

THOMAS P. DiNAPOLI
COMPTROLLER



110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 19, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 2008-F-33

Dear Dr. Daines:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution; and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Inappropriate Medicaid Payments For Community Based Services While Recipients Resided In Nursing Homes* (Report 2006-S-106).

Background, Scope and Objectives

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. In most cases, nursing homes receive rate payments from Medicaid for a comprehensive range of services provided to resident recipients. However, payments for community based services while a recipient is in a nursing home would be appropriate in certain situations, which include the day a recipient is admitted to or discharged from a nursing home and certain other instances governed by the guidelines of 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 to their personal home or some other community based setting.

Based on prior audit work, we had determined that the eMedNY system did not have controls specifically designed to prevent payments of community based services provided to patients while they were hospitalized. Similarly, the eMedNY system did not have controls to prevent payments of community based services provided to patients that resided in nursing homes. Because there were no edits for these claims, the Department relied on the Office of the Medicaid Inspector General (OMIG) to review them and to identify inappropriate payments on a post-payment basis. OMIG's process relied on providers to make the appropriate claim adjustments of any inappropriate payments that OMIG identified.

Our initial audit report, which was issued on December 10, 2007, identified about \$2.1 million in questionable Medicaid payments, during the five-year period ended September 30, 2006, for certain community based services provided to recipients in nursing homes. The objective of our follow-up was to assess the extent of implementation as of March 12, 2010 of the two recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made some progress in addressing the problems detailed in our initial report. At the time of our follow-up, officials had recovered or were in the process of recovering inappropriate payments totaling about \$647,000. However, additional actions need to be taken. Of the two prior audit recommendations, one recommendation has been implemented, and one recommendation has been partially implemented.

Follow-up Observations

Recommendation 1

Review the \$2.09 million payments we identified and recover inappropriate payments.

Status - Partially Implemented

Agency Action - Our initial audit identified about \$1.15 million in questionable payments to not-for-profit providers, licensed by the Office of Mental Health (OMH), primarily to provide case management services. Based on technical guidance provided by the Department during the audit, we questioned case management services that were provided to patients more than 30 days prior to their discharge from hospitals. However, subsequent to our audit, Department officials concluded that patients were eligible for case management services up to 90 days prior to discharge, thus increasing clients' eligibility for such services. In October 2008, the Office of the Medicaid Inspector General (OMIG) reviewed a small sample of the case management payments we questioned, and concluded (based on the 90-day criteria) that many of them were probably appropriate. Nevertheless, OMIG officials plan to expand their review to include all of the claims we questioned, as staff resources and time permit.

Our initial audit further identified about \$764,000 in questionable claim payments for home health services provided to certain OMH clients. To address this matter, the OMIG

initiated audits of payments made from January 2002 through December 2007 to 215 providers. At the time of our follow-up, the OMIG had recovered \$491,197 in improper payments and planned to recover an additional \$60,883. Officials considered most of the remaining payments (about \$212,000) to be appropriate or too old to recover.

We also identified questionable claim payments of about \$176,000 for services provided to clients of the Office of Mental Retardation and Developmental Disabilities (OMRDD). At the time of our follow-up, OMRDD officials had recovered about \$68,000 in improper payments, and the recovery of an additional \$27,000 was underway. OMRDD officials also stated that payments of nearly \$68,000 were appropriate, and the remaining claims (totaling about \$13,000) were too old to be researched and recovered.

Recommendation 2

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

Status - Implemented

Agency Action - The Department conferred with OMH and OMRDD officials on this matter. With respect to the OMH-related payments, officials concluded that it was not practical to design system edits to prevent the types of improper payments identified in our original audit. According to OMH officials, excessive (inappropriately repeated) case management services can only be detected through manual reviews of a series of claims for a particular nursing home patient and not from a system edit for a single claim. Nevertheless, OMH officials are considering updates to the formal guidance for billing Medicaid for case management services. The updated guidance would address documentation requirements for case management services when a discharge from a nursing home is anticipated within a period of 90 days. OMRDD officials have also considered edits to prevent improper payments for community based services. However, OMRDD has been unable to design edits that would identify improper claims that should be denied and allow payments for legitimate claims.

Major contributors to this report were Warren Fitzgerald, Earl Vincent, Karen Bogucki and Donald Collins.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report.

We also thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Brian E. Mason
Audit Manager

Cc: Mr. Stephen Abbott, Department of Health
Mr. Thomas Lukacs, Division of the Budget