A REPORT BY THE NEW YORK STATE OFFICE OF THE STATE COMPTROLLER

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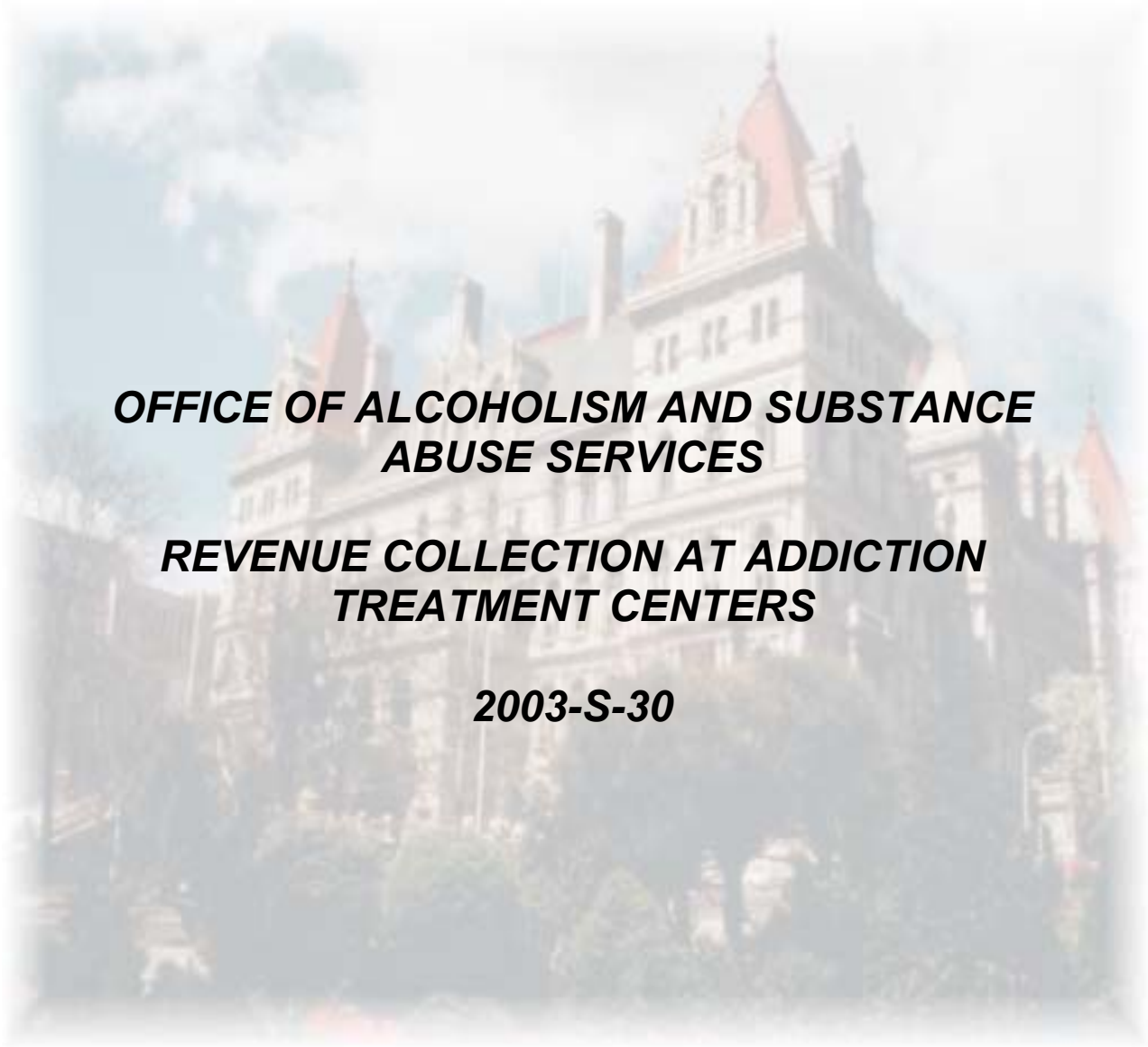

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVENUE COLLECTION AT ADDICTION TREATMENT CENTERS

2003-S-30

DIVISION OF STATE SERVICES

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Report 2003-S-30

William A. Gorman, Ph.D.
Commissioner
Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203-3526

Dear Dr. Gorman:

The following is our report on the Office of Alcoholism and Substance Abuse Services' revenue collection practices at Addiction Treatment Centers.

We performed this audit pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. We list major contributors to this report in Appendix A.

Office of the State Comptroller
Division of State Services

August 19, 2004

EXECUTIVE SUMMARY

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVENUE COLLECTION AT ADDICTION TREATMENT CENTERS

SCOPE OF AUDIT

The Office of Alcoholism and Substance Abuse Services (OASAS) provides alcoholism/chemical dependence inpatient rehabilitation services at 13 State-operated Addiction Treatment Centers (ATCs). ATCs provide treatment regardless of the patient's ability to pay. To offset the costs of patient care, ATCs submit bills for services to Computer Sciences Corporation (CSC), the Department of Health's (Health) fiscal agent for Medicaid; to private insurers; and to patients who have the resources to pay. More than 97 percent of the approximately $13 million OASAS collected in the 2001-02 and 2002-03 fiscal years was from Medicaid. OASAS does not receive federal Medicaid funds for this program. Rather, the State and the counties each provide 50 percent of the Medicaid funds for ATC services.

Each ATC employs a Resource and Reimbursement Agent (Agent) whose duties include maximizing revenue collections by billing responsible parties for services. ATC billing procedures state that Agents should identify Medicaid recipients prior to admission and verify their coverage data by consulting the Welfare Management System (WMS) and the Electronic Medicaid Eligibility Verification System (EMEVS). Agents must get carrier pre-approval before admitting patients with Medicaid Managed Care or private insurance. Persons who are not covered by Medicaid or private insurance, but who appear Medicaid-eligible, are told to apply for Medicaid at their county social services office. ATC policies state Agents should help patients make this application. According to Health officials, Medicaid coverage, once granted, can cover medical expenses a person incurred during the 90 days prior to application. Therefore, Medicaid can cover ATC treatment costs for patients who obtain Medicaid coverage during or immediately after their ATC stays.

Our audit addressed the following question about OASAS' revenue collection practices at ATCs for the period January 1, 2001 through June 30, 2003:

- Do ATCs maximize the revenue they are eligible to collect for services provided?

AUDIT OBSERVATIONS AND CONCLUSIONS

We found ATCs do not maximize revenue collection because Agents do not consistently bill treatment costs to the appropriate payers. Our tests of sampled patients at just 6 of the 13 ATCs over a 30-month period showed that ATCs: did not bill CSC more than $217,000 for services to Medicaid enrollees; did not collect almost $647,000 for services to patients who may have been eligible for Medicaid; and did not identify any payer for patient services costing more than $470,000. We also found ATCs do not adequately track or pursue collection from self-pay patients.

