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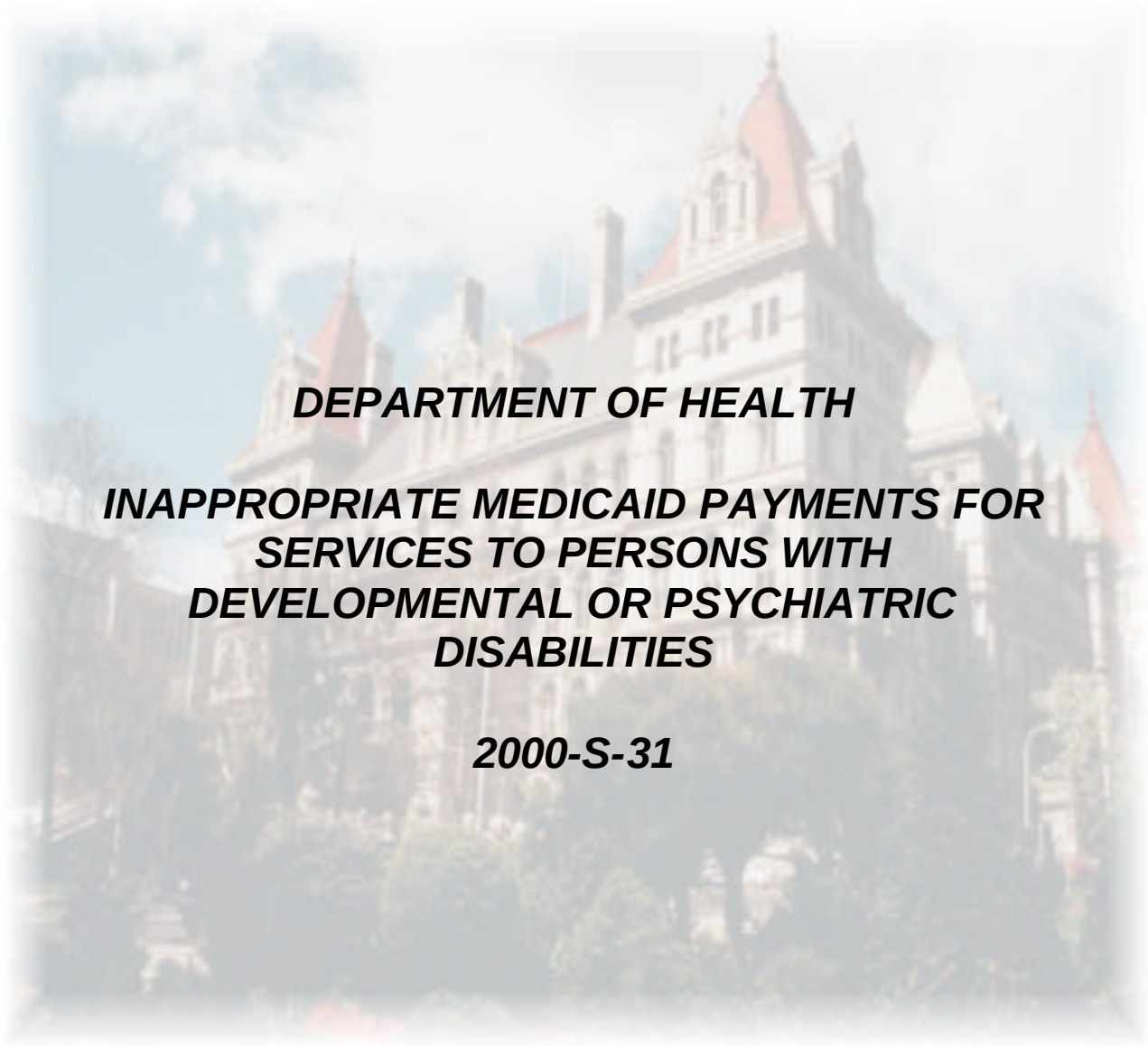

DEPARTMENT OF HEALTH

INAPPROPRIATE MEDICAID PAYMENTS FOR SERVICES TO PERSONS WITH DEVELOPMENTAL OR PSYCHIATRIC DISABILITIES

2000-S-31

DIVISION OF MANAGEMENT AUDIT AND
STATE FINANCIAL SERVICES

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Report 2000-S-31

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Novello:

The following is our report on the Department of Health's practices for controlling Medicaid payments for services to persons with developmental or psychiatric disabilities in institutional and community-based settings.

This audit was performed 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. Major contributors to this report are listed in Appendix A.

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

November 8, 2001

EXECUTIVE SUMMARY

DEPARTMENT OF HEALTH

INAPPROPRIATE MEDICAID PAYMENTS FOR SERVICES TO PERSONS WITH DEVELOPMENTAL OR PSYCHIATRIC DISABILITIES

SCOPE OF AUDIT

The Department of Health (Health) administers the State's Medical Assistance Program (Medicaid). Health uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay provider claims. Eligible Medicaid recipients receive services through the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD). These services can be provided in institutions such as Developmental Centers (OMRDD) and Psychiatric Centers (OMH), or in community-based settings, such as Intermediate Care Facilities (Facilities) and Community Residences (Residences).

As Medicaid clients transition from one mode of treatment to another, staff in the State's 58 local districts and in selected OMRDD regional offices update recipient eligibility information on the State's Welfare Management System (WMS). The MMIS uses WMS data to pay provider claims. The MMIS contains computer edits which flag certain types of transactions during claims processing, to avoid making duplicate payments to providers for the same service and to prevent paying providers for unnecessary services.

Our audit addressed the following question about payment of Medicaid claims from OMH and OMRDD providers for the four and one-half year period April 1, 1996 through June 30, 2000:

- Has Health established adequate computer controls within the MMIS to ensure that payments for services to persons with developmental or psychiatric disabilities are appropriate?

AUDIT OBSERVATIONS AND CONCLUSIONS

We found that providers received $4.4 million in potentially inappropriate Medicaid payments because Health has not established the necessary

computer edits in the MMIS to prevent such overpayments. Of the $4.4 million in potentially inappropriate payments, about $4 million in payments were made to providers of services to developmentally disabled clients (OMRDD). Further, Health did not ensure WMS data is updated timely, and OMRDD did not identify the clients who received certain on-site services.

Using computer-assisted audit techniques, we identified thousands of Medicaid claims for services to persons with developmental or psychiatric disabilities that were inappropriately paid because MMIS does not have the necessary edits. The MMIS does not have edits that identify overlapping, and potentially inappropriate, claims billed on different invoice types (e.g., a Facility claim and a community-based service provider claim) on the same day. In one instance, the absence of such cross-invoice edits resulted in Medicaid paying $2.1 million for 7,923 claims from community-based providers for on-site day treatment services to OMRDD clients. Since Medicaid had reimbursed the Facilities to deliver these services, the local providers should have sought payment from the Facilities, not from Medicaid. Recovering these overpayments may be difficult because OMRDD did not identify the recipients who received the on-site services. The absence of cross-invoice edits also resulted in provider overpayments of almost $700,000 for pharmacy claims, and for overlapping Residence and inpatient claims of more than $850,000. We recommend Health include cross-invoice edits in the design of its eMedNY payment system now in development, and that Health and OMRDD improve existing controls until eMedNY is functional. (See pp. 5-7, 9-11)

Recipients in Facilities are not eligible for waivered services, which are designed for recipients who live in the community. However, since local districts and OMRDD regional offices did not promptly update the WMS to show the type of service the recipient was currently eligible to receive, both Facilities and waivered service providers were overpaid a total of almost $750,000. We recommend Health recover all the overpayments we identified, and ensure the WMS is timely updated. (See pp. 7-9)

COMMENTS OF OFFICIALS

The Department of Health's response to our report included comments from OMRDD and OMH officials. In general, the officials agreed with the recommendations we made in our report. Additionally, based on comments made by OMRDD and OMH officials, we modified our report to acknowledge remedial actions taken by OMRDD and OMH officials, to clarify procedures, and to recognize the distinction between services for people with mental retardation and developmental disabilities and mental health services.

