

State of New York
Office of the State Comptroller
Division of Management Audit
and State Financial Services

DEPARTMENT OF HEALTH

**MONITORING NURSING HOME
COMPLIANCE WITH MEDICAID
PARTICIPATION REQUIREMENTS AND
CONTROLLING PROVIDER PAYMENTS**

REPORT 97-S-30



H. Carl McCall
Comptroller



State of New York Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 97-S-30

Barbara A. DeBuono, M.D.
Commissioner
Department of Health
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Dear Dr. DeBuono:

The following is our report on the monitoring of nursing home compliance with Medicaid participation requirements and the controls over Medicaid payments to selected providers.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this report are listed in Appendix A.

*Office of the State Comptroller
Division of Management Audit
and State Financial Services*

Executive Summary

Department Of Health Monitoring Nursing Home Compliance With Medicaid Participation Requirements And Controlling Provider Payments

Scope of Audit

The Department of Health (Department) supervises and certifies the State's nursing homes under Article 28 of the Public Health Law. The Department's Bureau of Long Term Care Services (Bureau) is responsible for licensing nursing homes and for certifying that they comply with Federal standards for safety and quality care. The Bureau has six area offices (Buffalo, Rochester, Syracuse, Northeast, New Rochelle and New York City) which monitor nursing homes' compliance by means of regular certification surveys and investigation of complaints that residents or other parties bring against nursing homes. The Department also administers the State's Medicaid program. For each Medicaid-eligible resident, nursing homes receive a per diem reimbursement rate that includes the provision of basic care, as well as many ancillary services, such as pharmacy services. The Department uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to reimburse providers. During the three years ended December 31, 1996, Medicaid reimbursed New York State nursing home providers \$13 billion.

Our audit addressed these questions about the monitoring of nursing home compliance with participation requirements and the payment of selected ancillary service providers for the period January 1, 1994 through December 31, 1996:

- Does the Bureau timely investigate and adequately track the complaints it receives?
 - Does the Bureau perform nursing home certification surveys on a timely basis?
 - Are MMIS controls adequate to prevent inappropriate payments for ancillary services?
-

Audit Observations and Conclusions

In our audit of three area offices, we found that the Syracuse and Northeast offices adequately handled complaint investigations. However, we determined that the New York City office needs to improve its complaint tracking system and investigate complaints more timely to ensure this patient protection mechanism serves its purpose. While all area offices performed certification surveys that were in general compliance with Federal regulations, improvements could be made in documenting survey results and in completing follow-up activities. We also determined that the Department needs to investigate about \$1.3 million

in potential overpayments to ancillary care providers, and develop programming changes to the MMIS to prevent future overpayments.

Federal regulations require the Bureau to establish written procedures and implement a control system to receive, investigate and resolve complaints. Such systems should ensure that area offices properly investigate all complaints timely, collect sufficient evidence and ensure that facilities correct all substantiated complaints. We found that the New York City area office does not always investigate all the complaints received or gather sufficient evidence to substantiate them. For example, three complaints that were received in 1996, and which alleged physical abuse or neglect, had not been investigated as of September 26, 1997. We also determined that this office lacked written procedures and a system to monitor complaint investigations. To ensure that nursing home residents are adequately protected, we recommend that the Bureau resolve the outstanding complaints, draft written procedures, provide training and develop a system to track the status of complaints. (See pp. 5-7)

The Federal Health Care Financing Administration, which is responsible for implementing Federal quality assurance standards among health care providers, contracts with states to conduct periodic certification surveys to ensure that Federal standards are met. While the three area offices we visited generally conduct timely surveys to ensure compliance, some surveys were missing documentation of required components, like resident interviews. Further, some Statements of Deficiency, which the Bureau sends nursing homes to identify compliance problems, and Plans of Correction, which facilities send the Bureau to propose solutions, are not issued timely. We recommend that the Bureau develop a uniform process for documenting survey results, and controls to ensure compliance follow-up is timely. (See pp. 7-10)

New York's Medicaid payment rate includes reimbursement for numerous ancillary services, such as pharmacy services. Since such services are included in the standard rate, the service provider should not separately bill Medicaid for providing them. However, during the three years ended December 31, 1996, we found that MMIS did not detect as much as \$1.3 million in potential Medicaid overpayments to ancillary service providers. We recommend that the Department investigate these potential overpayments and seek recoveries where appropriate. (See pp. 11-13)

Comments of Department Officials

Department of Health officials generally agreed with our recommendations.