Medicaid pays, or could potentially pay, for most patients' ATC treatment costs. However, our tests of 486 sampled patients at 6 ATCs found that ATCs did not collect Medicaid revenue for services to 178 patients. Of this number, 51 patients were Medicaid enrollees whose covered services were not billed, or were incorrectly billed. In these cases, ATCs did not track patients' Medicaid status or did not detect the unbilled services. The remaining 127 patients comprised Medicaid Managed Care patients for whom Agents did not obtain pre-approval; patients who either did not apply for Medicaid or did not complete the application process; and patients whose Medicaid coverage expired before, or began after, their ATC stays. Medicaid did not cover these services because Agents did not promptly identify Medicaid-eligible patients and then track their Medicaid status; did not assist patients in completing their applications; and did not give patients documentation of treatment cost to present to county social services offices. Further, Agents state they do not pursue retroactive Medicaid benefits because county social services offices are reluctant to provide such coverage for ATC treatment, or have refused to do so. However, when Agents do not maximize revenue collections to offset the cost of operating this State and county-funded program, patient treatment costs that remain unbilled and unpaid must be covered solely by the State. To collect all the revenue due for treatment services, we recommend that OASAS bill CSC for costs that are still collectible; ensure ATCs focus on maximizing Medicaid revenue; and work with county social services offices to resolve the issue of retroactive payment for ATC services. (See pp. 16-25)

Agents are required to interview all patients at admission to assess their resources and means of payment. When patients are not enrolled in Medicaid, Agents should determine whether patients are Medicaid-eligible, have private insurance or have the resources to self-pay. However, for 90 of our 486 sampled patients, Agents did not collect enough information to identify any payer at all. Thus, neither Medicaid nor any other party was billed for their services, which totaled more than $470,000. We also found that Agents did not always comply with ATC policies regarding the collection of almost $153,000 from self-pay patients. We recommend OASAS direct ATCs to do thorough patient assessments at admission and to comply with ATC collection procedures. (See pp. 25-29)

COMMENTS OF OASAS OFFICIALS

A draft copy of this report was provided to OASAS officials for their review and comment. Their comments were considered in preparing this final report, and are included as Appendix B.

OASAS officials replied that they agree with the majority of the findings presented in the report and advised of the steps taken to improve the revenue and collection procedures utilized by the ATCs. These steps include entering into a new contract to develop and implement an electronic patient record system that will ensure standardization across the system of services. They also indicated that they have retroactively billed and recovered a significant amount of Medicaid revenue for certain patients. OASAS officials are confident that these steps will have a beneficial impact on the revenues in the months ahead.

CONTENTS

INTRODUCTION

Background

The Office of Alcoholism and Substance Abuse Services (OASAS) is responsible for certifying and evaluating service providers, and for implementing and advocating policies and programs for the prevention, early intervention and treatment of alcoholism and substance abuse, in conjunction with local governments, providers and communities. OASAS also provides treatment services through 13 State-operated Addiction Treatment Centers (ATCs), whose operations are supervised by OASAS' Bureau of Addition Treatment Centers (Bureau). ATCs have been in operation for 30 years and provide alcoholism/chemical dependence inpatient rehabilitation services for persons who require this level of care. The mission of the ATCs is to provide inpatient addiction treatment to all those who need it. The Mental Hygiene Law (Law) states that every patient is responsible for the cost of care received at State-operated ATCs, but also mandates that services not be refused because the patient cannot pay for them. Thus, ATCs provide treatment services regardless of the patient's ability to pay.

OASAS obtains funds to operate the 13 ATCs from revenue it collects from Medicaid, insurance companies and individual patients for the services ATCs provide. Each ATC employs a Resource and Reimbursement Agent (Agent) whose duties, as enumerated by the individual ATC's policies, include billing responsible parties for services.

ATC billing procedures vary depending on the payer (Medicaid, private insurance or the patient), as summarized below. Prior to admission, the ATC Admissions Coordinator contacts the patient to determine whether he or she has Medicaid or private insurance. If the patient is a Medicaid recipient, the Agent queries the Department of Health's (Health) Welfare Management System (WMS) and the Electronic Medicaid Eligibility Verification System (EMEVS) to verify the patient's enrollment and to determine the time period for which the patient has Medicaid coverage. Agents must also identify the type of Medicaid enrollment (Fee for Service or Managed Care) to either verify the patient's Medicaid number (Fee for Service)

or obtain prior approval from the insurer to make sure the ATC stay will be covered (Managed Care). When patients do not have Medicaid, the Agent determines at admission whether the patient has private insurance or the resources to pay for services. If the patient has insurance, the Agent must obtain the carrier's pre-approval for the stay. If the patient does not have Medicaid or private insurance, the Agent assesses the patient's ability to pay, and negotiates a charge for ATC services based on a sliding scale that factors in family size and income. Persons who appear Medicaid-eligible are told to apply for Medicaid at their county social services office, and are given varying levels of assistance (depending on the ATC) in doing so. According to Health officials, Medicaid coverage, once granted, can cover medical expenses a person incurred during the 90-day period prior to application. Therefore, Medicaid can cover ATC treatment period costs for patients who obtain Medicaid coverage during or immediately after their ATC stays.

When patients who have Medicaid are discharged, the Agents enter billing information into the OASAS Client Billing System. OASAS Central Office staff produces a combined ATC billing disk that it sends to Computer Sciences Corporation (CSC), Health's fiscal agent, for processing and payment. For patients who have private insurance, the Agent submits a bill to the insurance carrier. Self-pay patients are expected to comply with the terms of payment plans they agreed to on admission to the ATC.

Data supplied by OASAS officials indicates that ATCs admitted 8,843 and 9,279 patients, respectively, in the 2001-02 and 2002-03 fiscal years. Most of the revenue OASAS collected to pay for the ATC services delivered to these patients came from Medicaid. However, OASAS does not receive federal Medicaid funds for this program. Rather, the State and the counties each provide 50 percent of the Medicaid funds for ATC services. The State's share of the Medicaid costs billed for ATC services is not paid directly to OASAS, but is instead included in OASAS' general appropriation in the State budget.

According to data supplied by OASAS officials, OASAS billed and collected funds from various revenue sources in fiscal years 2001-02 and 2002-03 to pay for ATC services. As shown in *Table 1*, Medicaid payments of about $12.8 million (2001-02) and about $12.7 million (2002-03) constituted 97.2 percent and 97.6 percent, respectively, of collections in these years.

Table 1: Sources of Revenue to Support ATCs		
Source	**Fiscal Year 2001-02**	**Fiscal Year 2002-03**
Medicaid	$12,824,000	$12,694,000
Private Pay [1]	32,000	99,000
Third Party [1]	82,000	207,000
Other	253,000	6,000
Total	**$13,191,000**	**$13,006,000**

[1] *OASAS began tracking "Private Pay" or "Third Party" revenue as separate items in December 2001.*

Audit Scope, Objective and Methodology

We audited OASAS' revenue collection practices at the ATCs for the period January 1, 2001 through June 30, 2003. The objective of our performance audit was to determine whether ATCs are maximizing the revenue they are eligible to collect for services provided.