CONTENTS

INTRODUCTION

Background

The New York State Department of Health (Health) is responsible for the overall supervision of New York State's Medicaid program and the State's Medicaid Management Information System (MMIS). The MMIS is a computerized Medicaid claims processing, payment and information reporting system operated by Health's fiscal agent, Computer Sciences Corporation.

Eligible Medicaid recipients receive services through the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD). These services can be provided in institutions, such as Developmental Centers (OMRDD) and Psychiatric Centers (OMH), or in community-based settings, such as Community Residences (Residences) and Intermediate Care Facilities (Facilities). Developmental Centers (Centers) provide 24-hour care, supervision and active treatment for clients whose needs are best served in an intensive treatment facility. Residences are designed to assist mentally ill persons in living as independently as possible through training and assistance in the skills of daily living and a focus on the person's overall rehabilitation. A Facility is a sheltered, residential setting that provides intensive care to individuals with developmental disabilities through structured programs in a 24-hour residential arrangement.

In recent years, OMH and OMRDD have focused on moving significant numbers of mentally ill and developmentally disabled clients out of large institutions and into smaller community-based settings. This move from institutions to community-based settings has also changed the way services to persons with developmental or psychiatric disabilities are reimbursed in New York State. Institutional providers, like Centers, receive an all-inclusive Medicaid reimbursement rate because the institution provides a full range of health services (clinic, pharmacy, dental) to recipients. By contrast, Residences and Facilities generally receive reimbursement rates that are not all-inclusive, since recipients in these settings often receive services from community-based providers such as physicians, outpatient clinics and pharmacies. For example, recipients at Facilities

receive day treatment services, which comprise a comprehensive array of services, including activities and programs that provide diagnostic treatment, active therapeutic treatment and habilitative services to the developmentally disabled. Although most recipients receive these services off-site from community-based providers, a Facility may be approved to provide day treatment services at the Facility for those recipients who are unable to travel off-site. In this case, the Facility receives a higher reimbursement rate to include the provision of these services, either by the Facility staff or by a contractor hired by the Facility.

Some Medicaid recipients who need services live independently in the community. Section 1915 (C) of the Social Security Act (Home and Community-Based Services Waiver) makes certain types of outpatient services available to Medicaid recipients under a Federal waiver. So-called "waivered" services are designed to help these clients assimilate into their communities and live on their own. Since Facility residents live in a sheltered, structured setting, Medicaid will not reimburse providers for delivering waivered services to these recipients.

Centers and Residences bill Medicaid for residential services on a monthly basis. MMIS billing guidelines require that a client spend at least 21 days at a Residence, excluding the day of discharge and time spent in a hospital or other Medicaid reimbursable treatment, for the Residence to obtain reimbursement for that client for the entire month.

The Medicaid law is complex, and clients often move from one mode of treatment to another. The State's Welfare Management System (WMS) is a computerized database that contains Medicaid and public assistance eligibility information used in administering the State's various assistance programs. MMIS uses WMS data to pay provider claims. Staff in the State's 58 local districts and in selected OMRDD regional offices are responsible for updating recipient eligibility information on two WMS subsystems: the Principal Provider subsystem and the Restriction/Exception subsystem. The Principal Provider subsystem contains current client status and treatment code data for recipients who need long-term care in facilities, such as psychiatric centers and hospitals; the Restriction/Exception subsystem identifies codes that either restrict or allow Medicaid payments to providers for certain services. Health uses information from both subsystems, in conjunction with MMIS billing guidelines, to pay providers for delivering appropriate

services to clients. The MMIS contains computer edits which flag certain types of transactions during claims processing in order to avoid making duplicate payments to providers for the same service and to prevent paying providers for unnecessary services.

In early 2000, Health began designing a new system, eMedNY, to replace the existing MMIS eligibility and processing systems for all medical service claims, including claims for services to persons with developmental or psychiatric disabilities. Health officials estimate the entire project will take several years to complete. Health officials have stated their belief that the new system will significantly improve Health's accounting for the Medicaid program.

Audit Scope, Objective and Methodology

We audited Health's practices for controlling payments to providers of services in both institutional and community-based settings for the period April 1, 1996 through June 30, 2000. The objective of our performance audit was to determine if Health made inappropriate payments to providers of these services. To accomplish our objective, we interviewed Health, OMH and OMRDD officials. We also reviewed various records, applicable Medicaid policies and pertinent Federal and State regulations. In addition, we developed computer programs that could extract and analyze claims so we could verify the appropriateness of Medicaid payments to OMH and OMRDD providers on behalf of recipients during our audit period. We also reviewed the MMIS editing process.

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 Health's responsibilities included in our audit scope. Further, these standards require that we understand the internal control structure of Health, OMH and OMRDD and these agencies' 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

We provided draft copies of this report to Health officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B. Appendix C contains State Comptroller's Notes, which address certain matters contained in the Department of Health's response.

Based on comments provided by OMRDD and OMH officials that were included in the Department of Health's response, we modified our report. We acknowledged remedial actions taken by OMRDD and OMH officials to address our findings. We clarified procedures. We also recognized the distinction between services for people with mental retardation and developmental disabilities and mental health services.

Within 90 days of the 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 in this report, and where recommendations were not implemented, the reasons therefor.

INAPPROPRIATE MEDICAID PAYMENTS FOR SERVICES TO PERSONS WITH DEVELOPMENTAL OR PSYCHIATRIC DISABILITIES

To ensure appropriate payments for Medicaid services, the MMIS uses computer controls and programs that verify the accuracy of claims submitted by providers. By using computer programs we developed to identify inappropriate billings by OMH and OMRDD providers, we determined that the MMIS lacks sufficient controls for detecting multiple claims for services delivered to the same Medicaid recipient on the same day. We also determined that OMRDD and local districts are not always prompt in updating the WMS Principal Provider and Restriction/Exception subsystems. Because of these weaknesses, we determined that Medicaid may have overpaid OMRDD and OMH providers of services to persons with either developmental disabilities or psychiatric disabilities, respectively, a total of $4.4 million for the period April 1, 1996 through June 30, 2000. Of the $4.4 million in potentially inappropriate payments, about $4 million in payments (90 percent) were made to providers of services to developmentally disabled clients (OMRDD), while the remaining $437,699 of payments were made to mental health providers (OMH). To avoid future overpayments, OMRDD and local district staff should update the WMS promptly and Health should incorporate relevant edits into the design of eMedNY. Until the new system is implemented, Health should strengthen MMIS controls, to the extent possible, to prevent inappropriate payments.

Overlapping Facility and Day Treatment Claims

When a Facility is approved to provide on-site day treatment services to recipients, the Facility staff can provide the day treatment services or the Facility can contract with a community-based day treatment provider to deliver the services on site. Medicaid directly reimburses the provider of day treatment services only if the cost of the service is not included in the

Facility's reimbursement rate; if the cost is included in the rate, the Facility must pay the provider for services rendered.

We found that MMIS may have inappropriately paid 7,923 claims, totaling approximately $2.1 million, from day treatment providers who delivered on-site services to recipients in Facilities. Since these Facilities were approved to provide on-site day treatment services, and had received a reimbursement rate adjustment to cover the associated costs, the Facilities should have paid the community-based day treatment providers for these services. We determined that Medicaid made these payments because of two control deficiencies: 1) OMRDD did not identify and maintain documentation for those recipients who were approved to receive on-site day treatment services; and 2) MMIS lacks a system edit to identify claims for recipients who receive on-site day treatment services.

We asked OMRDD officials for documentation that would identify recipients approved for on-site day treatment during our audit period. OMRDD gave us a roster of approximately 200 Medicaid recipients. However, we later determined that these 200 individuals were those people currently approved to receive on-site services, and that OMRDD had obtained the list from the Facilities. OMRDD had no independent documentation of clients currently approved for on-site day treatment, and had no records of clients approved for such services during the audit period. Therefore, OMRDD could not help in determining whether Medicaid made inappropriate payments to providers who should have been paid by Facilities. To avoid making such inappropriate payments, OMRDD must document those recipients approved for on-site day treatment.