Contents

Introduction	Background	1
	Audit Scope, Objectives and Methodology	2
	Response of Department Officials to Audit	4
 Monitoring Nursing Home Compliance	 Complaint Investigation	5
	Certification and Inspections	7
 Identification of Payments to Ancillary Service Providers		11
 Appendix A	Major Contributors to This Report	
 Appendix B	Comments of Department of Health Officials	

Introduction

Background

Beginning in 1987, Congress enacted nursing home reform legislation with the objective of ensuring that long-term care facilities across the country comply with Federal standards for safety and quality care. Nursing homes, which provide long-term care for elderly residents nationwide, must meet these standards to be certified as eligible to participate in the Medicaid program. The Medicaid program was authorized by Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Another objective of Federal nursing home reform was to streamline the process for certifying nursing homes as eligible for participation in the Medicaid program. The Omnibus Budget Reconciliation Act of 1987, implemented in 1990, introduced a national standard certification survey process for determining whether a nursing home meets Federal participation requirements. The Federal Health Care Financing Administration (HCFA) contracts with state governments to conduct these surveys. HCFA is an agency within the U.S. Department of Health and Human Services that is responsible for implementing Federal quality assurance standards among health care providers, for ensuring Medicaid's proper administration by states and contractors and for establishing policies for the reimbursement of health care providers.

In New York State, the Department of Health (Department) supervises and certifies the State's nursing homes under Article 28 of the Public Health Law. The Department's Bureau of Long Term Care Services (Bureau) is responsible for licensing nursing homes and for certifying that these facilities consistently comply with participation requirements. The Bureau has six area offices (Buffalo, Rochester, Syracuse, Northeast, New Rochelle and New York City) which monitor nursing homes' compliance by means of regular certification surveys and the investigation and resolution of complaints that are received.

According to the Department, there were 116,000 residents in New York State nursing homes as of October 1, 1997. The services these residents receive range from basic supervision to intensive medical care or restorative therapy for the elderly and chronically ill. The State's nursing homes are operated by proprietors, voluntary organizations or government units. Proprietary homes, which make up about 47 percent of the State's nursing homes, are privately-owned commercial operations that are usually profit-oriented. Voluntary facilities, which compose another 45 percent, are private nursing homes operated by not-for-profit organizations. The remaining 8 percent of nursing homes are operated by government units. Of the 666 nursing homes in the State, 664 are Medicaid-certified; the other two are private facilities that do not participate in the program.

The Department also administers the State's Medical Assistance Plan (Medicaid) and sets Medicaid reimbursement rates and fees for nursing homes

and other providers. New York's nursing home reimbursement rate includes reimbursement for numerous ancillary services such as pharmacy, dental, and restorative therapy services. Nursing homes either provide these services directly or contract with other providers for ancillary services. Neither the nursing home nor the ancillary service provider should separately bill Medicaid for these services. The Department uses the Medicaid Management Information System (MMIS)¹, a computerized payment and information reporting system, to process Medicaid claims and make payments to health care providers for services rendered to Medicaid recipients. During the three-year period ended December 31, 1996, Medicaid reimbursed New York State nursing home providers a total of \$13 billion.

Audit Scope, Objectives and Methodology

We audited the Department's monitoring of nursing home compliance with Federal Medicaid participation requirements, and MMIS controls over payments to ancillary care providers for the period January 1, 1994 through December 31, 1996. The objectives of our performance audit were to determine: whether the Bureau adequately investigates and resolves complaints about nursing homes; whether the Bureau conducts certification surveys on a timely basis; and whether MMIS controls are sufficient to ensure that it pays providers of ancillary services according to established reimbursement policy. To accomplish our objectives, we interviewed officials from the Department and the Bureau, reviewed applicable Medicaid policies, and reviewed pertinent Federal and State regulations. We also examined records at three Bureau area offices: Syracuse, Northeast and New York City. These area offices oversee approximately 60 percent of the nursing home beds in the State. In addition, we developed computer programs to verify the appropriateness of ancillary claims which Medicaid paid on behalf of nursing home recipients during our audit period. In particular, we analyzed claims paid by MMIS for pharmacy, dental, restorative therapy and transportation services to determine whether the cost of these services was already included in the nursing home's rate. During this audit, we did not visit any nursing homes or interview any nursing home staff or residents.

