

---

---

**Thomas P. DiNapoli  
COMPTROLLER**



Audit Objective.....	2
Audit Results - Summary .....	2
Background.....	2
Audit Findings and Recommendations.....	3
Medicaid Payments for Community Based Services .....	3
Recommendations.....	3
Audit Scope and Methodology.....	3
Authority .....	4
Reporting Requirements.....	4
Contributors to the Report .....	4
Appendix A - Auditee Response ....	5
Appendix B - State Comptroller's Comments .....	10

**OFFICE OF THE  
NEW YORK STATE COMPTROLLER**

**DIVISION OF STATE  
GOVERNMENT ACCOUNTABILITY**

---

## **DEPARTMENT OF HEALTH**

# **INAPPROPRIATE MEDICAID PAYMENTS FOR COMMUNITY BASED SERVICES WHILE RECIPIENTS RESIDED IN NURSING HOMES**

**Report 2006-S-106**

---

---

## AUDIT OBJECTIVE

The objective of our audit was to determine if New York State's medical assistance program (Medicaid) made inappropriate payments to community based service providers while recipients were residing in nursing homes.

## AUDIT RESULTS - SUMMARY

During our five year audit period, which ended September 30, 2006, we identified over \$2.09 million in inappropriate Medicaid payments to community based service providers while recipients resided in nursing homes. Our review of medical claims data showed the Medicaid recipients were residing in nursing homes at the time the community based services were supposedly provided. It is possible that the community based service providers billed for services that were never provided. The Department of Health (Department) should review the potentially inappropriate payments and make recoveries as appropriate from the providers.

Our report contains two recommendations to recover inappropriate Medicaid payments and improve controls over payments to community based service providers. Department officials generally agreed with our recommendations and will take steps to implement changes.

This report, dated December 10, 2007, is available on our website at: <http://www.osc.state.ny.us>. Add or update your mailing list address by contacting us at: (518) 474-3271 or  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street, 11<sup>th</sup> Floor  
Albany, NY 12236

## BACKGROUND

The Department administers the Medicaid program which was established under Title XIX of the federal Social Security Act to provide needy people with medical assistance. The program is funded jointly by the federal, State, and local governments. Its management information and claims processing functions are handled through the State's eMedNY system, which the Department implemented on March 24, 2005.

Community based services are intended to help recipients live at home rather than in a residential health care facility, such as a nursing home. A Medicaid claim for community based services generally should not be paid during a period in which the recipient resided in a nursing home. Nursing homes provide care needed by the resident recipients and receive payment from Medicaid for the costs of services provided. However, payments for community based services while a recipient is in a nursing home would be appropriate in certain situations: on the day a recipient is admitted to or discharged from the nursing home and in certain cases according to the guidelines of certain federal waiver programs. For example, Medicaid payments may be allowed for case management services or environmental (home) modifications to prepare for the recipient's transition from a nursing home into the community.

Based on our prior audit entitled Medicaid Clinic and Emergency Room Claims Paid during a Recipient's Hospital Stay (Report 98-S-10, issued August 29, 2000), Department officials recognized improvements were needed in the Medicaid claims processing system to prevent separate payments for services provided to patients that are hospitalized. However, the eMedNY system did not have edits specifically

designed to prevent the payment of community based services provided to patients that are hospitalized. Similarly, eMedNY does not have edits specifically designed to prevent the payment of community based services provided to patients that reside in nursing homes. Since there are no edits for these claims, the Department relies on the Office of the Medicaid Inspector General (OMIG) to perform claim analyses designed to identify inappropriate payments on a post payment basis. OMIG's process relies on providers to make the appropriate claim adjustments of any inappropriate payments OMIG has identified.

## **AUDIT FINDINGS AND RECOMMENDATIONS**

### *Medicaid Payments for Community Based Services*

During our five year audit period, Medicaid paid over \$2.09 million for claims community based providers inappropriately billed for services provided to recipients residing in nursing homes. For example, we identified 1,928 claims totaling \$206,090 billed by 108 providers for hourly community based services while recipients resided in nursing homes. We also identified 751 claims totaling \$323,330 billed by 22 providers for Office of Mental Health case management services while recipients resided in nursing homes. These overpayments occurred because the community based providers did not comply with the department guidelines for billing Medicaid and eMedNY lacks the controls necessary to detect and prevent these overpayments.