Health must also develop an MMIS computer edit to flag claims for day treatment services delivered to these recipients. MMIS claims processing includes a series of automated edits to avoid duplicate payments for services, as well as edit bypasses, which allow valid claims to avoid unnecessary edits that delay processing. For example, when a Facility resident travels off site to a provider to receive day treatment services, MMIS should properly pay both the Facility and provider claims. Therefore, an edit bypass allows for the payment of a Facility claim and a day treatment claim for a recipient on the same day. However, this edit bypass also allows for the payment of both the claim submitted by the Facility that is reimbursed to provide on-site day treatment and the claim submitted by the provider of the on-

site services. This provider should be paid by the Facility, and not by Medicaid.

The absence of documentation and the lack of an effective processing edit allowed these payments to be made without detection. As a result, Medicaid paid $2.1 million in potentially inappropriate day treatment claims. Due to OMRDD's lack of documentation, we believe that amounts paid for inappropriate claims may be difficult to recover.

In response to our draft report, OMRDD officials stated they have in place a new internal control procedure to annually survey all existing Facility providers to identify the consumers who receive in-house day treatment services. Also, according to OMRDD officials, before any new Facility rate is established, the Facility provider must document the names of all consumers whom the provider projects will receive in-house day treatment services. Additionally, internal control procedures have been implemented to monitor outside billing of day treatment services for consumers whose day treatment costs are included in the Facility rate. Facility rates will be adjusted for days when any outside day treatment services are included in the Facility rate.

Overlapping Facility and Waivered Service Claims

A Facility is a sheltered, residential setting that provides 24-hour residential arrangements and intensive care to individuals with developmental disabilities. Recipients who live in Facilities are not eligible to receive waivered services, which are designed to help recipients assimilate into the community and live independently. According to Section 1915 (C) of the Social Security Act, waivered services will not be furnished to recipients while they are inpatients of a hospital, nursing facility or a Facility.

Using computer-assisted audit techniques, we analyzed Medicaid claims paid for Facility and waivered services during our audit period. We found that providers billed Medicaid for Facility services for recipients who were not in a Facility and were, in fact, receiving waivered services. Likewise, we found that providers billed Medicaid for waivered services when the recipients were actually in a Facility, and not eligible for waivered services. As a result, we identified 206 inappropriate payments totaling $748,145 ($568,935 in inappropriate

waivered service claims and $179,210 in inappropriate Facility claims).

The reason these inappropriate payments occurred is that OMRDD and local districts do not update WMS recipient eligibility data timely and accurately. MMIS processes Facility claims using information from the WMS Principal Provider subsystem, and processes claims for waivered services using information from the WMS Restriction/Exception subsystem. It is essential that the Principal Provider and Restriction/Exception subsystems be updated simultaneously to ensure that Medicaid pays for only those services the recipient is actually receiving. Recipients often transition from one type of service level to another. Simultaneous updating reflects such changes and pays providers accordingly.

We found that some overpayments were for services that were not provided. For example, the local district worker should end-date the recipient's eligibility information on the WMS Principal Provider subsystem when a recipient leaves a Facility. Unless this happens, the Facility can continue to bill and receive a Medicaid payment for the recipient, even if the recipient is no longer in the Facility and is instead receiving waivered services. Further when a recipient transitions from the waivered service program into a Facility, the local district must enter a code on the Restriction/Exception subsystem to indicate that the recipient is now residing in a Facility and is no longer eligible to receive waivered services.

Since the claims for Facility and waivered services are processed separately, the claim for Facility services and the claim for waivered services for the same recipient can both be processed and paid. Thus, duplicate payments can be made without detection until both subsystems are properly updated. In addition, when district and OMRDD staff enter eligibility code data late (e.g., months after a client has transitioned from one type of service to another), there is no process in place by which Health can retroactively recover overpayments made to Facilities or waivered service providers.

In response to our draft report, OMRDD officials stated that, on a post-audit basis, they instituted an internal control program to identify overlapping Facility and waiver service claims. As part of this process, OMRDD reviews Medicaid payment data and identifies duplicate claims. Also, at OMRDD's request, a new edit was implemented in MMIS to allow waiver services to be

paid only where a restriction exception code is present identifying the consumer as waiver-enrolled.

Overlapping Developmental Center and Pharmacy Claims

Recipients in Centers receive a variety of services, including physician, transportation, referred ambulatory, laboratory and pharmacy services. Centers receive a Medicaid reimbursement rate that is all-inclusive (i.e., covers the cost of all approved services), and the Center bills Medicaid, on a monthly basis, for the cost of these services. If community-based providers provide services to recipients who reside in the Center, the cost of these services should be paid by the Center and not by Medicaid.

We identified 20,566 pharmacy claims totaling $689,349 that were paid inappropriately by MMIS for recipients in 15 Centers. Of the $689,349, $650,584 (94 percent) was paid to three Centers. Health officials explained that some overpayments occurred when recipients were on leave from the Center and had prescriptions filled by a local pharmacy. Another example, cited by OMRDD officials, involved a Center that contracted with a local pharmacy to fill recipients' prescriptions for an extended period because it had no pharmacist on site. Regardless of the reasons for using local pharmacists, the Centers - and not Medicaid - should pay for their services.

We discussed this issue with Health officials to determine if there are edits within MMIS to prevent the payment of pharmacy claims for recipients in Centers. We determined that Health has implemented edits that prevent duplicate claims of the same invoice type (e.g., two pharmacy claims for the same prescription and the same client on the same day). However, there are no edits to prevent the payment of inappropriate payments on different invoice types (e.g., a pharmacy claim and a Center claim for the same client on the same day). These edits, known as cross-invoice edits, would prevent inappropriate payments. Without a cross-invoice editing process that includes other MMIS payments made on behalf of the same recipient on the same day, Health cannot prevent inappropriate payments to pharmacies for recipients who are residents in Centers.

In response to our draft report, OMRDD officials stated they implemented several internal control procedures. For example, OMRDD prohibits the use of agreements with pharmacists that would allow the pharmacist to bill Medicaid for the services

delivered under the agreement. Also, OMRDD annually reviews MMIS billing records to Center residents and investigates the appropriateness of outside claims. Further, OMRDD has taken steps to ensure that Center staff members are aware of the prohibition against outside billing of Medicaid services for Center residents.

Regarding OMRDD's pharmacy policy, we noted instances where the policy did not prevent pharmacies from billing Medicaid for services provided to residents in Centers. In our judgment, a system edit is needed to further preclude inappropriate Medicaid payments.

Overlapping Community Residence and Inpatient Claims

Residences are facilities for mentally ill and developmentally disabled persons who are unable to live independently at a particular time. Both OMH and OMRDD license community residences for their respective clients. According to MMIS billing guidelines for OMH community residence rehabilitation services, "Full monthly billing requires at a minimum: 21 days in residence, excluding discharge day, days in hospital or in any other Medicaid reimbursable setting. Half-month billing requires, at a minimum, 11 days in residence (excluding discharge day, days in hospital or in any other Medicaid reimbursable facility)." MMIS billing guidelines for OMRDD community residence services are similar for full-month billings: "21 days in residence with four services delivered."

MMIS payment guidelines require that the recipient be in an OMH community residence for at least 21 days to bill the monthly rate; the Residence should not bill the monthly rate when the recipient is hospitalized for more than 11 days in a given month. OMRDD MMIS payment guidelines allow Residences to count days toward the 21-day residency requirement when a client is absent from the community residence on therapeutic leave. Therapeutic leave includes, among other things, absences from the community residence to visit relatives/friends or for an inpatient hospital stay. The regulation allows Residences to charge up to 40 days of therapeutic leave per certified bed per year. However, OMRDD has no documentation to identify the therapeutic leave days

claimed by Residences, and MMIS has no edits to detect therapeutic leave on monthly claims.