In conducting this audit, we participated in a joint audit of issues related to residential care services for Medicaid recipients. This joint audit was initiated by the National State Auditors Association (NSAA), of which New York State is a member. Each year, NSAA selects a single audit topic of national scope and importance, and invites member states to participate in a joint audit effort to obtain information about specific aspects of the audit topic. One of the participating states, in this case, Louisiana, coordinates the states' audit efforts and combines all the state reports into a single joint report. The final

¹ The Department of Social Services administered MMIS through its fiscal agent, Computer Sciences Corporation, until October 1, 1996, when the Department of Health assumed this responsibility.

report will be presented to the NSAA Audit Performance Committee and shared with states that participated in the joint audit.

Taking part in this joint audit effort requires New York and each of the other nine participating states (Connecticut, Kentucky, Louisiana, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee and Texas) to select and implement a number of audit objectives from among a group of four objectives developed by NSAA. We carried out three of these compliance-related audit objectives by determining: whether the State complies with regulations related to licensing and certification of nursing homes; whether the State conducts adequate complaint investigations to ensure nursing homes are in compliance with regulations; and whether the State ensures that reimbursement is appropriate and for services that were actually 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 the Department operations included in our audit scope. Further, these standards require that we understand the Department's internal control structure and 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 that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Department Officials to Audit

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

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller and 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.

Monitoring Nursing Home Compliance

We examined the operation of three area offices: Syracuse, Northeast and New York City. Our audit showed that complaint investigations at the Syracuse and Northeast area offices were adequately performed and resolved in accordance with State and Federal statutes and regulations. However, we found the New York City area office complaint process provides Bureau management little assurance that this patient protection mechanism is meeting its objectives. We also reviewed certification activities at these area offices and found that these offices are generally in compliance with Federal regulations for conducting timely certification surveys. However, improvements could be made in documenting survey results and in completing survey follow-up activities in a timely manner.

Complaint Investigation

Investigation and resolution of complaints is a critical certification activity. Complaints may come from a variety of sources including nursing home residents, their families or representatives, and State and local government agencies. Federal regulations require states to establish written procedures and maintain adequate staff to receive, investigate, and resolve complaints in a timely manner. In addition, a control system should be in place to track and monitor complaints until they are resolved. The Bureau's responsibilities include ensuring that it properly receives and timely investigates all complaints, that it collects sufficient evidence to substantiate complaints and that it follows up to ensure that facilities take immediate corrective action to resolve problems. The Bureau relies on its six area offices to implement a process for controlling and resolving complaints in accordance with relevant State and Federal statutes and regulations.

For each complaint received, an area office employee categorizes it as either a Chapter 340 complaint, or a general complaint, depending on its nature, scope, and severity. Chapter 340 complaints are violations of the New York State Public Health Law Section 2803-d involving physical abuse, neglect, or mistreatment of nursing home residents. General complaints are incidents or events resulting from a breakdown in a nursing home's policies and procedures for care services, treatments, medications and physical environment. HCFA requires that Chapter 340 complaint investigations be initiated within two working days of their receipt. However, it allows states to use their professional judgement to determine the timing, scope and duration of general complaint investigations. During 1996, the Department reported that it received a total of 938 Chapter 340 complaints and 1,731 general complaints.

To assess the adequacy of the Department's process for investigating and resolving complaints, we reviewed 78 complaint investigation files (randomly

selected from the Syracuse, Northeast, and New York City area offices) for complaints that were received during calendar year 1996. Our review showed that complaints at Syracuse and Northeast area offices were adequately investigated and resolved in accordance with program requirements. However, our review of 34 complaint investigations (16 Chapter 340 complaints and 18 general complaints) conducted by the New York City area office showed that investigators did not always comply with Federal requirements intended to ensure the health and safety of nursing home residents. We determined that the New York City area office personnel do not always investigate the complaints received or gather sufficient credible evidence to substantiate complaints. Further, this area office has not processed all substantiated complaints for legal action. For example, we found that, as of September 26, 1997, three Chapter 340 complaints and seven general complaints had not been investigated since they were received in 1996. Our further review of the seven general complaints revealed that office personnel may have incorrectly categorized as "general" three complaints that they should have investigated as Chapter 340 complaints. In each case, the complaint alleged that the nursing home resident had experienced physical abuse. In one complaint, it was alleged that the resident had been beaten by staff at the nursing home; in another case, the resident had suffered a fractured leg from an improper lift. In the third instance, an orderly working at the nursing home allegedly twisted the right arm of a resident.