## **Recommendations**

1. Review the \$2.09 million payments we identified and recover inappropriate payments.
2. Determine if edits could be designed to prevent these overpayments from occurring.

## **AUDIT SCOPE AND METHODOLOGY**

We conducted our audit according to generally accepted government auditing standards. We audited selected Medicaid claims paid to nursing home and community based service providers during the five year audit period ended September 30, 2006. To accomplish our audit objective, we extracted questionable claims from the Medicaid payment file and verified the accuracy of the payments. We interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant payment policies and procedures.

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

---

## **AUTHORITY**

The 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.

## **REPORTING REQUIREMENTS**

We provided a draft copy of this report to Department officials for their review and comment. Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them. Certain matters presented in the draft report were changed based on the Department's response. A complete copy of the Department's response is included as Appendix A. Appendix B contains State

Comptroller's comments which address matters contained in the Department's response and changes to the final report based on the Department's response.

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

## **CONTRIBUTORS TO THE REPORT**

Major contributors to the report include Steve Sossei, Sheila Emminger, Warren Fitzgerald, Earl Vincent and Wendy Matson.

---

## APPENDIX A - AUDITEE RESPONSE

---



Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.  
*Commissioner*

Wendy E. Saunders  
*Chief of Staff*

November 14, 2007

Sheila A. Emminger, Audit Manager  
Office of the State Comptroller  
Division of State Services  
State Audit Bureau  
110 State Street, 11<sup>th</sup> Floor  
Albany, New York 12236

Dear Ms. Emminger:

On September 27, 2007, the Department of Health forwarded comments on the Office of the State Comptroller's draft audit report on "Inappropriate Medicaid Payments for Personal Care Services While Recipients Resided in Nursing Homes" (2006-S-106). It has come to our attention that a portion of the final sentence that begins on page two and carries over to page three was inadvertently deleted during final formatting. We are therefore resending these comments with the complete sentence inserted.

We apologize for the inconvenience. Thank you.

Sincerely,

Wendy E. Saunders  
Chief of Staff

Enclosure

---

cc: Deborah Bachrach  
Homer Charbonneau  
Randall Griffin  
John Guskie  
Gail Kerker  
Katherine Napoli  
Robert W. Reed  
James Russo  
Philip Seward  
James Sheehan

**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2006-S-106 on  
"Inappropriate Medicaid Payments  
for Personal Care Services  
While Recipients Resided in Nursing Homes"**

---

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2006-S-106 on "Inappropriate Medicaid Payments for Personal Care Services While Recipients Resided in Nursing Homes", including general comments followed by responses to the specific recommendations included in the draft audit report.

**General Comments**

On August 13, 2007, Department and OSC staff discussed the following draft report modifications that should be reflected in the final audit report:

- The references to "personal care services" throughout the report, including the title, should be changed to "community based services" to properly describe the activities reviewed.
- The circumstances when it would be appropriate to pay a Medicaid claim for a recipient residing in a nursing home should be clarified and the findings adjusted accordingly.
- On page 2, the final sentence of the first paragraph under "Audit Results – Summary" should be modified to clarify that the Department should *review the potentially inappropriate payments and make recoveries as appropriate from the providers*.

**Recommendation #1:**

Review the \$3.3 million payments we identified and recover inappropriate payments.

**Response #1:**

A review of the OSC data shows the total amount of services which fall under Home Health is \$764,557 for the five year audit period. The Office of the Medicaid Inspector General (OMIG) has mailed 170 requests for recoupment to providers totaling \$425,115 for the period January 1, 2002 through December 31, 2004, and will continue projects for subsequent years. The balance of the findings are not personal care services but

\*  
Comment  
1

\*  
Comment  
2

\*See State Comptroller's Comments, page 10



rather services subject to the policies of the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD).

OMH has not had adequate opportunity to review the details of the report findings and is therefore unable to comment on the specific findings at this time. OMH will review payments applicable to OMH providers, estimated at \$1.1 million over the five year audit period, and recover any determined to be inappropriate. However, we noted that on page 3 under "Audit Findings and Recommendations", the report states "...personal care providers inappropriately billed for services provided to recipients residing in nursing homes... these overpayments occurred because the personal care providers did not comply with department guidelines for billing Medicaid". There are circumstances that permit billing, for up to 180 days, for both personal care services and nursing home stays. Until a determination has been made as to whether or not these circumstances applied to the subject payments, the report should not conclude that payments were inappropriate or that personal care providers did not comply with billing guidelines.