We identified 381 inappropriate Medicaid claims totaling $853,676 ($437,699 in OMH monthly claims and $415,977 in OMRDD monthly claims) paid to Residences while recipients were hospitalized for more than 11 days in a given month. While Residences should not have billed - and Medicaid should not have paid - monthly claims for these recipients, billing and paying for services at the half-month rate may have been appropriate, depending on eligibility for half-month payments.

In examining the MMIS claims payment process to determine why these inappropriate payments occurred, we again found that the cause of the problem was a lack of cross-invoice edits. In this case, there are no edits to identify overlapping Residence claims and inpatient claims for the same recipient on the same day. As a result, Health cannot ensure that Medicaid payments paid to Residences are appropriate.

Recommendations

1. Investigate and recover the overpayments identified in this report, as appropriate.
2. Identify all recipients approved to receive on-site day treatment services at Facilities and maintain a roster of those recipients.
3. Ensure that OMRDD and local district workers update both the Principal Provider and the Restriction/Exception systems timely and accurately to prevent inappropriate overlapping payments to Facilities and waivered service providers.
4. Develop edits as part of the new eMedNY system to:
   - identify recipients receiving on-site day treatment services;
   - prevent the payment of pharmacy claims for recipients in Centers; and
   - prevent the payment of monthly Residence claims for recipients who are hospitalized for more than 11 days in a given month.

Recommendations (Cont'd)

5. Until eMedNY is implemented, conduct periodic audits to ensure that recipient rosters are complete and current.

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Appendix A

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DEPARTMENT OF HEALTH
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Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 24, 2001

Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2000-S-31, entitled "Inappropriate Medicaid Payments for Mental Health Services".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix B

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2000-S-31 Entitled
"Inappropriate Medicaid Payments for
Mental Health Services"

The following are the Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Mental Health (OMH) and Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2000-S-31 entitled "Inappropriate Medicaid Payments for Mental Health Services".

The following are the OMRDD and OMH's general comments:

OMRDD General Comments - Before addressing OSC's recommended corrective actions, there are several issues that need to be clarified in OSC's report findings. Throughout the audit process, OMRDD has worked with OSC staff to review earlier drafts and provide supporting documentation where appropriate. In several cases, the comments and materials that OMRDD provided to OSC were not incorporated in this draft report.

* Note 1

Overlapping Facility and Day Treatment Claims - The report states that as much as $2.1 million in day treatment claims may have been paid inappropriately to community-based day treatment providers for services delivered to consumers approved for ICF funded in-house day treatment. We addressed this issue in our December 7, 2000 memorandum (Enclosure 1). The latest OSC draft report does not incorporate OMRDD's earlier comments.

* Note 1

The assumption of a $2.1 million "overpayment" is based on the value of the community-based day treatment services that were paid through MMIS rather than the day treatment costs incorporated in the ICF rates. The value of day treatment costs included in the ICF rates is **substantially lower** than the MMIS payments for the community-based day treatment services. OMRDD is in the process of adjusting ICF rates in effect during the OSC audit period to accurately reflect when in-house day treatment services were provided. OMRDD will make appropriate recoveries from ICF providers.

* Note 2

As discussed in the December 7, 2000 memorandum, OMRDD has implemented internal control procedures to address this matter. No mention of this is included in the draft report. OMRDD has in place a procedure to annually survey all existing ICF providers to identify the consumers who receive in-house day treatment services (Enclosures 2 & 3). Similarly, before any new ICF rate is established, the ICF provider must document the names of all consumers whom the provider projects will receive

* See State Comptroller's Notes, Appendix C

in-house day treatment services. Internal control procedures have been implemented to monitor outside billing of day treatment services for consumers whose day treatment costs are included in the ICF rate. ICF rates will be adjusted for days when any outside day treatment services are billed for consumers whose day treatment costs are included in the ICF rate.

* Note 2

Since issuing the December 7, 2000 memorandum, OMRDD has taken further action and adjusted all 2001 ICF/DD rates. ICF/DD providers specified the names of all consumers receiving in-house day programming and identified whether a consumer received in-house day programming on a part-time or full-time basis. Based on this information, the 2001 ICF/DD rates were then adjusted to precisely reflect days when in-house day programming is provided and reimbursement should be provided in the ICF rate.

* Note 2

Overlapping Facility and Waivered Service Claims - The OSC report states that "there is no process in place by which Health can retroactively recover overpayments made to facilities or waivered service providers" (page 8). OMRDD instituted an internal control program to, on a post-audit basis, identify overlapping facility and waiver service claims. This internal control process was implemented in May 2000. As part of this process, OMRDD reviews Medicaid payment data and identifies duplicate claims; OMRDD then contacts the providers to determine which service is valid. OMRDD then electronically transmits system voids to MMIS to eliminate the incorrect payment.

* Note 2

It should also be noted that effective November 1, 2000, at OMRDD's request, a new edit was implemented in MMIS. This edit allows waiver services to be paid only where a restriction exception code is present identifying the consumer as waiver-enrolled. Since ICF consumers cannot be enrolled in the waiver, OMRDD has thus substantially reduced the incidences of overlapping facility and waiver service claims. As another safeguard, OMRDD is pursuing use of the principal provider subsystem for waiver residential services. This system change will ensure that there is no ICF and waiver residential billing on the same day.

* Note 2

Overlapping Developmental Center (DC) and Pharmacy Claims - In OMRDD's February 2, 2001 memorandum, several internal controls procedures were identified which were implemented by OMRDD (Enclosure 4). OMRDD is concerned that little of the material provided in that memorandum was incorporated in the draft report. Specifically, the report fails to mention that OMRDD prohibits the use of agreements with pharmacists that would allow the pharmacist to bill Medicaid for the services delivered under the agreement.

* Note 2

The report also fails to mention OMRDD's procedures for ensuring that duplicate payments are not made for DC residents. As discussed in the February 2, 2001 memorandum, OMRDD annually reviews MMIS billing records for DC residents and investigates the appropriateness of outside claims. The value of any inappropriate

* Note 2

* See State Comptroller's Notes, Appendix C

outside claims is then deducted from OMRDD's Medicaid claim for DC services. In addition to the annual review of Medicaid billing for DC residents, OMRDD has also taken steps to ensure DC staff are aware of the prohibition against outside billing of Medicaid services for DC residents.

* Note 2

Overlapping Community Residence and Inpatient Claims - On page 9, the report states that MMIS payment guidelines require that "the recipient be in either an OMRDD or OMH community residence for at least 21 days to bill the monthly rate, the Residence [therefore] should not bill the monthly rate when the recipient is hospitalized for more than 11 days in a given month." This is incorrect. As clarified in our February 5, 2001 memorandum, days that an OMRDD CR resident is in a hospital may be counted toward the residency requirement (Enclosure 5). OMRDD regulations 14 NYCRR 686.13 allow the provider to count days when a consumer is absent from the CR to visit relatives or friends or for an inpatient hospital stay toward the 21-day residency requirement up to 40 days annually per certified bed. As a result of these regulatory provisions, a full month CR claim is not necessarily invalid when the consumer is hospitalized for 11 or more days during the same month.

OMH Comments on Conclusion - OSC's draft report concluded that "...mental health providers received $4.4 million in inappropriate Medicaid payments..." That conclusion is not correct.

* Note 2

A review of the four observations in the report shows that over 90 percent of the $4.4 million in question was paid to providers offering services to people with developmental disabilities, not to mental health providers. OSC observations on page 10 of the report cite mental health providers as receiving only $437,699 in questioned payments, and not $4.4 million as specified in the conclusion.

* Note 2

Accordingly, OMH believes the report needs to be changed, both for clarity and precision, before it is issued in its final version so that emphasis is appropriately placed on claims for services to people with developmental disabilities, and not for "mental health services." Corrections should be made to the transmittal letter, the report title, and to the report sections entitled: Executive Summary, Introduction and Inappropriate Medicaid Payments for Mental Health Services.

* Note 3

OMH Comments on Overlapping Community Residence and Inpatient Claims – Regarding OSC's estimate of $4.4 million in potentially inappropriate Medicaid payments, OMH believes that the figure is overstated. While many of the claims submitted by State-operated community residence providers may be ineligible for full-month payments, many should still be eligible for half-month payments which would reduce the estimate of inappropriate payments. The same situation may also exist for claims submitted by not-for-profit community residence providers.

