Offices of the Inspector General

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Inspector General

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February 7, 2023

Kerri Neifeld
Commissioner
New York State Office for People
With Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Re: NYS IG 2843-031-2021

Dear Commissioner Neifeld:

On November 28, 2021, the New York State Office for People With Developmental Disabilities (OPWDD) alleged to the Offices of the New York State Inspector General that [redacted], a psychiatric nurse practitioner working under contract with OPWDD, overbilled for services rendered between April 2018 and September 2021.

The Inspector General's investigation of this allegation found that during the aforementioned period, [redacted] billed and was paid by OPWDD for eight-hour workdays but, in fact, typically worked approximately six hours per workday. However, the investigation also that found [redacted] was not provided clear guidance as to her required work hours or billing. Interviews of [redacted] OPWDD supervisory personnel, and OPWDD's Business Office revealed a lack of uniform expectations for [redacted] hours and billing practices. This ambiguity and the lack of meaningful supervision prevented this office from being able to conclusively determine whether [redacted] was actually overpaid for her services.

By way of background, [redacted] began working under contract with OPWDD in January 2014 at [redacted] Developmental Disability State Operations Office (DDSOO) campus in [redacted], New York. In this position, [redacted] typically worked one day each week at the facility providing psychiatric services to individuals with disabilities. Prior to summer 2020, [redacted] ostensible supervisor was Dr. [redacted] the then regional medical director of the [redacted] DDSOO. After [redacted] retirement in 2020, Masco was supervised by Dr. [redacted], a clinical physician 2.

Notably, the Inspector General was unable to determine the exact hours worked by [redacted] during her tenure due to deficiencies in OPWDD's record keeping practices and a lack of daily supervision of [redacted] Although OPWDD provided a calculation of overpayments to [redacted] this calculation relied on informal notes of tentative schedules of patient appointments. Despite a request from the Inspector General, OPWDD was unable to produce any corroborating records, including logs of the duration of actual appointments, employee sign in/sign out sheets, surveillance footage, or keycard swipe data. In addition, OPWDD did not take into consideration [redacted] other responsibilities, which included handling prescriptions, reviewing documentation, and handling patient transfers. [redacted] in her testimony to the Inspector General, was forthcoming, readily admitting that she worked approximately six hours of each workday and billed OPWDD for eight-hour workdays.

Lack of Uniform Expectations for [redacted] Hours and Billing Practices

[redacted] testified to the Inspector General that during her initial employment interview with [redacted] he told her that she would be paid for eight hours of service each workday regardless of the actual number of hours she worked. She further stated that the [redacted] DDSOO scheduling nurse advised her during her first workday that she need not arrive at the facility prior to clients arriving for the first appointment at 9:30 a.m. According to [redacted] she typically left work each day after her final appointment concluded around 3:30 p.m. [redacted] further testified that she did not receive any training on billing or hourly expectations and was only trained as to paperwork used for treating clients.

[redacted] testified differently. He stated that he was under the impression that [redacted] contract specified her hours as 8:30 a.m. to 4:30 p.m., and that the contract required her to be on site for those hours to offer her services. However, a review of the contract found no such language. [redacted] also testified that he believed that if [redacted] was present at the facility and available to provide services she was entitled to payment. In contrast, OPWDD business office staff testified that [redacted] was only to be paid for "services rendered" during her time spent in appointments with clients.

In April 2018, [redacted] and OPWDD executed her most recent contract to provide psychiatric services at the facility. The contract term ran from April 1, 2018, through March 31, 2023. The agreement's "Scope of Work" dictated OPWDD's expectations regarding services. It states, in pertinent part:

> Under the direction and supervision of the [redacted] DDSOO/Article 16 Medical Directors or Designee, services shall be provided to people with developmental disabilities who reside in the [redacted] DDSOO region . . . [t]he services shall include, but not necessarily [be] limited to the following: [p]rovide one (1) consultation clinic session, up to eight (8) hours, on a weekly basis, at the [redacted] Clinic.

The agreement does not specify the number of appointments, duration of appointments, [redacted] start and end times at the facility, whether any of her duties

outside of clinical sessions would be compensated, or whether she would be compensated for her mere presence at the facility.

[redacted] Lacked Adequate Supervision

The investigation also found that OPWDD did not provide [redacted] with adequate supervision, which resulted in her practices going unnoticed and uncorrected for nearly a decade. Testimony from [redacted] and [redacted] confirmed that neither supervisor regularly spoke to [redacted] throughout her tenure, and both supervisors were based out of a different facility. Indeed, the supervisors' offices were located in Newark, New York, while [redacted] provided services at the [redacted] DDSOO, which is located in [redacted], New York. [redacted] testified that she saw [redacted] approximately three times a year and that any practical supervision she received was provided by another psychiatrist then at the facility, as [redacted] is not a psychiatrist. According to [redacted] he relied upon reports from the clinic to apprise himself of [redacted] efficacy and attendance. [redacted] testified, "If problems were not reported to [me] then [I] would think things are going well."

[redacted] testified that she did not know the details of [redacted] contract, did not have conversations with her regarding her work hours, and only spoke with her when they both provided services to the same patient. [redacted] did not proactively offer supervision to [redacted] advising that she would only need to supervise [redacted] if an issue were brought to her attention.

In essence, the supervisors' sole responsibility regarding [redacted] was to approve and sign her time sheets, which they did, without having direct knowledge of her actual work activities, time, or attendance. This lack of meaningful and informed supervision enabled [redacted] to work less than a full workday and prevented OPWDD from promptly addressing her practices.

OPWDD's Corrective Actions

In light of the instant issue, OPWDD advised it has adopted or plans to adopt several remedial measures regarding contracted practitioners. The measures will increase accountability through additional record keeping procedures, supervision, and amending practitioner contracts. Such staff will be required to complete mandatory sign-in/sign-out logs; document all services provided, including the location, date, and time of services; and provide a summary explaining hours worked.

Accordingly, I recommend that OPWDD conduct a review of all psychiatric nurse practitioner contracts and ensure the contracts specify the time, place, and manner of work to be performed; describe payment/billing expectations in detail; and address any deficiencies/ambiguities discovered with amendments and training.

Notably, these corrective actions are limited in scope, as OPWDD utilizes just four contracted psychiatric nurse practitioners statewide. Moreover, other practitioners working at OPWDD under contract follow provisions established in more standardized contracts used across New York State agencies. Therefore, I additionally recommend that OPWDD take the following actions with regard to all contract practitioners:

- Improve employee time tracking procedures (sign-in/sign-out logs, key cards, etc.)
- Ensure supervisors regularly contact and provide meaningful supervision in their area of discipline to their subordinates, such that they can provide direction and guidance as needed.
- Ensure that supervisors responsible for reviewing and approving the time and attendance of contract employees have personal knowledge of the employees' time and attendance.
- Train supervisory staff regarding expectations for contract employees and the importance of ensuring billing vouchers/timesheets are accurate prior to their signature.

Please advise me of any action taken by OPWDD in response to these recommendations within 45 days of the date of this letter. If you require further information, please contact Deputy Inspector General Jeffrey J. Hagen at 716.847.7118.

Sincerely,

Lucy Lang
Inspector General

cc: Eileen M. Haynes, Esq.
Deputy Commissioner and General Counsel