a program every minute of the day. The Commission does not disagree with this. In fact, the Commission recognizes that programs are motivated by a desire to help these individuals. However, the issue is not whether these individuals should be attending the programs, but whether Medicaid should be billed for simply providing a roof and a meal.

Other Documentation Problems

In January 2004, OMH provided a summary of the requirements, including documentation requirements, for receipt of Medicaid payments. Although OMH did not address the issue noted above, it did enumerate the most common documentation reasons associated with a Medicaid disallowance. The various reasons included: missing records (progress notes, treatment plans or case records), duration of visit not documented, the untimely completion of treatment plans and no physician signature on the treatment plan. The Commission's review found several incidents of the above problems.

Medicare Maximization

It is well established that Medicaid is always the payer of last resort. Therefore, if a recipient is eligible under another insurance plan or is a private payer, these plans should pay for services first before Medicaid pays. Many CDT recipients are dually-eligible for both Medicare and Medicaid. When this occurs, Medicare should be billed first before Medicaid pays. The Commission reviewed five hospital-based CDT programs and found two instances where co-insurance claims involving both Medicare and Medicaid were problematic.

In one instance, the Commission found that one hospital had overcharged the Medicaid program by more than \$215,000 for a two and one-half year period due to the way it was billing recipients who were dually-eligible. The Commission conducted a detailed review of the hospital's claims, recommended they reimburse the Medicaid program for the amount overcharged and revise its system to stop the overpayments. The hospital agreed with the Commission's findings and repaid the amount in question.

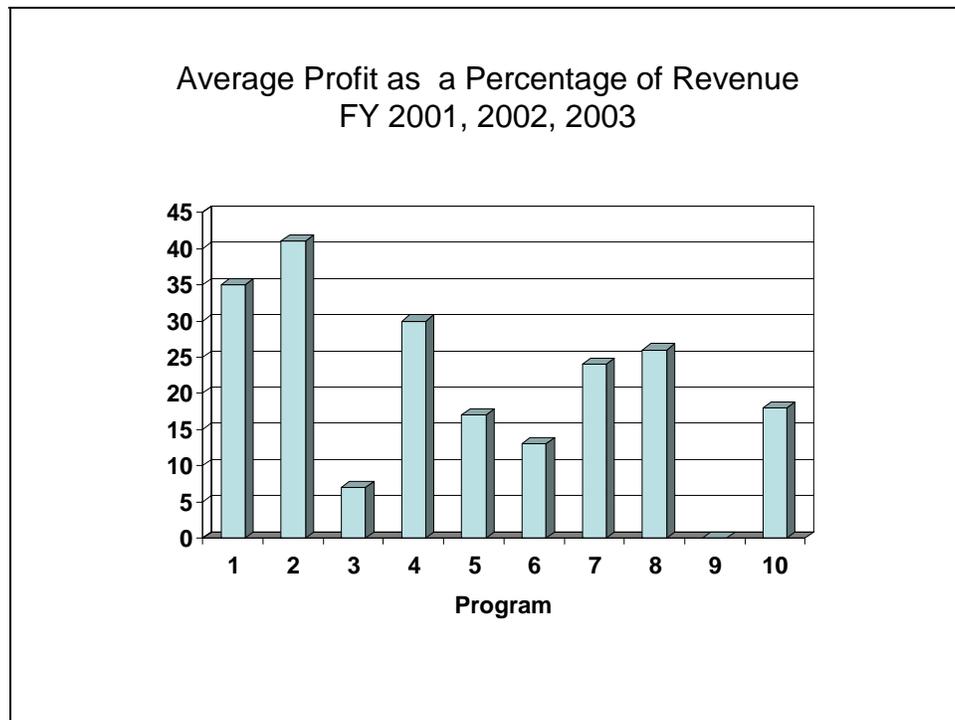
In the second case, the Commission found that a second hospital billed Medicaid more than \$56,000 for one individual for a single month of services at its CDT program. Again, the overcharge was the result of the way the hospital billed for recipients who were dually-eligible. Prior to the Commission's visit, the hospital had become aware of the billing problem and was in the process of correcting it. Interestingly, the excessive charge had passed all Medicaid edits and was paid to the hospital.

Because of the complexity of hospital reimbursement systems and the regulations governing Medicare reimbursement, a detailed explanation in this report is prohibitive. In both cases reviewed by the Commission, the hospital misreported the amount approved and paid by Medicare, causing the Medicaid payment to be excessive. The problems regarding co-insurance

issues should be reviewed further by OMH and Medicaid officials to ensure that reimbursement from the Medicare program is maximized to the fullest extent.

CDT Profitability

The Commission attempted to determine the profitability of the programs visited for the three-year period 2001 to 2003 by reviewing the Consolidated Fiscal Reports (CFRs) that each agency is required to submit to OMH. The cost review was restricted to the ten not-for-profit agencies in the Commission's sample. Of the 29 CFRs available for review,⁹ 28 reflected surpluses in the CDT programs, ranging up to a surplus of \$4.5 million. One CFR recorded a loss of \$665,000. As noted in the chart below, the percent of surplus to total revenue over the three-year period ranged from zero to 40 percent of total revenue.



However, as one knowledgeable OMH official advised Commission staff, the CFR is “illusory” because the revenue data for CDT’s is misleading. The revenue numbers include COPS and CSP payments¹⁰ which are designed to cover deficits in other outpatient programs and therefore, should be applied to those other programs. As a result, the CFR revenue data for CDT programs is overstated. To get a clearer picture of profitability, one would need more detailed information on the proper composition of the revenues reported.¹¹

⁹ Each year a provider is required to submit a CFR. Therefore, for the three-year period, for 10 agencies, 30 CFRs should have been filed. However, OMH only had 29 CFRs on file.

¹⁰ COPS is the Comprehensive Outpatient Program and CSP is the Community Support Program.

¹¹ OMH reportedly ceased reporting revenue in this manner in 2004.

Recommendations

Programmatic Recommendations

OMH should provide written guidelines to supplement current certification standards. These guidelines should direct CDT providers' attention to treatment planning and treatment strategies that promote a recipient's integration into everyday life activities. This guidance should clarify that OMH certification reviews will include a renewed focus on the following:

- There is an expectation that engagement in a CDT program will result in progress in meeting rehabilitation and recovery goals. In addition to the quarterly review of treatment plans, an analysis of factors impeding progress and remedial actions undertaken should be required at least annually for persons not meeting goals.
- Meaningful review and revision of treatment plans, based on the recipient's response to treatment and life events likely to affect treatment, must occur in a timely manner. Consideration needs to be given to providing 1:1 time with a counselor when circumstances suggest the need.
- Persons whose CDT participation is billed to Medicaid must, at a minimum, accept some CDT core services. A written rationale must justify exceptions.
- The goals of the treatment review process must include the successful identification of persons who wish to work and are able to engage in programs which advance this objective. Persons so identified will be guided into programs which prepare them for work or vocational training and increasing independence.

Fiscal Recommendations

OMH should develop guidelines to address the proper billing of services to Medicaid in the following areas:

- Guidelines must address or otherwise put providers on notice regarding any requirements applicable to billing under Medicaid, whether issued by OMH, DOH or the federal Centers for Medicare and Medicaid Services.
- Only definable medical services should be billed to the Medicaid program. Guidelines should be comprehensive to cover the nature and duration of services regardless of billing methodology.
- OMH should ensure that the revised billing guidelines are consistently applied where two programs offer similar services; e.g., CDT and PROS.
- A review of program billings should be conducted to ensure that all third-party revenues, such as Medicare, are maximized and the Medicaid is the payer of last resort.