* See State Comptroller's Notes, Appendix C

Finally, it should be noted that the $437,699 in questioned claims from community residence providers serving persons with psychiatric disabilities represents less than one percent of Medicaid billings for these providers.

The following represents responses to each of OSC's recommendations.

Recommendation #1:

Investigate and recover the overpayments identified in this report, as appropriate.

Response #1:

DOH - The Department will assist OMRDD and OMH, as necessary, to investigate and recover overpayments where appropriate.

OMRDD - OMRDD concurs that any inappropriate overpayments identified in the report should be recovered. For each component of the report, the following method of recovering inappropriate payments is recommended.

* Note 1

For overlapping ICF/DD and day treatment claims, it is recommended that the identified community-based day treatment services **not** be recovered. The regulatory preference is that day program services be provided in the community. OMRDD is in the process of adjusting ICF/DD rates to remove in-house day programming costs where consumers received duplicative community-based day treatment services. This method eliminates the duplicative payment without penalizing the day treatment provider who legitimately provided the community-based day treatment service and furthers the state's policy preference that day treatment services are provided in the Community.

For overlapping facility and waivered service claims, OMRDD has implemented a procedure for identifying and voiding inappropriate claims. This is explained more fully in the general comments section of the response.

For overlapping Developmental Center and Pharmacy Claims, OMRDD routinely identifies pharmacy claims paid by MMIS for Developmental Center residents. The value of these pharmacy services is then deducted from the claim that OMRDD submits to Medicaid for Developmental Center services. This method eliminates duplicative payments pending the development of a cross-invoice edit.

For overlapping Community Residence and inpatient claims, OMRDD recommends that an in-depth study be conducted which examines each monthly claim where the consumer was in the hospital 11 or more days in the month. This review will take into account the regulatory provision allowing specified numbers of leave days to count toward the monthly residency requirement. OMRDD will work with OSC to conduct such a study and void any claims that prove to be inappropriate.

* See State Comptroller's Notes, Appendix C

Response #1 (cont'd):

OMH - OMH will work with DOH and the providers to identify and recover the actual inappropriate payments resulting from this review.

Recommendation #2:

Identify all recipients approved to receive on-site day treatment services at Facilities and maintain a roster of those recipients.

Response #2:

DOH – The Department defers to OMRDD for the response to this recommendation.

OMRDD – OMRDD concurs with OSC that a roster of all recipients approved to receive on-site day treatment be maintained. As discussed earlier in this response, OMRDD has implemented these procedures and has provided OSC with documentation (Enclosure 2 and 3).

Recommendation #3:

Ensure that OMRDD and local district workers update both the Principal Provider and the Restriction/Exception systems timely and accurately to prevent inappropriate overlapping payments to Facilities and waivered service providers.

Response #3:

DOH – To ensure appropriate entry on the Principal Provider Subsystem (PPS) to indicate admission/discharge to/from an ICF, it is incumbent upon the ICF to notify the LDSS timely. It is subsequently the responsibility of the LDSS to make the appropriate coding entries timely. LDSSs will be reminded of the importance of timely data entry in a GIS message. In addition, ICF providers will be reminded of their responsibility via a Medicaid Update article.

Restriction/Exception subsystem entry of waiver codes to indicate a consumer is enrolled in the HCBS waiver is primarily done for the LDSS by OMRDD.

As a reminder, edit 1319 was implemented in November of 2000 preventing waiver providers from being paid unless an appropriate waiver code is recorded on the system. This should prevent inappropriate payments for waiver services.

OMRDD – OMRDD concurs that the Principal Provider and Restriction/Exception systems should be updated in a timely fashion.

Recommendation #4:

Develop edits as part of the new eMedNY system to:

- identify recipients receiving on-site day treatment services;
- prevent the payment of pharmacy claims for recipients in Centers; and
- prevent the payment of monthly Residence claims for recipients who are hospitalized for more than 11 days in a given month.

Response #4:

DOH – This recommendation is primarily focused on cross-invoice editing. Cross-invoice editing is planned as a feature of eMedNY and the Department will insure that the specific instances/codes represented by these findings are included to the extent they are feasible.

OMRDD – OMRDD makes the following recommendation regarding the OSC's suggested eMedNY system edits.

An edit that identifies consumers receiving in-house day programming is not feasible. The scheduling of consumers' participation in in-house or community-based day programming is determined by consumer need. In some instances older or frail consumers may participate in both in-house and community-based day services because five days a week of outside day programming is too taxing. An edit would not provide sufficient flexibility allowing an ICF provider to be paid for a day treatment service if the consumer receives in-house day programming one day a week and then participates in community-based day programming on other weekdays. As discussed earlier, the same objective is accomplished by OMRDD routinely adjusting ICF/DD rates to reflect the latest in-house day programming survey information.

At this time a "cross-invoice" for Developmental Center and pharmacy services is not technically feasible. As discussed earlier, the offset to the OMRDD Medicaid claim accomplishes the same objective without undue burden for residents or pharmacy providers.

An edit cannot be implemented that would prevent the payment of a full-month OMRDD CR claim for months where 11 or more days of hospital services are billed. As discussed earlier, OMRDD regulations 14 NYCRR 686.13 allow the provider to count days when a consumer is absent from the CR to visit relatives or friends or for an inpatient hospital stay, toward the 21-day residency requirement up to 40 days per certified bed (Enclosure 5). As a result of these regulatory provisions, a full month CR claim is **not** necessarily invalid when the consumer is hospitalized for 11 or more days during the same month.

Recommendation #5:

Until eMedNY is implemented, conduct periodic audits to ensure that recipient rosters are complete and current.

Response #5:

DOH – The Department defers to OMRDD for the response to this recommendation.

OMRDD – OMRDD concurs that periodic audits of service payment information should be conducted. OMRDD has, in fact, already taken proactive action to identify and correct duplicative payments. Internal control procedures have been established including the:

- Adjustment of ICF/DD rates to eliminate duplicative day programming costs and the routine survey of ICF/DDs to maintain a current roster of consumers receiving in-house day programming.
- Routine survey of Medicaid payment information to identify and resolve duplicative facility and waivered service claims.
- Offset of pharmacy costs from the Developmental Center claim OMRDD submits to Medicaid.

OMRDD will work with OSC to investigate each instance where a full-month CR claim and 11 days of hospital services were billed to MMIS for the same consumer during the month to identify where recoveries are appropriate.

* Note 2

In addition to the above-mentioned changes, there were technical errors that should be corrected in the final document. In the section titled "Scope of Audit" and throughout the document, the services provided by OMRDD and the voluntary agencies it licenses are referred to as mental health services. As noted in the November 17, 2000 memorandum, OMRDD regulates services for people with mental retardation and developmental disabilities, not mental health services (Enclosure 6). The Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities are separate entities under Mental Hygiene Law §5.01. In addition, the quote on page 7 is incorrectly assigned to section 1915(C) of the Social Security Act. There is no such statement in the Social Security Act.

* See State Comptroller's Notes, Appendix C

George E. Pataki
Governor

Enclosure 1

Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
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(518) 473-1997 • TDD (518) 474-3694

MEMORANDUM

TO: Vincent Sleasman

FROM: Alden B. Kaplan

DATE: December 7, 2000

SUBJECT: Audit #2000-S-031 ICF and Day Treatment Services

This memo is in response to William Warner's November 8, 2000 letter regarding the preliminary audit findings related to overlapping ICF and Day Treatment claims (2000-S-031). We recommend the following revisions to OSC's proposed language:

Page One - Last sentence

The sentence currently reads: An ICF provider may request a higher rate of reimbursement to provide day treatment services at the ICF for all, or some, Medicaid recipients.

This sentence should be revised to state: An ICF provider may request a rate adjustment to reflect the inclusion of day treatment services in the ICF rate for some or all of its residents.