Our audit also determined that the New York City area office lacked written procedures and a system to track and monitor complaint investigations. During our audit, New York City staff could not locate several complaint investigation files we had requested. We had originally requested staff to pull 50 randomly selected complaint files (25 Chapter 340 and 25 general); however, at the end of the first day of our review, area office staff had found only five files. We then requested that staff pull another 12 files so that we would have a reasonable number of files (17) to begin reviewing. Staff located another 17 files during the course of our field work in New York City, so that we were eventually able to review 34 of the 62 complaint investigation files we had requested. At the close of our field work at the New York City area office, staff had located 12 of the missing files. However, they could not find 16 of the 62 (25.8 percent) complaint investigation files (9 Chapter 340 and 7 general).

As a result of the breakdowns and deficiencies we identified in the New York City area office's management of complaint processing, we conclude the Bureau has little assurance that this mechanism is meeting its patient protection objectives. In view of the deficiencies we identified in the New York City office's processing and investigation of complaints, and its lack of written procedures for investigative staff, we believe it is essential that the Bureau take steps to ensure that this office processes and resolves complaints

timely and properly. In addition, the incomplete or inadequate nature of some of the investigations leads us to question whether investigators in the New York City area office are sufficiently trained. We believe the Bureau should address these problems by providing thorough training for investigators and by adequately monitoring office operations.

New York City area office officials told us that the office's Complaint Unit was reorganized in 1997, and that they were in the process of drafting written procedures. At the conclusion of our field work, we noted that the Bureau was taking steps to improve investigations of complaints received in the New York City area office.

Certification and Inspections

Nursing homes must meet Federal requirements for long-term care facilities in order to participate in the Medicaid program. HCFA contracts with state governments to conduct periodic certification surveys and ensure Federal standards are met. In June 1995, HCFA provided state agencies with the State Operations Manual (SOM) to assist them in conducting surveys. The SOM is a compilation of required procedures and authorized survey protocols to be used in surveys that measure nursing home compliance with Federal requirements.

During surveys, states assess the quality of services provided, the accuracy of resident care plans, the observance of residents' rights and the adequacy of residents' safety. According to Federal regulations, state agencies must conduct a survey of each nursing home no later than 15 months after the last day of the previous survey. The statewide average for these surveys is 12 months. Surveys must be unannounced and conducted by a multi-disciplinary team of professionals, at least one of whom must be a registered nurse. At the conclusion of a survey, the state agency determines whether or not the nursing home is in substantial compliance with Federal participation requirements. Substantial compliance means that any deficiencies found during the survey pose no greater risk to resident health and safety than the potential for causing minimal harm.

If a nursing home is not in substantial compliance, agencies responsible for ensuring compliance, such as the Department's Bureau of Long Term Care Services in New York State, are required to impose some form of corrective action, depending on the scope and severity of the deficiencies found during a survey. For example, the Bureau is required to impose Federal remedies in cases where a nursing home is determined to be rendering substandard quality care. Remedies include money penalties, a change in management, state monitoring, denial of payment for new admissions, transfer of residents, and closure of the facility. However, nursing homes are given an opportunity to correct deficiencies before remedies are imposed. Nursing homes are notified of any deficiencies through a Statement of Deficiency. The Bureau

is required to provide a nursing home with a Statement of Deficiency within ten days of the completion of the survey. Following the receipt of a Statement of Deficiency, a nursing home is required to submit to the Bureau a plan to correct deficiencies, showing what measures will be taken and the date deficiencies will be corrected. In turn, the Bureau is required to approve the plan and follow up to ensure such measures are in place.