To accomplish our objective, we interviewed staff in OASAS Central Office and staff from the Bureau of Addiction Treatment Centers. During our audit survey, we conducted site visits to two of the 13 ATCs (the John L. Norris ATC in Rochester and the Dick Van Dyke ATC in Ovid) to interview Agents and obtain an overview of Agent duties and responsibilities. Following our audit survey, we conducted site visits to six other OASAS ATCs, interviewed ATC staff, and reviewed random samples of patient files containing information regarding a patient's payment capabilities. We did not review patient clinical records.

The six ATCs selected for site visits were as follows: Russell E. Blaisdell ATC (Blaisdell) in Orangeburg; Kingsboro ATC (Kingsboro) in Brooklyn; Manhattan ATC (Manhattan) on Ward's Island; Charles K. Post ATC (Post) in West Brentwood; Margaret A. Stutzman ATC (Stutzman) in Buffalo; and the Richard C. Ward ATC (Ward) in Middletown. We selected these 6 ATCs based on data provided by OASAS officials regarding the 13 facilities' respective service days and revenue collections. We judgmentally selected the ATCs in our sample to include two ATCs that appeared to be collecting a large percentage of revenue from Medicaid (Kingsboro and Manhattan); two ATCs (Post and Ward) that were collecting a low percentage of revenue from Medicaid; and two facilities

(Blaisdell and Stutzman) that were collecting an average percentage of Medicaid revenue.

For our review of billing practices at the above facilities, we randomly selected a total of 486 patients from among the 13,511 patients who were discharged from these 6 ATCs between January 1, 2001 and June 30, 2003. The 486 patient files we reviewed comprised several discrete samples. First, we selected random samples of 50 patients from each of the 6 ATCs using data supplied from OASAS' Client Data System. Using this data, we then identified all patients who had been categorized as "no-pays" (patients from whom no reimbursement was received or whose payment source was unknown), and selected additional random samples of 25 "no-pay" patients from each of five ATCs. At Kingsboro, we reviewed only 11 "no-pay" patient files because only 11 patients were classified as "no-pays." As a result, we reviewed a total of 136 "no-pay" patients. Finally, we reviewed another random sample of 50 patients discharged from Post between October 2001 and May 2002. We decided to review this separate sample because Post's revenue collections during this period were low compared to the other ATCs.

We reviewed each of the above sampled patient files to determine:

- whether Agents assessed the patient's ability to pay;
- whether Agents correctly billed Medicaid (CSC) for services provided to Medicaid patients;
- whether patients without Medicaid prior to discharge applied for, and were enrolled in Medicaid, and whether Agents subsequently billed CSC for ATC services; and
- whether persons with private insurance and/or the ability to self-pay were properly billed for services provided.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of OASAS that are within our audit scope. Further, these standards require that we understand OASAS' internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing

procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under Generally Accepted Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

Response of OASAS Officials to Audit

A draft copy of this report was provided to OASAS officials for their review and comment. Their comments were considered in preparing this final report, and are included as Appendix B. Where appropriate, we have made changes to our report to address information provide in the OASAS response. In addition, the State Comptroller's Notes to the response are included in Appendix C.

Within 90 days of final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Alcoholism and Substance Abuse Services shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

REVENUE COLLECTION AT ADDICTION TREATMENT CENTERS

The Law obligates OASAS to provide ATC services to persons who need them. OASAS incurs significant cost to deliver these services. To offset these costs, ATC policies require Agents to maximize revenue collections. However, our tests of sampled patient files at 6 of the 13 ATCs revealed that Agents did not collect $217,677 in Medicaid revenue for services to enrolled Medicaid recipients during our audit period, and did not pursue collection of $647,356 in potential Medicaid payments for services to patients whose ATC stays could have been covered by Medicaid. We also found Agents did not collect enough data to identify a payer for services totaling more than $470,000, and made minimal efforts to collect more than $153,000 owed by self-pay patients. Since our sample constituted less than 4 percent of the patients treated in 6 of the 13 ATCs over just a 30-month period, we conclude that OASAS could collect significant amounts of additional funds if ATCs focused on maximizing revenue.

Among the reasons Agents do not consistently bill costs are delays in determining patient payment status, or not making the determination at all; a lack of standard collection procedures, such as Agent follow-up to determine when discharged patients enroll in Medicaid; and not ensuring that patients potentially eligible for Medicaid apply for Medicaid and complete the application process. Further, some Agents said they do not pursue retroactive Medicaid coverage for patients who enroll during or after treatment because the process is lengthy and county social services offices are reluctant to provide coverage. However, when Agents do not maximize revenue collections to offset the cost of operating this State and county-funded program, patient treatment costs that remain unbilled and unpaid must be covered solely by the State. To maximize revenue collections, OASAS should develop standard collection procedures, ensure Agents follow these procedures and examine the resources ATCs dedicate to collection efforts.

Revenue from Medicaid

We found that ATCs collect less than half the costs of patient treatment. According to OASAS records for the 6 ATCs we visited, these ATCs provided services costing almost $76 million to 13,511 patients who were discharged between January 1, 2001 and June 30, 2003, but collected only $35.6 million (47 percent) in revenue to cover these costs. (See *Exhibit A* for individual ATC collections.) Historical data for collections and patient payment status shows the vast majority of revenue is collected, or potentially collectible, from Medicaid.

To collect all the Medicaid revenue due, Agents should bill CSC for the costs of all eligible patients. Of the 13,511 patients above, we reviewed the files of 486 (3.6 percent) randomly selected patients to determine the procedures ATC Agents followed in billing CSC and collecting Medicaid revenue. We found these 6 ATCs did not collect a total of $217,677 in actual Medicaid revenue (51 patients), and $647,356 in potential Medicaid revenue (127 patients) for the reasons stated below.

- ATC procedures do not specify how Agents should track patients' Medicaid status.
- Agents do not consistently verify the dates of patient treatment.
- The Bureau does not audit revenue collections.
- ATCs do not always obtain required pre-approval for Medicaid Managed Care patients.
- ATCs do not identify, or delay identifying, all patients who may be Medicaid-eligible.
- Some ATCs provide patients with no help in completing the Medicaid application process; most ATCs give patients no bills to document the ATC services they received.
- Local offices are reportedly reluctant to provide retroactive Medicaid coverage; the New York City office has refused to provide such coverage.

We discuss the details of our findings and conclusions in the following report section.

Actual Medicaid Revenue

Our tests of randomly selected samples of patients in each of the 6 facilities found that Agents either did not bill or incorrectly billed CSC for services totaling $217,677 provided to 51 of the 486 patients we sampled. These 51 patients were enrolled in Medicaid for the duration of their stay. Of this number, 46 patients had Medicaid coverage for the treatment period, but Agents did not bill CSC for services; Agents billed CSC incorrectly for services to the remaining 5 patients. ATCs can no longer collect $55,231 (25 percent) of these funds because the CSC deadline for submitting the bills for payment has passed. *Table 2* shows the detail of these sample exceptions.