Page 4 - First paragraph

The first full sentence at the top of the page currently reads: When an ICF receives approval to provide in-house day treatment services to, all or some recipients, payment for day treatment services to community-based providers is the responsibility of the ICF, not Medicaid.

This sentence should be replaced with the following: When an ICF receives approval to provide in-house day treatment services on specified days to all or some of its residents, billing for the day treatment services for those residents whose day treatment costs are included in the ICF rate cannot be submitted to MMIS. For those residents whose day treatment costs are <u>not</u> included in the ICF rate, day treatment services provided by an outside agency are billed to MMIS.

Page 4 - Second Paragraph

* Note 2

The report states that "as much as $2.1 million in day treatment claims may have been paid inappropriately" to community-based day treatment providers for services delivered to consumers approved for ICF funded in-house day treatment. OSC's assumption of a $2.1 million "overpayment" is based on the value of the community based day treatment services that were paid through MMIS rather than the day treatment costs incorporated in the ICF rates. If in fact payment duplication can be substantiated for these consumers we recommend, rather than voiding MMIS day treatment payments, pursuing ICF rate adjustments to eliminate the day treatment component of the ICF rates. We recommend this approach because the ICF rate information is less current. With the approach of removing the in-house day treatment costs from the ICF rate, we anticipate that the projected impact would be substantially less than the $2.1 million estimated in OSC's preliminary findings.

Review of OSC Recommendations

We have reviewed OSC's recommendations and we concur with their first recommendation that all recipients approved to receive in-house day treatment services at ICFs be identified and a roster of these recipients be maintained. To address, on an on-going basis, the important issue that OSC has raised, OMRDD has already implemented a procedure to annually survey all existing ICF providers to identify the consumers who receive in-house day treatment services (Attachment A). Similarly, before any <u>new</u> ICF rate is established, the ICF provider must document the names of all consumers who the provider projects will receive in-house day treatment services. New internal control procedures have also been developed and implemented to monitor outside billing of day treatment services for consumers whose day treatment costs are included in the ICF rate. ICF rates will be adjusted for days when any outside day treatment services are billed for consumers whose day treatment costs are included in the ICF rate. OMRDD developed the attached survey form (Attachment B) to, on an annual basis, identify ICF consumers receiving in-house services and facilitate the review of separately billed day treatment services.

* See State Comptroller's Notes, Appendix C

We do not support OSC's second recommendation that we consider requiring that an ICF provider provide in-house day treatment services to all residents at an ICF if any residents currently receive in-house day treatment services. Whether a consumer's day treatment services are most appropriately provided by the ICF or an outside community-based agency, depends upon each consumer's individual service needs. As an agency, OMRDD is committed to individualizing each consumer's service package.

C: L. Kagan
J. Howard
D. Collins
S. Ellrott

Internal Control: ICFs with On- Site Day Program Services* in Rate

*** Excludes Sheltered Workshop, Day Training and State Education Dept. funding and all other off-site day services**

Purpose: To ensure the correct reimbursement of on-site Day Program Services reimbursement in certain ICF rates, including reasonable assurance that duplicate reimbursement (i.e., a separately billed day treatment program) is not occurring.

A. Existing Rates with Existing On-Site Day Program Services in the Rate		
Action	**Responsible Party**	**When**
1. Annually survey all ICF providers to obtain: • Names and CIN #s of consumers whose on-site day program services reimbursement will be included in the ICF rate • Number of annual projected full days and half days for each consumer • Attestation, signed by executive director, of the accuracy of the information	Rate Setting	September 15 (non-NYC) March 15 (NYC)
2. Complete survey, including attestation of executive director, and return it to Rate Setting	ICF Provider	October 15 (non-NYC) April 15 (NYC)
3. Provide list of consumers identified in Step 1 to Community Funding	Rate Setting	October 20 (non-NYC) April 20 (NYC)
4. Compare list supplied by the provider to list of ICF/DD consumers who receive funding for sheltered workshops, day training or from the State Education Department program. Report findings to Rate Setting	Community Funding	November 15 (non-NYC) May 15 (NYC)
5. Adjust prospective ICF rates in accordance with provider survey and Community Funding information	Rate Setting	December 1 (non-NYC) June 1 (NYC)
6. Promulgate rate and notify ICF provider. Include notification that provider must report any change that would affect the on-site day program services portion of the ICF rate, e.g., change in number of or composition of consumers, number of program hours	Rate Setting	January 1 (non-NYC) July 1 (NYC)

7. Notify Rate Setting immediately of any change that would affect the on-site day program services portion of the ICF rate	ICF Provider	As necessary
8. Produce adjudicated claim (ADJ) report of ICF rates that include on-site day program services reimbursement. Report includes: • Names and CIN #s of consumers with on-site day program services reimbursement included in the ICF rate who also received separately billed day treatment • Number of days of separately billed day treatment • Names and CIN #s of consumers with on-site day program services reimbursement included in the ICF rate who also received separately billed Waiver day habilitation • Number of days of separately billed Waiver day habilitation Share ADJ report with Rate Setting	Central Operations	Annually
9. Using information from the provider, Community Funding and the ADJ report , adjust retroactive prices where funding for on-site day program services is not justified	Rate Setting	Annually
B. New Rates		
1. Survey the provider to obtain: • Names and CIN #s of consumers whose on-site day program services reimbursement will be included in the ICF rate • Number of annual projected full days and half days for each consumer • Attestation, signed by executive director, of the accuracy of the information	Rate Setting	Prior to ICF opening
2. Provide a letter or e-mail to Rate Setting of support for on-site day program services to be included in ICF rate	DDSO	Prior to ICF opening

3. Develop ICF rate with on-site day program services reimbursement included. Notify provider of # of days of on-site day program services included in the rate.	Rate Setting	At time of ICF rate promulgation
4. Follow steps for existing rates (1 to 9 above) during subsequent rate years	All	

OMRDD Bureau of Rate Setting
Information Needed for Inclusion of On-Site Day Program Services* Costs into an ICF Rate
To Be Completed by the ICF Provider

*** Excludes Sheltered Workshop, Day Training or State Education Dept. Funding and any other off-site day services**

Agency:_____

ICF Address:_____

Rate Period:_____

For the identified rate period above, please list the names and CIN #s (client identification number for Medicaid) of the consumers for whom you are requesting on-site day program services reimbursement in your ICF rate. Also provide the projected number of annual full days and the projected number of annual half days for each consumer.

Consumer's Name	CIN	Projected No. Of Annual Full Days	Projected No. of Annual Half Days

Attestation

By signing below, I declare that the requested information is accurate to the best of my knowledge. I understand that OMRDD will monitor billing for these consumers to identify any day treatment or Waiver day habilitation claims separately billed to Medicaid by another provider which result in duplicate reimbursement.

Executive Director_____

Date_____

Enclosure 4

George E. Pataki
Governor

Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001
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MEMORANDUM

TO: Vincent Sleasman

FROM: Alden B. Kaplan

DATE: February 2, 2001

SUBJECT: OSC Audit 2000-S-031 (Developmental Center/Pharmacy Audit)

This is in response to OSC's findings on overlapping Developmental Center (DC) and pharmacy claims. The OSC report correctly identifies OMRDD's position regarding outside Medicaid services for DC residents. OMRDD policy is that the DC rate is all-inclusive. This means that the DC rate includes the cost of all services, except emergency ambulance, acute medical services (i.e., hospitalization and related physician care) and specialized wheelchairs for DC residents for whom there is a community placement planned. Pharmacy services **are** included in the DC rate **and separate payment for these services should not occur.**

Recommended Revisions to the OSC Report

The OSC report identifies two circumstances that may have led to outside billing of pharmacy services for DC residents. The first circumstance is when a DC resident is on leave and uses his or her Medicaid card at a community pharmacy. The second circumstance is where a DC establishes a contract with a pharmacist under which the pharmacist bills Medicaid. OMRDD has addressed both circumstances. DC staff have been instructed to ensure that consumers have an adequate supply of medications before going on leave. OMRDD also implemented a policy that prohibits establishing contracts with outside pharmacists who then bill Medicaid.