We found that the three area offices included in our audit are generally in compliance with Federal regulations and requirements for conducting timely surveys that ensure nursing homes comply with Medicaid participation requirements. Based on our audit work, we conclude that these offices are also generally in compliance with the Federal requirements for imposing remedies for noncompliance, and for conducting survey follow-up activities. However, we did find some minor problems with documenting survey results, meeting time frames for issuing Statements of Deficiency and monitoring nursing home Plans of Correction.

HCFA requires that a survey include interviews with a certain number of nursing home residents and family members. Such interviews provide assurance that the nursing home is protecting the rights of its residents and is providing equal access to quality care. In addition, survey takers are required to review the total care environment for a sample of residents to determine if the care provided by the nursing home has enabled residents to reach or maintain their highest practicable physical, mental, and psychosocial well-being. These resident reviews include an examination of the room, bedding, care equipment and drug therapy the resident receives. The results of resident reviews and interviews should be recorded on HCFA-designated forms. Our examination of 60 nursing home survey files selected at random showed that some resident reviews were incomplete, and that survey takers did not always do the required number of interviews. For example, in 16 files, there was incomplete or missing documentation of completed resident reviews; in seven other files, survey takers completed fewer than the required number of interviews.

In addition to interviewing residents and conducting resident reviews, survey takers are required to ensure that the nursing home has established a Quality Assessment and Assurance committee. In accordance with regulatory requirements, this committee should establish a formal method to identify and resolve quality deficiencies and meet on a regular basis. Survey takers are required to provide a written description of the committee's process for identifying deficiencies, and to interview nursing home employees to ensure the process is actually followed. Our audit showed that, in 46 percent of the survey files we examined, the survey takers did not provide evidence that this task was performed. We discussed our findings with area office personnel and found that some survey takers believe - incorrectly - that survey results should be documented on an "exception basis" only. Without such

documentation, there is little assurance that the required survey tasks were completed.

When nursing homes are not in substantial compliance with Federal regulations, the Bureau prepares a Statement of Deficiency describing the specific areas of noncompliance. According to Federal regulations, the Bureau must provide the Statement of Deficiency to the nursing home within ten days of the completion of the survey. However, we found that the Syracuse and New York City area offices do not always issue Statements of Deficiency within the required time frames. In these two area offices, survey takers did not issue the Statement of Deficiency timely for 33 of the 45 (73 percent) survey files we reviewed. The average length of time for issuing the Statements of Deficiency for these 33 surveys was 15 days.

According to Department officials, staff reductions and limited computer resources have caused the delays for issuing the Statements of Deficiency. We recognize that limited resources can make it more difficult to comply with Federal regulations. However, since a Statement of Deficiency is intended to alert nursing home officials to existing problems so they can correct them quickly, issuing a Statement of Deficiency late may result in delays in addressing situations risking patient health and quality of care. For example, one Statement of Deficiency - which the Bureau took 26 days to issue - cited a nursing home for not establishing an infection control program to prevent the development of disease and infection. Nursing home officials should have been alerted to this deficiency as quickly as possible so they could have corrected it.

Once nursing home officials receive the Statement of Deficiency, they have ten days to prepare and submit a Plan of Correction to the Bureau. We found that the nursing homes do not always submit a Plan of Correction within the required time frame. In 11 of the 60 (18 percent) survey files we reviewed in the three regions, the nursing homes took longer than ten days to submit their Plans of Correction, with the average being 16 days.

Implementation of the Plan of Correction is a critical step in the process for correcting nursing home deficiencies and achieving compliance with program requirements. The nursing home that did not have an effective infection control program did not submit a Plan of Correction to the Bureau until 27 days after the Statement of Deficiency was issued to the facility. In total, 53 days elapsed from the completion of the survey to the receipt of the Plan of Correction. Such delays in issuing the Statement of Deficiency and in reporting the Plan of Correction can impact the timeliness of the corrective action taken and jeopardize patients' quality of care.

Recommendations

1. Follow up on the three outstanding Chapter 340 complaints and the seven outstanding general complaints we identified during the audit.
2. Ensure that the New York City area office has written procedures in place to help provide greater control over complaint investigations.
3. Ensure that the New York City area office develops a control mechanism to track and monitor the progress of all outstanding complaint investigations.
4. Develop and implement a system to monitor and improve the performance of complaint investigators. Consider requiring periodic training refresher courses on proper investigative and evidentiary techniques, and identifying best practices of area office complaint units.
5. Develop a uniform process for documenting certification survey results and ensure this process is followed by all Bureau employees.
6. Instruct area offices to develop controls to monitor the progress and timeliness of survey follow-up activities, such as issuing deficiency statements and reviewing correction plans.