Table 2: Actual Medicaid Funds Not Collected

ATC	Medicaid Costs Not Billed	Medicaid Costs Billed Incorrectly	Medicaid Funds Not Collected	Medicaid Funds Still Collectible	Medicaid Funds No Longer Collectible
Blaisdell	1	0	$6,244	$6,244	-
Kingsboro	4	3	19,243	15,545	$3,698
Manhattan	2	2	7,256	5,952	1,304
Post	17	0	84,020	57,218	26,802
Stutzman	11	0	59,176	59,176	-
Ward	11	0	41,738	18,311	23,427
Total	46	5	$217,677	$162,446	$55,231

Of the 46 patients with Medicaid coverage whose services were not billed to CSC, 14 patients had Medicaid during their stays, and 32 patients obtained Medicaid coverage subsequent to discharge. We identified a number of factors that contributed to ATCs' failure to bill costs for these certified Medicaid patients. For example, ATCs do not have adequate controls in place to ensure bills are submitted for all patients who have Medicaid at the time of their treatment. We found that Agents at five of the six ATCs we visited maintained manual logs with patient information (e.g., name, date admitted, date discharged and Medicaid status); at one ATC (Post), the Agent maintains an electronic database of this information. Some Agents also reconciled Medicaid billings to Medicaid revenue received. However, most of the ATCs had not established efficient control procedures to ensure CSC was billed at the time of discharge for every patient with current Medicaid coverage. Without such a control feature, Agents are less likely to detect unbilled costs,

such as those we identified for 14 patients already enrolled in Medicaid, and collect the related Medicaid revenue.

We also found that ATCs do not consistently follow up on discharged patients' subsequent enrollment in Medicaid, or regularly bill costs that do become recoverable from Medicaid. At admission to the ATC, Agents interview all patients who do not have Medicaid, and encourage those who appear eligible to apply for Medicaid through their county social services office. Each county social services office has its own application process the patient must complete to certify for Medicaid, and this process can be complex and time-consuming. The county social services office also has 45 days to approve a Medicaid application. As a result, ATC patients who apply for Medicaid while in treatment may not receive Medicaid until after their discharge. Agents must track such patients so they can bill for ATC services when Medicaid certification is granted.

We found that each ATC does have policies that state the Agent is responsible for tracking the status of patients' Medicaid applications. However, these policies do not specify the procedures Agents should use to do the tracking, how often Agents should perform the review, and how long they are expected to follow up on discharged patients. In addition, Agents at two ATCs told us they segregate the files of patients whose Medicaid status is pending from the files of other discharged patients; Agents at three ATCs told us they maintained a manual log of patients who may have applied for Medicaid. All Agents said they can then periodically review these patients' Medicaid status on WMS or EMEVS and bill CSC as appropriate.

However, the manual tracking and review process used at most of the ATCs we visited is cumbersome, and not an efficient and reliable method of identifying and billing these patient costs. As a result of ATCs' lack of specific control procedures, as well as ineffective patient tracking mechanisms, Agents did not identify the 32 patients who became Medicaid certified after discharge, and whose treatment costs should have been billed to CSC.

We also found that Agents incorrectly billed Medicaid for the periods patients received services. ATC procedures state Agents are responsible for verifying dates of inpatient treatment to ensure CSC is properly billed for services provided. However, we found that two Agents did not collect all the

Medicaid payments due for 5 of the 51 patients because the Agent did not bill CSC for all days these patients received services. As a result, the ATCs did not collect almost $1,500.

Of the $217,677 in uncollected Medicaid revenue our tests identified, about $84,000 (39 percent) was revenue not collected by Post. According to officials at this ATC, Post was without an on-site Agent from January 2001 through May 2002, and the South Beach Agent who covered the function during this period billed CSC for only those costs associated with patients who had Medicaid at the time of admission. This accounts for our identifying 17 Post patients who were certified after discharge, but whose services were not billed to CSC. In response to our preliminary audit findings, OASAS officials indicated that, immediately following our site visit, Post officials began reviewing the Medicaid status of all patients discharged during the period September 1, 2001 through March 31, 2002, and are retroactively billing CSC for those patients determined to have Medicaid.

We also determined that the Bureau, which has oversight responsibility for ATC revenue collection, does not collect sufficient information to determine whether Agents are maximizing revenue collections. Bureau officials have not conducted any audits or reviews to determine whether Agents are maximizing revenue. In addition, Bureau officials do not receive periodic reports that would allow them to determine if Agents are collecting all Medicaid funds due. Currently, Bureau officials only receive a monthly report from the Agents, which contains data such as: number of admissions, number of clients interviewed, number of patients that have Medicaid, pending Medicaid, private insurance and self pay. OASAS replied to our draft report that the Bureau of Addiction Treatment Centers also receives a Quarterly Revenue Report which provides comparison data (and now revenue targets) to help gauge whether revenue is being maximized for each ATC.

In terms of billing information, the report shows number of dollars billed, rebilled, and collected. These reports contain only summary data, and the billing and collection data for that month does not correspond to that month's admissions, therefore, these reports cannot be used to determine to what extent the Agents are billing and collecting all Medicaid revenue due.

Potential Additional Medicaid Revenue

Our tests of randomly selected samples of patients in each of the 6 facilities also identified another $647,356 in treatment costs, for services delivered to 127 patients, that could potentially have been paid by Medicaid, if Agents had taken the necessary action to collect this revenue. As shown in *Table 3*, these 127 persons comprised patients who had Medicaid Managed Care; patients who appeared eligible for Medicaid but did not become Medicaid-certified; and patients for whom a Medicaid coverage gap resulted in ATCs' recovering only part of the cost of patient treatment. We discuss each potential Medicaid payment area below.

Table 3: Potential Additional Medicaid Revenue

ATC	Medicaid Managed Care Patients		Patients Who Appear Medicaid Eligible				Patients With a Medicaid Coverage Gap		Total Potential Additional Medicaid Revenue
	Stay Not Pre-approved	Cost of Stay	Applied and Denied	Cost of Stay	Did not Apply	Cost of Stay	Number of Patients	Cost Not Paid	
Post	2	$12,658	1	$6,329	37	$209,078	11	$69,633	$297,698
Ward	-	-	9	40,661	5	24,235	2	15,165	80,061
Stutzman	2	10,001	5	28,790	11	49,397	2	12,728	100,916
Kingsboro	1	2,853	-	-	-	-	3	21,269	24,122
Blaisdell	1	2,674	6	27,272	3	14,617	22	84,521	129,084
Manhattan	-	-	-	-	-	-	4	15,475	15,475
Total	*6*	*$28,186*	*21*	*$103,052*	*56*	*$297,327*	*44*	*$218,791*	*$647,356*

We found that ATCs did not collect Medicaid revenue for services provided to six Medicaid Managed Care patients. According to ATC policy, Agents or other ATC staff should determine patient resources to identify the potential payer for treatment either prior to or upon admission to the ATC. If the patient has Medicaid coverage at the time of discharge, the Agent can bill CSC directly for treatment services. However, some Medicaid recipients are enrolled in Medicaid Managed Care. ATCs must identify these patients prior to admission so the Medicaid Managed Care insurer can either pre-approve ATC admission or refer the patient to one of its participating providers. Without pre-approval, the ATC will not receive Medicaid reimbursement.