To reflect these actions, we recommend that the following language be added to the end of the third paragraph on page three:

> OMRDD has implemented policies to address the outside billing of pharmacy services for DC residents. These measures include the prohibition of outside contracts with pharmacists who then bill Medicaid for the services delivered under the contract. DC staff also ensure that DC residents have an adequate supply of medication prior to going on leave.

OMRDD Internal Control Procedures Regarding Duplicate DC Payments

Last year OMRDD initiated a procedure for eliminating duplicate payments for DC residents. OMRDD annually evaluates MMIS billing records for DC residents and investigates all non-DC claims to determine the appropriateness of outside claims. The value of any inappropriate outside claims is then deducted from OMRDD's Medicaid claim for DC services. OMRDD's March 2000 DC claim shows a deduction of $577,618 for outside pharmacy services (Attachment 1). OMRDD is currently processing an additional reduction to the January 2001 claim to complete the refund of the $689,349 in outside pharmacy billing for DC residents identified in the OSC report. In addition to the annual review of Medicaid billing for DC residents, OMRDD has also taken steps to ensure DC staff are aware of the prohibition against outside billing of Medicaid services for DC residents (Attachment 2).

OSC's Recommendations

The OSC report recommends that, prospectively, MMIS implement a cross-invoice edit and that past inappropriate claims be recovered. OMRDD concurs with OSC that the only method for ensuring that no future DC/pharmacy payments are made is to implement a "cross-invoice" edit in the Medicaid payment system. We do not, however, agree that past inappropriate outside pharmacy services should be recovered. We recommend that, until the cross-invoice edit is implemented, OMRDD carry out its procedure for monitoring outside billing and reducing the DC claim by the value of any inappropriate outside claims. This method will ensure that duplicate Medicaid payments are not made for these services without inconveniencing pharmacy providers.

Attachment
c: L. Kagan
J. Moran
L. Carusone

Attachment 1

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Accounts Management

Standard State Agency Claim Form
Assistance and Administration Relating to the Medical Assistance Program

Department: OMRDD/51000
Time Period of Claim: MARCH 2000
XX Original ☐ Supplemental
Roll No.: 00-416
Program: ICF/MR Medicaid
3/2000

I. Assistance Costs	AMOUNT
1. Total Expenditures	109,145,948
2. Third Party	542,165
3. Probate	
4. Fraud & Abuse	
5. Other	* 577,618
6. Total Recoveries (sum of lines 2 - 5)	1,119,783
7. Net Claim (line 1 minus line 6)	108,026,165
8. Federal Share	54,013,083
9. Balance after Federal Share (line 7 minus line 8)	54,013,082
10. State Share	54,013,082
11. Local Share	

II. Administration Costs	FEDERAL REIMBURSEMENT RATE 50%	TOTAL
12. Salaries		
13. Travel		
14. Equipment		
15. Other		
16. Total Expenditures		
17. FP% (if all expenditures are eligible for FFP, enter 100%)		
18. FP Amount (line 16 times line 17)		
19. Federal Share (line 18 times Column %)		
20. Balance after Federal Share (line 18 minus line 19)		
21. State Share		
22. Local Share		

* Pharmacy 1/1/99-9/31/99

I certify that this claim represents the true value of care furnished by the above department, for the persons and periods described in the roll specifed, and that all such care was provided pursuant to appropriate authorizations.

In the case of Administration, I certify that the claimed expenditures are reasonable and were necessary and required in the administration of the medical assistance program under Title XIX of the federal Social Security Act. Such costs were expended in accordance with appropriate cooperative agreements between the above department and the NYS Department of Health. No part of such expenditures has been claimed previously in the medical assistance or any other program for which federal financial participation is available.

Signature

Deputy Treasurer
Title

5/3/00
Date Signed

B-18

Attachment 2

George E. Pataki
Governor

Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
44 HOLLAND AVENUE
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(518) 473-1997 • TDD (518) 474-3694

MEMORANDUM

TO: All DDSO Directors

FROM: Alden B. Kaplan
Deputy Commissioner
Administration and Revenue Support

DATE: August 4, 1999

SUBJECT: Use of Medicaid Card for Individuals Residing In Developmental Center and Special Population Units.

This is to clarify that the Developmental Centers, including all special population units, have an all-inclusive Medicaid per diem rate.

Accordingly, DDSOs should not be utilizing the residents' Medicaid card for services with the following exceptions. The exceptions are: specialized wheelchairs for DC residents who have a planned community placement, emergency ambulance services, and acute medical services, i.e. hospital and related physician care.

If you have any questions regarding this matter, please contact Jim Moran at (518) 473-2747.

c: Mr. Johnson
Ms. Broderick
Mr. Pezzolla
Mr. Moran
Ms. Kagan
Mr. Carusone
Mr. Brady
Mr. Collins
Mr. Patricia
Mr. Sheedy

George E. Pataki
Governor

Thomas A. Maul
Commissioner

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OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
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MEMORANDUM

TO: Vincent Sleasman

FROM: Alden B. Kaplan

DATE: February 5, 2001

SUBJECT: OSC Audit 2000-S-031 (Community Residence/Inpatient Claims)

This is in response to OSC's preliminary audit findings regarding overlapping Community Residence (CR) and inpatient claims. OMRDD agrees that all identified claims should be investigated and where appropriate overpayments should be recovered. The OSC report, however, does not accurately represent the OMRDD policy and regulations governing the billing of OMRDD CR services.

Allowable CR Billing during Consumer Hospitalization

In most cases when a consumer is in residence at the CR, the provider is eligible to bill a full month of CR Residential Habilitation when the consumer resides at the CR for at least 21 days during a Calendar month and receives four habilitation services. OMRDD regulations, however, allow CR providers under certain circumstances to bill for a full month of CR Residential Habilitation when the consumer does not meet the 21-day residency requirement. OMRDD regulations 14 NYCRR 686.13 allow the provider to count days when a consumer is absent from the CR to visit relatives or friends or for an inpatient hospital stay toward the 21-day residency requirement up to 40 days annually per certified bed (Attachment 1). As a result of these regulatory provisions, a full month CR claim is not necessarily invalid when the consumer is hospitalized for 11 or more days during the same month.

Recommended Revisions to the OSC Report

We recommend that Section III of the OSC report be revised to represent MMIS billing guidelines for OMRDD-operated CR Residential Habilitation. Section III, paragraph 2 currently states that:

> ...MMIS billing guidelines for community residence rehabilitation services indicate that, "Full monthly billing requires at a minimum: 21 days in residence excluding discharge days, days in hospital or in any other Medicaid reimbursable facility".

This statement was taken from the *MMIS Provider Manual for Office of Mental Health Certified Rehabilitation Services* and **does not pertain to OMRDD CR services**.

The MMIS Provider Manual for OMRDD CR services states that providers are eligible to bill OMRDD CR Residential Habilitation as follows:

FULL MONTH = 21 Days in residence with 4 services delivered
HALF MONTH = 11Days in residence with 2 services delivered.

A copy of the pertinent page of the MMIS Provider Manual for OMRDD CR services is attached for your information (Attachment 2). We recommend that the OSC report be revised to include appropriate language from the manual and the attached regulatory citation that allows up to 40 days of leave day billing annually per certified bed.

OSC Findings

We cannot conclude on the basis of MMIS claims alone that $415,977 in inappropriate Medicaid payments were made to OMRDD CR providers for hospitalized CR residents. Rather, further investigation of each claim is required to ensure that the "40 day per bed" allowance for leave has not been exceeded. OMRDD will conduct such a review with OSC. Note that because of the regulatory provision for leave days in CRs cited above, a cross-invoice appears not to be feasible for OMRDD CR services.

Attachment
c: L. Kagan

(a) a homestead that is the home and land owned and occupied by a client and the members of a client's family, including adjacent parts, such as garages. Homes may be trailers or mobile homes, and apartments or flats;
(b) personal effects, household goods and furnishings, and life insurance with a total face value of $1,500 or less; and
(c) one vehicle which belongs to and is used by the clients.

(d) Residency.

(1) Client days.