Identification of Payments to Ancillary Service Providers

Nursing homes provide their residents with 24-hour nursing care. Included in nursing home care are basic services, such as assisting residents with personal hygiene and toileting, as well as more complex care, such as tube feedings. According to Medicaid payment policy, nursing homes are paid a per diem rate to provide such services for each Medicaid-eligible recipient. New York's Medicaid nursing home reimbursement rate includes reimbursement for these basic care services, as well as for numerous ancillary services. These ancillary services, such as pharmacy, dental and restorative therapy services are generally included in a nursing home's reimbursement rate. Some nursing homes also provide their residents with non-emergency medical transportation services, which also may be included in the nursing home rate. Nursing homes either deliver these services directly or contract with ancillary service providers to render them to residents. Therefore, if Medicaid pays separately for a resident's ancillary services, it may be paying twice for the same service: first when it pays the facility at the nursing home rate, and again when it pays the provider for a separate ancillary service claim.

To detect duplicate payments for ancillary services covered by the nursing home rate, MMIS has computer programs that verify the appropriateness of claims submitted by ancillary service providers. However, during our audit period, some of these computer programs were not completely developed, which allowed claims to bypass the MMIS controls. For the three-year period ended December 31, 1996, we found that MMIS did not detect as much as \$1.3 million in potential Medicaid overpayments to ancillary service providers.

To measure the effectiveness of MMIS controls in detecting inappropriate payments to ancillary service providers, we developed computer programs to identify claims for ancillary services rendered to Medicaid recipients in nursing homes. Our programs matched nursing home claims with ancillary service claims and identified potential overpayments for ancillary services which were already included in the nursing home reimbursement rate. The following table presents a summary of the potential overpayments we identified.

Ancillary Service	Potential Overpayment
Pharmacy	\$595,000
Dental practitioner	\$33,000
Dental clinic	\$260,000
Physical, occupational, and speech therapy	\$32,000
Transportation	\$390,000
Total Ancillary Services	\$1,310,000

Of the \$595,000 in potential overpayments for pharmacy claims, \$245,000 was paid to providers for a variety of pharmacy services delivered to Medicaid recipients in nursing homes, and \$350,000 was paid to providers for certain “excluded” drugs. Periodically, officials from the Department and the New York State Division of the Budget agree to categorize certain drugs as “excluded.” A drug’s placement on the Department’s excluded list allows ancillary providers to be paid separately for its use. The drugs on this list are typically expensive and not uniformly used. However, prior to the effective date of the agreement, nursing homes are responsible for paying for these drugs through their standard reimbursement rate. We found that MMIS paid providers approximately \$350,000 for such drugs before they were placed on the list of excluded drugs. These claims were paid inappropriately because the program MMIS used to test the validity of pharmacy claims does not evaluate the effective date of a drug’s categorization as “excluded.” In response to our preliminary audit findings, Department officials agreed these claims were inappropriate, and stated they would investigate the payments that were made. The Department has also directed MMIS to take steps to correct its computer programs to verify the effective date of a drug’s placement on the list of excluded drugs.

In addition to pharmacy claims, we identified other inappropriate ancillary payments made on behalf of recipients in nursing homes as follows:

- \$ 33,000 in dental practitioner claims
- \$ 260,000 in dental clinic claims
- \$ 32,000 in therapy (physical, occupational and speech) claims

Department officials stated they would review these claims to determine why MMIS did not detect duplicate payments.

We also evaluated the reimbursement rates for 20 of the largest nursing homes to determine which services were included in their rates. We found

that transportation was included in the Medicaid reimbursement for 3 of the 20 providers. We evaluated all the nonemergency transportation billed by ancillary providers for recipients at these three facilities, and found that about \$390,000 had been paid for transportation. It seems reasonable to conclude that transportation providers should not be paid separately for services rendered to residents in facilities that explicitly cover transportation in their reimbursement rates. The Department agreed to investigate these claims to determine whether the payments were appropriate.