We identified 6 Medicaid Managed Care patients at 4 ATCs who received services totaling $28,186 that Medicaid did not reimburse. In each case, the ATC did not receive payment

because the ATC did not request the insurer's prior approval to admit the patient. Agents told us they do not always identify Medicaid Managed Care recipients because some patients do not know they are enrolled in Medicaid Managed Care. We also found that only 4 of the 13 ATCs (Bronx, Creedmore, Manhattan and South Beach) have policies that specifically require Agents to identify Medicaid Managed Care enrollees prior to admission. However, standard ATC policy does require Agents to consult WMS or EMEVS prior to a patient's admission to determine the individual's Medicaid status, including Medicaid Managed Care enrollment. Therefore, even absent specific policy directives and the patient's correct identification of his or her Medicaid status, the Agent should be able to identify Medicaid Managed Care patients prior to admission, and in time to obtain the necessary pre-approval or referral. If Agents had received pre-approvals for these six patients, the ATCs may have collected additional Medicaid revenue of $28,186.

We also found ATCs did not collect Medicaid revenue for services to patients who, while appearing to be Medicaid eligible, either did not apply for Medicaid or did not complete the application process. According to ATC policies, patients with Medicaid should be identified prior to admission; patients without Medicaid should be interviewed upon admission to assess the patient's resources and potential means of payment for ATC services.

Patients who appear eligible for Medicaid at admission should be directed to apply for benefits. ATC policies also state that Agents should help those patients who appear Medicaid-eligible apply for Medicaid, and should track the status of applications. When such patients become approved for Medicaid, Agents can bill CSC for their services. Medicaid is the primary source of revenue for the ATC program, and, as such, Agents should ensure all eligible patients obtain Medicaid benefits.

However, in reviewing our sampled patients, we found that ATCs did not collect $400,379 in Medicaid revenue for services provided to 77 patients whom Agents identified as potentially eligible for Medicaid. Following our site visits, we obtained access to WMS and determined that 56 of these patients never applied for Medicaid; another 21 patients applied for Medicaid, but were denied benefits for failing to complete the application process.

ATC officials said they have limited control over the number of potentially eligible patients who actually get approved for Medicaid because county social services offices make this determination. ATC officials also noted they cannot ensure patients who are already discharged will complete the application process and receive Medicaid. Most ATC patients are discharged within 28 days, and county social services offices generally have 45 days from the date of application to approve patients for Medicaid.

In conducting our site visits, however, we found that most patients who may be Medicaid-eligible are not identified until some time after admission to the ATC, delaying the start of the application process. In addition, Agents at individual ATCs give potential recipients varying levels of assistance in applying for Medicaid. For example, the Agents at Blaisdell, Post and Stutzman help patients complete the application (the Stutzman Agent even brings the patient to the county office), and Ward case managers (staff who coordinate individual patients' care) are responsible for helping patients apply for benefits. On the other hand, Kingsboro and Manhattan Agents give no assistance to potentially eligible patients who should apply for Medicaid. To receive Medicaid revenue for services they provide to all patients who meet Medicaid criteria, ATC officials need to ensure that potentially Medicaid-eligible patients are identified at admission, in accordance with ATC policy, and given adequate assistance in completing the application process.

In response to our preliminary audit findings, OASAS officials indicated there were a number of factors that limited the Agents' ability to ensure patients obtain Medicaid. For example, officials said that county social services offices are under tremendous pressure to control costs. Thus, these offices have introduced procedural impediments and documentation requirements that make it difficult for even well-organized and motivated individuals to navigate the eligibility process. Officials noted that many upstate ATCs cannot provide patients with transportation to their home counties to apply, and that patients' condition at the time of admission may sometimes limit their ability to negotiate the Medicaid application process. In addition, officials stated that most Agents do not have the time, given their workload, to help patients complete this process.

Finally, tests of our sampled patients showed that, because of a Medicaid coverage gap, the ATCs we visited collected only $58,987 in Medicaid revenue for services to 44 patients that cost a total of $277,779. ATCs did not collect the remaining $218,792 from Medicaid because the patients' Medicaid coverage:

- expired just prior to or during treatment;
- paid for some, but not all of the treatment period; or
- began subsequent to their ATC stay.

Because some of these patients were discharged more than two years ago, $48,433 of this potential revenue is no longer collectible.

When a patient's Medicaid certification ends just prior to admission or during the treatment period, the ATC must encourage the patient to renew Medicaid coverage, since the person is likely still eligible. If Agents check WMS or EMEVS to verify Medicaid status prior to admission as required, they should be able to identify patients whose coverage is due to expire. The ATC or a referring agency should take steps necessary to extend these patients' Medicaid certification.

When a patient's Medicaid certification begins after treatment has started or immediately after the service period, ATC officials should contact the county social services office to request that the Medicaid coverage be made retroactive to cover the treatment period. However, OASAS officials told us that ATCs usually do not seek retroactive coverage. Officials indicated that, while the response to this request may vary from one county social services office to another, most are reluctant to grant retroactive Medicaid coverage. Thus, officials stated, Agents are not likely to invest the time and effort needed to collect Medicaid revenue for services delivered within 90 days before Medicaid certification.

Officials told us they can still recover some of these costs because most ATC patients are released to programs (e.g., halfway houses) that will also be paid for by Medicaid. When such discharged patients become enrolled in Medicaid while in the program, OASAS can bill CSC for prior treatment costs. However, the problem with this procedure is that patients are generally granted Medicaid coverage from the first of the month in which they apply. Since these patients do not apply until after discharge, Medicaid covers, at best, only a portion of the

treatment period. For example, if a patient is admitted to an ATC on November 15, is discharged on December 20, and applies for Medicaid on December 21, the ATC can bill CSC only for the services received from December 1 through December 20.

Compounding the problems related to obtaining retroactive payment for services is the fact that most ATCs do not provide patients with bills or other documentation of their ATC treatment to present to county social services offices at the time they apply for Medicaid. As a result, county social services office officials are not always aware of the costs the applicants have incurred within the prior 90-day period. Retroactive Medicaid benefits will not be provided without documentation to show the services provided.

In an effort to provide the documentation needed to obtain retroactive payment from Medicaid, the Agents at two ATCs each developed letters that notified county social services offices about the treatment services a discharged patient had received, the dates of service and the treatment cost. Giving patients such a letter, or a statement of treatment cost, at discharge with instruction to present this information to county social services officials may help obtain retroactive Medicaid payments.

The Blaisdell Agent indicated she was at one time able to obtain retroactive Medicaid coverage for some New York City residents, but that the New York City Human Resources Administration's Medical Assistance Program (HRA) now refuses to provide retroactive Medicaid coverage. The Agent had previously used a form, approved by HRA, to request retroactive Medicaid payment, but HRA officials stopped accepting this form in March 2000. In July 2000, OASAS officials formally requested HRA to advise them in writing of the regulatory citations for their agency's justification for denying retroactive Medicaid benefits to eligible individuals. According to OASAS officials, this issue was not resolved.

In response to our preliminary audit findings, OASAS officials indicated that beginning September 2003, the ATCs implemented a standardized billing template. The new template establishes a consistent format across the ATC system that will allow for easy billing of "self-pay" patients and provide Medicaid

eligible patients with a bill to present to local county social services offices and NYC HRA when applying for Medicaid.