The information provided by the OSC indicates \$852,363 in potential overpayments for OMRDD services delivered to nursing home residents. OMRDD completed a review of the raw data and concluded the potential value of overlapping claims is actually \$126,889, and therefore recommends the overall findings be reduced by \$725,474. Issues associated with the underlying methodology utilized by the OSC account for \$676,349 of the reduction amount, while timing issues associated with claims that OMRDD either recovered or for which recovery action is underway account for the \$49,125 remainder. Additional details relative to the OMRDD payments follow.

\*  
Comment  
1

#### **Specific Timing Issues**

It appears the subject claims were extracted during the fall of last year, as the latest services appear to have been rendered in September 2006. In May 2007, a total of 179 of the claims (\$39,408.17) identified in the audit were voided by OMRDD as a result of billing review activity. In addition, a periodic review of nursing home and service coordination claims was conducted earlier this year before OMRDD learned of the OSC audit. An additional 36 claims (\$9,717.29) identified in the audit were also identified by OMRDD through this review. Recovery notices have been forwarded to providers, and the file to execute these recoveries will be forwarded to the Department of Health in October.

#### **Methodology Issues**

- **Inclusion of contractual service rate codes (\$54,000).** OSC included environmental modification and adaptive technology rate codes in its claim comparison. These services are paid under contract and the service date used is typically the date the contract was completed and the final payment issued. The fact that the individual may be in a nursing home on that date is irrelevant. For example,

\*See State Comptroller's Comments, page 10



the environmental modification or adaptive technology might have been required in order to enable the individual to return home from a temporary nursing home stay.

- **Not adjusting for Medicaid convention used in billing monthly services (\$116,601.97).** Monthly services are billed on the first or second day of the month following the month of actual service delivery. It appears this was not accounted for by the OSC when attempting to identify conflicting claims. For example, to identify a conflicting nursing home service for an Individualized Residential Alternative (IRA) residential habilitation service with a date of November 1, 2006, one would need to review nursing home claims with service dates in October 2006.
- **Too few nursing home service days to reject Home and Community Based Services (HCBS) Waiver residential claim (\$254,870.35).** To bill a "full month" of Community Residence (CR) services, the individual must have resided in CR for at least 21 days. To bill "full month" IRA services, the minimum is 22 days. For both IRA and CR "half month" claims, the minimum is 11 days. Hence, an individual may have recorded a few service days in a Skilled Nursing Facility (SNF) and still meet the standards for a full or half month CR or IRA claim during the same month.
- **Rejecting a service coordination claim when the consumer was a SNF resident for only part of the service month in question (\$250,876.25).** When an individual is a nursing home resident for only part of a month, there is opportunity for a legitimate service coordination service to be recorded. In fact, one would expect service coordinators to be working closely with individuals to arrange resumption of community-based supports immediately following release from a nursing facility.

Additionally, of the \$126,889 in potentially overlapping OMRDD claims, the largest claim group is for HCBS Waiver day habilitation services (\$107,288). In January 2006, OMRDD changed the reimbursement methodology for this service. With this change, OMRDD has in place an internal review for overlapping day habilitation services and nursing home claims. This same day nursing home/"community service" claim review is conducted for all OMRDD services.

#### **Recommendation #2:**

Determine if edits could be designed to prevent these overpayments from occurring.

#### **Response #2:**

The Department will review and, if feasible, develop edit(s) to prevent this type of overpayment.

---

## APPENDIX B - STATE COMPTROLLER'S COMMENTS

---

- |  |   |
|--|---|
| <ol style="list-style-type: none"><li>1. Certain matters in our draft audit report were changed based on the Department's response.</li><li>2. After reviewing the detailed information the Department, the Office of the Medicaid Inspector General and the Office of Mental Retardation and Developmental Disabilities provided in</li></ol> | <p>response to this recommendation, certain matters contained in our draft audit report were changed. We reduced our audit findings accordingly and now report potential overpayments of over \$2.09 million.</p> |
|--|---|