Recommendations

7. Investigate the \$1.3 million in potential overpayments identified in this report, and as warranted, take steps to recover overpayments.
8. Correct MMIS programming to verify the effective date a drug is placed on the excluded list.
9. Investigate the reasons why MMIS controls did not prevent the other ancillary care provider payments (for dental, therapy and transportation services) that are identified in this report.

Major Contributors to This Report

Jerry Barber
Frank Houston
Kevin McClune
Lee Eggleston
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January 16, 1998

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Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 97-S-30 entitled, "Monitoring Nursing Home Compliance with Medicaid Participation Requirements and Controlling Provider Payments". Please excuse the delay in responding to the report.

Thank you for the opportunity to comment.

Very truly yours,

A handwritten signature in black ink, appearing to read "Barbara A. DeBuono".
Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

enclosure

**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit 97-S-30 Entitled
"Monitoring Nursing Home Compliance"**

The following are the Department of Health's comments in response to the above cited Office of State Comptroller (OSC) Draft Audit Report entitled "Monitoring Nursing Home Compliance" (97-S-30).

Recommendation #1:

Follow up on the three outstanding Chapter 340 complaints and the seven outstanding general complaints we identified during the audit.

Response #1:

With respect to the three resident abuse cases not investigated, after medical review, one case was completed on August 20, 1997, another case was identified as a companion to a case closed in April 1997. The last case is under investigation. All seven general complaints were followed up, six were closed, but filed incorrectly and one was in progress and is now completed.

Recommendation #2:

Ensure that the New York City area office has written procedures in place to help provide greater control over complaint investigations.

Recommendation #3:

Ensure that the New York City area office develops a control mechanism to track and monitor the progress of all outstanding complaint investigations.

Recommendation #4:

Develop and implement a system to monitor and improve the performance of complaint investigators. Consider requiring periodic training refresher courses on proper investigative and evidentiary techniques, and identifying best practices of area office complaint units.

Response #2, #3, #4:

As stated, in 1997 we reorganized the complaint unit in New York City. The focus of the efforts in 1998 will be instituting written procedures and implementing the new computer-based tracking system. The planned implementation date for the tracking system for New York City is February 15, 1998. Each field office will be using the same tracking system.

As part of our HCFA-required State Agency Quality Improvement Plan (SAQIP) we will be providing statewide feedback on cycle time, decision making to field staff and managers.

In addition, we have begun a series of training programs for field investigations. Each office will be scheduled for refresher training. Future training needs will be based on periodic review of complaints which identifies issues.

Recommendation #5:

Develop a uniform process for documenting certification survey results and ensure this process is followed by all Bureau employees.

Response #5:

We will establish a policy addressing paperwork that is expected to account for time worked in the field.

Recommendation #6:

Instruct area offices to develop controls to monitor the progress and timeliness of survey follow-up activities, such as issuing deficiency statements and reviewing correction plans.

Response #6:

As part of SAQIP, we will provide information on cycle time for each portion of survey processing to ensure that we, at a minimum, meet the HCFA-specified time frames.

Recommendation #7:

Investigate the \$1.3 million in potential overpayments identified in this report, and as warranted, take steps to recover overpayments.

Response #7:

Further investigation of these overpayments will be greatly facilitated by OSC's provision of some additional information so that appropriate recovery can be instituted. It is unclear from the information provided, of the \$1.3 million in potential overpayments, which portion of the \$595,000 identified as potential overpayments for pharmacy services provided to Medicaid recipients residing in nursing homes, might be appropriate. There are a number of drugs which are paid for outside the inclusive rate. With the additional information from OSC, we would be able to make a more accurate review of these payments.

Recommendation #8:

Correct MMIS programming to verify the effective date a drug is placed on the excluded list.

Response #8:

As recommended by the auditors, DOH Office of Medicaid Management (OMM) staff have corrected the programming to verify the effective date a drug is placed on the excluded list.

Recommendation #9:

Investigate the reasons why MMIS controls did not prevent the other ancillary care provider payments (for dental, therapy and transportation services) that are identified in this report.

Response #9:

OMM staff will thoroughly investigate the problem cited and determine the appropriate corrections to MMIS controls.