Even if ATCs identify Medicaid-eligible patients more promptly, and assist these patients in applying for Medicaid benefits at county social services offices, there will still be a number of patients who do not apply for Medicaid until after discharge. As the issue of retroactive Medicaid benefits impacts ATC patients in all counties, OASAS officials should resolve this issue with HRA, and with county social services offices statewide. The State and the counties have committed to jointly fund Medicaid benefits for county residents who receive inpatient treatment services at State-operated ATCs. Resolving issues concerning the availability of retroactive Medicaid benefits should help ensure that each party pays an equitable share of the cost of providing ATC services.

Revenue from Unidentified Payers

ATC policy states that Agents should interview each patient at admission to assess the patient's resources and potential means of reimbursement. When patients are not enrolled in Medicaid, the Agent is supposed to determine whether the patient has private insurance, appears to be eligible for Medicaid or has the resources to pay for services. However, in reviewing the patient files in our sample, we found that Agents did not gather enough information to assess patient resources in 90 (18.5 percent) of the 486 patient files we reviewed. These patients may have been Medicaid-eligible or had enough personal resources to pay for treatment. (None of our sampled patients had private insurance that covered ATC services.) However, since patient resource information was incomplete or missing in these cases, Agents did not direct patients to apply for Medicaid or pursue payment from patients themselves. As a result, ATCs did not collect $470,948 in revenue to offset the costs of these patients' treatments.

We discussed this lack of patient data with ATC staff. The Kingsboro Agent told us he does not have time to do such an assessment. Instead, this Agent gathers only the information needed to determine whether the patient is enrolled in Medicaid. The Kingsboro Agent encourages non-Medicaid patients to apply, but does not help them to apply. At the other five ATCs, we found some patient assessments were missing information on the patient's income, marital status, family or assets, all of

which are factors used in determining a patient's Medicaid eligibility or self-pay status. We also identified a number of patients for whom no financial assessment was completed. As a result, ATCs did not have enough data about these patients to pursue collection of potential Medicaid revenue or payment from patients.

Revenue from Self-pay Patients

We also found that ATCs did not collect revenue owed by patients who were identified as having the resources to self-pay because Agents did not gather enough information or did not follow OASAS policy for collecting payment. OASAS charges individuals a per diem ATC rate based on a sliding scale. For example, a single person with annual income of less than $12,000 would not be required to pay at all, whereas a single person with annual income of $60,000 or more would be charged the full per diem rate. When an Agent assesses patient information and determines the patient has the resources to self-pay, ATC policy requires that the Agent and patient agree on a rate to be charged and complete a payment agreement, including the number of monthly payments. Agents have the discretion to grant waivers to those patients they believe do not have the ability to pay.

However, we found varying levels of compliance with this policy. In conducting our site visits to the ATCs, we found that all Agents did not use the rate agreement; two Agents did not send periodic bills to patients; and another Agent did not use the OASAS sliding scale to determine the rate of payment due. We also found that two Agents had never assessed a patient as private pay. Lack of adequate information about patient resources, as well as Agents' noncompliance with stated ATC policy, reduces the likelihood that ATCs will collect the money patients owe for services they received.

For example, we identified 28 patients at 5 of the 6 ATCs we visited who should have been self-pay patients, based on the information contained in their files. These 28 patients received services totaling $152,514. For 20 of these 28 cases, Agents did not collect enough information to determine if the patient could pay for services; in 24 cases, the Agent did not complete a rate agreement or grant a waiver to release the patient from payment obligations. ATCs did not collect any funds from

patients in the remaining four cases that did have rate agreements.

During our site visits, we did not find appropriate supporting documentation in patient files to determine the basis for the Agent's determination of a patient's fee amount or for granting a waiver. However, we did find that waivers were granted in many instances; at two ATCs, the Agents did not classify any patients as self-pay. ATC officials should document the basis for waiving payment, and require two approvals to authorize granting a waiver.

OASAS officials indicated that because of the time and effort required to obtain funds from self-pay patients (obtaining needed information, billing, tracking, etc.) and the limited funds they receive, it is not worth the effort to try to obtain this additional revenue. In their response to our preliminary audit findings, officials stated that our findings regarding "self-pay" patients were generally accurate as they relate to inconsistencies in conducting financial assessments, the use of rate agreements, the degree of documentation maintained, the granting of waivers and patient billing. Officials acknowledged the need for improvement and expect that with the implementation of the previously mentioned standardized billing template, a more consistent format and process for billing these patients will result.

Recommendations

1. Submit bills to CSC and recover those funds that are still collectible for services provided to patients whom we identified as having Medicaid coverage during the treatment period.

2. Ensure that Post officials pursue Medicaid collections still due and collectible for services this facility provided in the last two years.

3. Ensure the collection of all actual and potential Medicaid revenue due for services by requiring that Agents:

   - establish procedures to ensure ATCs bill CSC for the correct amounts for all patients who have Medicaid;
   - obtain pre-approval for all patients enrolled in Medicaid Managed Care prior to admission;

Recommendations (Cont'd)

- collect and maintain all information required to determine patient resources;
- identify Medicaid-eligible patients prior to admission to begin the Medicaid application process as early as possible;
- assist patients, to the fullest extent practicable, in completing the application process;
- establish a system for tracking and monitoring the status of patients who apply for Medicaid during treatment or after discharge; and
- issue discharged patients a bill or other documentation that shows the dates and cost of ATC treatment services they received.

4. Develop formal procedures that state the follow up Agents should perform, and for what time period, to check the Medicaid status of patients who may obtain Medicaid coverage after discharge.

5. Work with officials from county social services offices; including HRA in New York City, to resolve the issue of providing retroactive Medicaid benefits to cover ATC services provided to eligible patients.

6. Conduct periodic Bureau audits of Agent performance and regularly compare discharge data to billing and collections data to determine the extent to which Agents are maximizing revenue.

7. Evaluate Agents' workload to determine if additional resources should be allocated to this area to ensure revenue collections are maximized.

8. Comply with ATC policy for identifying and collecting service cost from self-pay patients by:

   - gathering all information needed to make an assessment of the patient's resources;
   - completing a rate agreement with self-pay patients, including a billing schedule; and
   - sending periodic bills to self-pay patients.

Recommendations (Cont'd)

9. Document the reason the ATC waives repayment for patients who would otherwise be required to pay for their treatment, and require that such waivers be approved by both the Agent and the ATC Director.