(i) A *client day* shall be the unit of measure denoting lodging and services rendered to one client between the census-taking hours of the community residence on two successive days; the day of admission as well as the day of discharge shall be counted. One client day shall be counted if the client is discharged on the same day the client is admitted, providing there was an expectation that the admission would have at least a 24-hour duration.

(ii) A *therapeutic leave day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days in which a client does not receive lodging and services from a provider for one or more of the following reasons:

(a) The client is visiting with relatives or friends, where such visit is not programmatically contraindicated; or the client is participating in a programmatically acceptable therapeutic or rehabilitative plan of care outside the community residence, provided that such leave of absence is provided for in the client's individual program plan.
(b) The client is in a hospital for medical treatment requiring inpatient hospital services, or in an intermediate care facility for the developmentally disabled (ICF/DD) for treatment of a behavior problem which requires residential services in an ICF/DD, provided that the provider has a reasonable expectation that the client will return to the community residence after such placement and documents the client's anticipated length of stay in the hospital or ICF/DD.
(c) Notwithstanding the above and except in accordance with clause (*e*) of this subparagraph, the total amount of therapeutic leave days for a community residence shall not exceed the certified capacity times 40 days on an annual basis.
(d) If the certified capacity approved for the community residence changes, the increase or decrease in therapeutic leave days shall be computed by multiplying the change in certified capacity by 40 days.
(e) The total number of therapeutic leave days for a certified community residence, calculated in accordance with clause (*c*) of this subparagraph, may be exceeded based on prior approval of the commissioner and the Division of the Budget in cases where

there is documentation of:

(1) appropriate usage of at least 80 percent of the total approved therapeutic leave days for the community residence; and

(2) the justification for exceeding the approved limit is for the reasons of:

(i) the client requires medical care away from the community residence for an extended period of time, but is expected to return to the community residence following convalescence; or

(ii) the client requires the additional leave for the purpose of participating with his/her family in religious activities or celebrations.

(iii) A *respite day* shall mean a period of at least 10 hours within the 24-hour period between the census-taking hours of the community residence on two successive days, during which a client living with family or in family care receives overnight lodging, at least one meal, and services according to subparagraph (b)(2)(vi) of this section.

(iv) A *temporary transfer day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days during which an individual on therapeutic leave from his or her permanent residence receives lodging and services. Temporary transfer days shall not be reimbursable when the person's permanent residence is another community residence or a family care home. Temporary transfer days shall be reimbursable when the person's permanent residence is with family or an independent living situation.

(v) A *trial visit day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days during which a person who is developmentally disabled is being considered for admission to the community residence receives lodging and services. For any given person, the number of trial visit days shall not exceed seven in a continuous six-month period.

(vi) *Emergency housing day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days during which a person who requires alternative housing due to natural disaster which rendered the individual's existing residence temporarily uninhabitable (*e.g.*, due to fire, extended power failure, etc.) receives lodging and services.

(2) *Total person days applicable only to those community residences that are certified as an individualized residential alternative (IRAs)* shall be equal to the person days upon which the Individualized Service Plan (ISP) is based.

(3) Reimbursement for allowable respite shall be equal to the final net fee calculated pursuant to section 671.7(a)(1)(vii) of this Title. This fee shall be billed through the community residence billing system.

(e) Cost category standards applicable to sections 635.10(b) and 686.13 (g).

(1) Nonprofessional and professional client services cost category standards shall be determined as follows:

42. DATE OF SERVICE (cont'd)

NOTE: Special Rules

For Community Residence Habilitation monthly and semi-monthly rate codes enter dates on the first claim line according to the following:

Monthly	Enter the first day of the month subsequent to the month in which the services were rendered.
Semi-Monthly (1st half)	The recipient must be admitted prior to the 11th day of the month. The Date of Service is the first day of the subsequent month.
Semi-monthly (2nd half)	The recipient is admitted on or after the 11th day of the month. The Date of Service is the 2nd day of the subsequent month.

FULL MONTH = 21 Days in residence with 4 Services Delivered
HALF MONTH = 11 Days in residence with 2 Services Delivered

The actual dates of service for each of the required 4 face-to-face contacts must also be reported on subsequent claim lines following the monthly service charge line.

For Waiver Case Management enter the first day of the month subsequent to the month in which services were rendered

NOTE: Enter the first day of the month subsequent to the month in which services are rendered unless the recipient loses Medicaid eligibility during the service month. (Providers are required to consult EMEVS to verify recipient eligibility in order to ensure payment.) If the recipient should lose eligibility before the first of the subsequent month, the provider should enter the last date of medical coverage.

Enclosure 6

George E. Pataki
Governor

Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
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(518) 473-1997 • TDD (518) 474-3694

TO: Vincent Sleasman

FROM: Alden B. Kaplan
Administration and Revenue Support

DATE: November 17, 2000

SUBJECT: Audit # 2000-S-031, ICF and Waiver Services

This memorandum is in response to William Warner's November 6, 2000 letter regarding the preliminary audit findings for Intermediate Care Facilities (ICFs) and Home and Community Based Services (HCBS) Waiver services (Audit # 2000-S-031). These are our suggested changes.

Page Two, first sentence

The sentence currently reads: OMRDD regulates mental health services and has developed different institutional and community-based programs to address their clients' needs.

Please change "mental health services" to "services for people with mental retardation and developmental disabilities."

Page Two, Second paragraph

Please replace the second paragraph on page two with the following text:

"OMRDD consumers who are eligible for an ICF level of care, but prefer not to live in an ICF may choose enrollment in the Home and Community Based Services (HCBS) Waiver. HCBS Waiver services emphasize individualization, community integration, independence and productivity. In order for a consumer to be enrolled in the HCBS Waiver he or she must either live at home with family, friends or independently, or in the following OMRDD certified residential settings: Community Residence (CR), Individualized Residential Alternative (IRA) or Family Care. Residents of ICFs are not eligible for enrollment in the HCBS Waiver and therefore are not eligible to receive HCBS Waiver services."

Page Six, Middle of Page

A sentence currently reads, "Since waiver service claims process through the WMS Restriction Exception file, a different subsystem, any Medicaid claims submitted by an ICF for the same recipient will not be detected during claims processing." We recommend that this sentence be deleted because the R/E subsystem does not process claims. Rather, this subsystem contains information that is used for editing claims processing.

We recommend that this sentence be replaced with the following statement. "Effective November 1, 2000 a new edit was implemented in MMIS so that a 46, 47 or 48 R/E code, identifying the consumer as an HCBS enrollee, needed to be present in order for a provider to be paid for an HCBS waiver service. An R/E code of 46, 47 or 48 cannot be entered in WMS when a 38 code is present which identifies the consumer as an ICF resident. It was not, therefore, until November 1, 2000 that there was a barrier to providers being paid for ICF and HCBS Waiver services on the same day."

Please also note in your communication with OSC that OMRDD concurs with their recommendations that inappropriate payments be investigated and recovered where appropriate. OMRDD will continue its efforts to review MMIS payments and recover funds where appropriate.

cc: J. Moran
L. Kagan
D. Collins

State Comptroller's Notes

1. OMRDD officials are correct that our estimate of the amount of day treatment claims that may have been overpaid is based on the value of the community-based day treatment services paid through MMIS. We used this information because it was the only information upon which to base an estimate. As we state in our report, OMRDD did not identify and maintain documentation for those recipients who were approved to receive on-site day treatment services. We also acknowledge that the value of day treatment costs included in the Facility rates is lower than the MMIS payments for the community-based day treatment services. Therefore, OMRDD's regulatory preference that day program services be provided in the community and decision to adjust the Facility rates in effect during the audit period will result in a lower overpayment; however, the amount of this overpayment cannot be estimated.

2. We have modified our report to reflect these comments.

3. As OMH officials state in their response, mental health providers received only $437,699 of the $4.4 million in potentially inappropriate Medicaid payments. Hence, any overstatement of the overpayment to mental health providers as a result of their eligibility for half-month payments instead of full-month payments would not be material. Additionally, we could not determine the extent to which providers would be eligible for these half-month payments.