Exhibit A

Revenue Collected for Patient Services at Sampled ATCs
From January 1, 2001 to June 30, 2003

ATC	Patient Population Size	Cost of Services Provided to Population	Revenue Collected
Blaisdell	1,725	$ 7,884,182	$4,278,005
Kingsboro	3,230	21,069,551	15,268,324
Manhattan	1,959	9,622,678	6,557,120
Post	2,726	15,575,239	1,642,816
Stutzman	1,456	8,193,271	3,571,720
Ward	2,415	13,606,588	4,310,269
Total	13,511	$75,951,509	$35,628,254

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Appendix B

NEW YORK STATE
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William A. Gorman, Ph.D.
Commissioner

Neil C. Grogin
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May 20, 2004

Ms. Carmen Maldonado, Audit Director
NYS Office of the State Comptroller
Division of State Services
123 William Street, 21st Floor
New York, New York 10038

Dear Ms. Maldonado:

Thank you for the opportunity to provide a written response to the Office of the State Comptroller's (OSC) Draft Audit Report on the Office of Alcoholism and Substance Abuse Services (OASAS) entitled, *Revenue Collection at Addiction Treatment Centers (2003-S-30).*

As previously communicated to OSC, OASAS agrees with the majority of the findings presented in the Report and acknowledges that there are opportunities for improvement in the revenue collection procedures and practices utilized by the Addiction Treatment Centers (ATCs). To address these findings, OASAS has undertaken the following steps to improve upon its performance.

- Entering into a new contract (March 19, 2004) to develop and implement an electronic patient record system. A kick-off meeting with the vendor and the ATC Directors occurred on May 12th and 13th, with implementation of the system, including patient billing, slated to occur over the next 18 months for all thirteen ATCs. This new system will be a significant improvement over what is currently in place at the ATCs, and will ensure standardization across the system of services.

- Evaluating the need for two new Resource and Reimbursement (R&R) Agent supervisory positions, one for upstate and one for downstate. The R&R Agent Supervisors would provide indirect supervision, technical assistance and oversight of the thirteen R&R Agents, as well as audit capability.

While OASAS is confident that these steps will have a beneficial impact on its revenue collection efforts in the months ahead, we must clarify some of the issues raised in the Report, as well as provide a more complete picture of the challenges faced by the ATCs.

Workload of the R&R Agent -- While the Report makes a couple of general references to the workload demands on R&R Agents, and the difficulty they have interacting with local Departments of Social Services (DSS) to establish Medicaid eligibility, it does not directly address the issue of workload versus resources. This is a concern that was discussed with the OSC Audit Team at length during most of their site visits. As a point of comparison, it should be noted that the NYS Office of Mental Health (OMH) employs 50 R&R Agents and 23 support staff who are dedicated to this function. OASAS employs one R&R Agent at each of its 13 facilities, regardless of size. More importantly, OMH facilities admitted approximately 5,500 individuals systemwide during the last fiscal year; OASAS' ATCs admitted over 9,200 individuals whose length of stay were markedly shorter than those admitted to OMH facilities. In addition, OMH has the benefit of serving as its own DSS district (district 99 status), whereas OASAS' ATCs must interact with 58 different local DSS offices, each of which have their own, and often widely varying, policies and procedures regarding Medicaid applications.

References to R&R Agents -- The Report contains numerous references to what R&R Agents did or did not do relative to revenue maximization. OASAS requests that such references be modified to convey ATC or OASAS responsibility, where appropriate.

Nature of Patient Population -- Most ATC patients arrive at the door with a multitude of problems, ranging from unemployment or homelessness to unmet medical needs and alienation of friends and family. They are typically destitute and not capable of functioning at a level which promotes access to Medicaid and other third party payment systems. The OSC Report does not adequately capture the dysfunctional nature of this patient population, the difficulty they have performing simple tasks such as keeping appointments or providing documentation to DSS caseworkers, and the clinical risks associated with sending them into local DSS offices during a time when they are highly susceptible to relapse.

Central Office Billing -- On page 6, paragraph 2 of the Report, reference is made to OASAS Central Office sending bills ". . .to the appropriate parties for payment." This is not correct. For Medicaid, the R&R Agents enter billing information into the OASAS Client Billing System and Management and Information Services staff produce a combined ATC billing disk that is sent by Central Office to Computer Sciences Corporation (CSC) for payment. For non-Medicaid billings, the R&R Agents prepare the appropriate billing documents and send them directly to insurance companies, etc. for payment.

* Note 1

Monitoring Revenue Collections -- On page 14, paragraph 3 of the Report, OSC states that the Bureau of Addiction Treatment Centers (BATC) only receives a monthly report from the R&R Agents to monitor revenue collection performance. In fact, BATC also receives a Quarterly Revenue Report which provides comparison data (and now revenue targets) to help gauge whether revenue is being maximized for each ATC. The OSC Report also calls for the compilation of data which would allow for comparison of patient admissions to billing/collection activity for those admissions on a monthly basis. With the implementation of the new electronic patient record and billing system (referenced on page 1), OASAS expects to have a capacity to produce reports that will enable BATC to monitor revenue collection performance at each ATC on a date-of-service basis.

* Note 1

* See State Comptroller's Notes, p. 43

Limited Control over Patient Medicaid Eligibility -- On page 15, Table 3, a total of $103,052 is identified as the cost of care for patients who had been denied Medicaid by local DSS offices, and yet is still presented as potential additional Medicaid revenue. It is not clear how the ATCs can be held responsible for "potential additional Medicaid revenue" in cases where local DSS offices deny Medicaid eligibility to their patients. Given that the ability to realize this additional potential revenue is often beyond the control of the ATCs, this does not appear to be a reasonable expectation.

* Note 2

Recommendations

1. **Submit bills to CSC and recover those funds that are still collectible for services provided to patients whom we identified as having Medicaid coverage during the treatment period.**

   Subsequent to the OSC audit, R&R Agents retroactively billed and recovered a significant amount of Medicaid revenue ($141,623) for those patients who were identified as having Medicaid coverage during the period that they were in treatment. In addition, another $26,098 in pending Medicaid billings is currently in process. For each of the six ATCs listed on page 12, Table 2 of the Report, revenue collection performance is as follows:

Blaisdell ATC	$6,244	MA Still Collectible
	$6,244	MA Collected
Kingboro ATC*	$15,545	MA Still Collectible
	$16,600	MA Collected
	$ 1,038	MA Billed -- Pending
Manhattan ATC**	$ 5,952	MA Still Collectible
	$ 5,651	MA Collected
C.K. Post ATC*	$57,218	MA Still Collectible
	$59,314	MA Collected
	$ 9,891	MA Billed -- Pending
Stutzman ATC	$59,176	MA Still Collectible
	$44,007	MA Collected
	$15,169	MA Denied and Rebilled
Ward ATC*	$18,311	MA Still Collectible
	$ 9,807	MA Collected
	$ 8,886	MA Denied

* MA billings/collection in excess of the amount "Still Collectible" is attributed to a retroactive adjustment in per diem rates.

* See State Comptroller's Notes, p. 43

** MA Still Collectible (Table 2 of the Report) does not correspond with the amount identified in OSC's supporting workpapers ($5,734), that was provided to OASAS. MA Collected represents payments received for all 26 days identified by OSC in 2002, but not at the rate calculated by OSC.

* Note 3

2. **Ensure that Post officials pursue Medicaid collections still due and collectible for services this facility provided in the last two years.**

Immediately following the OSC site visit, C.K. Post ATC staff reviewed the Medicaid status of all patients discharged during the period September 1, 2001 through March 31, 2002, and proceeded to retroactively bill for those determined to be Medicaid active. The retroactive billing for this period is now completed. The amount collected was $245,742.

3. **Ensure the collection of all actual and potential Medicaid revenue due for services by requiring that Agents:**

- **Establish procedures to ensure ATCs bill CSC for the correct amounts for all patients who have Medicaid.**

  ATC Directors have been advised to work with staff to ensure: adherence to existing Medicaid billing procedures; and that billing errors are minimized. These efforts will be reinforced with the addition of the electronic patient record and billing system (referenced on page 1), which is scheduled for installation throughout the ATC system over the next 18 months.

- **Obtain pre-approval for all patients enrolled in Medicaid Managed Care prior to admission.**

  Providing that the ATCs can reasonably establish a patient's status prior to admission, they will make every effort to obtain pre-approval for all patients enrolled in Medicaid Managed Care.

- **Collect and maintain all information required to determine patient resources.**

  While the ATCs collect and maintain the information needed to determine patient resources in the vast majority of cases, some exceptions were noted by OSC during the audit. All ATCs have since been instructed to consistently collect and maintain this information, when resources allow.

- **Identify Medicaid-eligible patients prior to admission to begin the Medicaid application process as early as possible.**

  ATCs have cultivated relationships with many of their referral sources to initiate the Medicaid application process prior to admission. Given existing resources, it

* See State Comptroller's Notes, p. 43

is not possible for R&R Agents to screen all patients prior to admission. However, every effort will be made to initiate the Medicaid application process through collaboration with referral sources.

- **Assist patients, to the fullest extent practicable, in completing the application process.**

  The OSC Report acknowledges many of the difficulties ATCs experience in attempting to move patients through the Medicaid application and eligibility process at local DSS offices. Add to this the patient's unstable condition, particularly in the early stages of treatment, interaction with DSS caseworkers may not always produce the desired outcome (both in terms of recovery and reimbursement potential). For this reason, many ATCs reserve the right to postpone involvement in the Medicaid application process if they determine that the patient is not clinically ready. Nevertheless, the ATCs have committed, to the extent possible, to assist patients through the Medicaid application process.

- **Establish a system for tracking and monitoring the status of patients who apply for Medicaid during treatment or after discharge.**

  While the existing OASAS Medicaid Billing System is limited in its ability to cross-reference ATC patient discharges with data relative to patients' post-discharge Medicaid status, the electronic patient record and billing system (referenced on page 1) will greatly aid in this process. In the interim period, BATC has directed all facilities to track discharged patients on a monthly basis, for a full two-year period after discharge. As part of this effort, OASAS will attempt to determine the post-discharge period during which most successful billing recoveries occur, as a way to ensure the optimal use of the limited staffing resources available.

- **Issue discharged patients a bill or other documentation that shows the dates and cost of ATC treatment services they received.**

  BATC officials have implemented a Statewide billing template in order to provide all patients with a billing statement at the time of discharge. However, it is important to emphasize that this in no way assures that the patient will follow through with the DSS application process post-discharge.

4. **Develop formal procedures that state the follow-up Agents should perform, and for what time period, to check the Medicaid status of patients who may obtain Medicaid coverage after discharge.**

As indicated above, BATC has expanded on its existing procedures by directing all facilities to track discharged patients on a monthly basis for a full two-year period after discharge.

5. **Work with officials from county social services offices; including HRA in New York City, to resolve the issue of providing retroactive Medicaid benefits to cover ATC services provided to eligible patients.**

   OASAS assumes that this is a reference to the policy adopted by HRA. This matter is now under review by OASAS Counsel for a determination as to the appropriateness of the policy; and advice in terms of actions that might be taken by OASAS to ensure that services provided to Medicaid recipients are appropriately reimbursed.

6. **Conduct periodic Bureau audits of Agent performance and regularly compare discharge data to billing and collections data to determine the extent to which Agents are maximizing revenue.**

   R&R Agent performance is being addressed in three ways: (1) revenue maximization performance has been added to each ATC Director's performance program; (2) BATC staff will continue to review, on a monthly basis, the R&R Agents' monthly reports, as well as Quarterly Revenue Reports, to identify patterns, trends and opportunities for improvement. Improvement opportunities will be addressed with the appropriate ATC Director, as warranted; and (3) revenue maximization has been added as a primary internal control function of BATC.

7. **Evaluate Agents' workload to determine if additional resources should be allocated to this area to ensure revenue collections are maximized.**

   In order to fully comply with all existing policy and procedures that relate to maximizing revenue in the ATCs, OASAS agrees that additional resources may be needed. However, given the Agency's staffing resources and geographic considerations, these decisions will need to be made in the context of other Agency priorities.

8. **Comply with ATC policy for identifying and collecting service cost from self-pay patients by:**

   - **Gathering all information needed to make an assessment of the patient's resources.**

     See response following Recommendation #9.

   - **Completing a rate agreement with self-pay patients, including a billing schedule.**

     See response following Recommendation #9.

   - **Sending periodic bills to self-pay patients.**

     See response following Recommendation #9.

9. **Document the reason the ATC waives repayment for patients who would otherwise be required to pay for their treatment, and require that such waivers be approved by both the Agent and the ATC Director.**

In general, OASAS agrees with recommendations #8 and #9. While most of the issues identified are currently built into existing ATC policies and procedures, there continue to be inconsistencies in how they are implemented. OASAS acknowledges the need for improvement in this area and has already taken action by directing its ATCs to implement a consistent approach and process for "self-pay" patients. This involves documented financial assessments, entering into rate agreements and documenting "waivers" that are granted. By strengthening these procedures and implementing the previously mentioned standardized billing template, a more consistent format and process for billing of "self-pay" patients will result.

OASAS would also like to reiterate the nature of the population that is served by the ATC system. The system was created specifically to serve the uninsured and underinsured who cannot otherwise access services to meet their needs. The overwhelming majority of patients arrive at the doors of the ATCs with extraordinarily limited means, and often with debts far in excess of whatever resources they may have. In light of this, OASAS continues to maintain that the more prudent use of staff time is in the maximization of Medicaid revenue.

In closing, OASAS would like to thank the OSC Audit Team for identifying potential areas of improvement and for recommending actions that may favorably impact our revenue collection performance. In response to the findings, OASAS is pleased to report that we have billed all remaining billable Medicaid expenses cited in the report. We have also implemented, where practicable, systemic and procedural improvements in the revenue collection practices at ATCs that will have a positive impact on reimbursement levels.

Sincerely,

Neil C. Grogin

Neil C. Grogin
Associate Commissioner
Standards and Quality Assurance

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State Comptroller's Notes

1. We revised the report to reflect information provided in the OASAS response.

2. We included the $103,052 in our report, because based on our review of documentation maintained by the ATC's, these patients appeared Medicaid eligible. While these patients were denied Medicaid, in some cases we were unable to determine why these patients were denied Medicaid. However, in some other cases, patients were denied Medicaid for failing to complete the application process. If ATC's are able to assist patients in successfully completing the application process additional revenues may be collected.

3. The figures presented in the report are correct. The Medicaid Funds Still Collectible totaled $162,446. This figure includes $161,710 from the 46 patients for whom Medicaid Costs were not billed and $736 from the 5 patients for whom Medicaid costs was billed incorrectly. These figures were provided to OASAS officials.