



**Office of the
Medicaid Inspector
General**

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

**REVIEW OF CLINTON COUNTY CHAPTER NYSARC, INC.
CLAIMS FOR OPWDD MEDICAID SERVICE COORDINATION SERVICES
PAID FROM
JANUARY 1, 2009 – DECEMBER 31, 2011**

**FINAL AUDIT REPORT
AUDIT #: 14-6327**

**Dennis Rosen
Medicaid Inspector General**

July 8, 2015



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

July 8, 2015

[REDACTED]

Clinton County Chapter NYSARC
P.O. Box 826
231 New York Road
Plattsburgh, New York 12903

Re: Final Audit Report
Audit #: 14-6327
Provider ID #: [REDACTED]
FEIN: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Clinton County Chapter NYSARC, Inc." (Provider) paid claims for OPWDD Medicaid service coordination (MSC) services covering the period January 1, 2009, through December 31, 2011. Since you agreed to our draft audit report dated May 20, 2015, the findings in the final audit report are identical to those in the draft audit report.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated May 20, 2015. The adjusted mean point estimate overpaid is \$102,060. The adjusted lower confidence limit of the amount overpaid is \$28,377. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$28,377.

[REDACTED]

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July 8, 2015

If the Provider has any questions or comments concerning this final audit report, please contact me at [REDACTED] or through email at [REDACTED]. Please refer to report number 14-6327 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Albany Office
Office of the Medicaid Inspector General

[REDACTED]

Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People With Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purpose the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities and through a home and community based Federal waiver program. The waiver program, established under the authority of section 1915 [c] of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 635, 671, 679, and 690.

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by OPWDD, which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators who develop an Individualized Service Plan (ISP) by identifying the person's desired outcomes and those supports and services the person wants and needs; coordinating the access and delivery of supports and services chosen in the ISP; and reviewing the ISP and Medicaid Service Coordination Agreement, making any necessary revisions to ensure these documents are up-to-date. The specific standards and criteria for OPWDD services, including MSC services, are outlined in Title 14 NYCRR Parts 635, 671, 679, 690, and in Administrative Memorandums issued by OPWDD. The *Medicaid Service Coordination Vendor Manual* also provides substantial program guidance for MSC services including regulatory language, instructions for claiming Medicaid reimbursement and various MSC forms and templates.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OPWDD Medicaid service coordination (MSC) services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OPWDD MSC services, this audit covered services paid by Medicaid from January 1, 2009, through December 31, 2011.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$25,577.84 in Medicaid payments. Of the 100 services in our random sample, 7 services had at least one error and did not comply with state requirements. Of the 7 noncompliant services, none contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Services Performed by Unqualified Medicaid Service Coordinator Staff	4
Missing Documentation of Intermediate Care Facility/Mental Retardation (ICF/MR) Level of Care Eligibility Determination	1
Distribution of the Individualized Service Plan (ISP) Exceeded 45 Days	1
Missing Medicaid Service Coordination Agreement	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$1,767.13 in sample overpayments with an extrapolated adjusted point estimate of \$102,060. The adjusted lower confidence limit of the amount overpaid is \$28,377.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including OPWDD Medicaid service coordination services claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's OPWDD Medicaid Service Coordination Program

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People With Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purpose the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities and through a home and community based Federal waiver program. The waiver program, established under the authority of section 1915 [c] of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 635, 671, 679, and 690.

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by OPWDD, which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators who develop an Individualized Service Plan (ISP) by identifying the person's desired outcomes and those supports and services the person wants and needs; coordinating the access and delivery of supports and services chosen in the ISP; and reviewing the ISP and Medicaid Service Coordination Agreement, making any necessary revisions to ensure these documents are up-to-date. The specific standards and criteria for OPWDD services, including MSC services, are outlined in Title 14 NYCRR Parts 635, 671, 679, 690, and in Administrative Memorandums issued by OPWDD. The *Medicaid Service Coordination Vendor Manual* also provides substantial program guidance for MSC services including regulatory language, instructions for claiming Medicaid reimbursement and various MSC forms and templates.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OPWDD Medicaid service coordination (MSC) services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to the Provider for OPWDD MSC services paid by Medicaid from January 1, 2009, through December 31, 2011. Our audit universe consisted of 8,059 claims totaling \$2,052,010.74.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the OPWDD MSC program;
- ran computer programming application of claims in our data warehouse that identified 8,059 paid OPWDD MSC claims, totaling \$2,052,010.74;
- selected a random sample of 100 services from the population of 8,059 services; and,
- estimated the overpayment paid in the population of 8,059 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - List of all other affiliates and related parties
 - Operating certificate – during audit period and current
 - Training documentation for MSC staff
 - Supervision policy for MSC staff
 - Notification of any self-disclosures
 - Notification of any audits of subject area by other federal/state agencies
 - Complete recipient record covering audit period

- List of staff members involved in recipient care, including license numbers or other credentials, signatures and initials
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6, OPWDD Administrative Memoranda #2009-05, #2010-03, #2011-01, and the *Medicaid Service Coordination Vendor Manual*.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department ... for audit and review."
18 NYCRR Section 517.3(b)

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the provider understands that payment and satisfaction of

this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

18 NYCRR Section 540.7(a)(1)-(3) and (8)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

18 NYCRR Section 518.1(c)

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

18 NYCRR Section 540.1

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

18 NYCRR Section 518.3(a)

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

18 NYCRR Section 518.3(b)

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

18 NYCRR Section 518.3(b)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated May 20, 2015.

The information provided resulted in no change to any of the disallowances. The findings in the Final Audit Report are identical to those in the Draft Audit Report.

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011, identified 7 claims with at least one error, for a total sample overpayment of \$1,767.13 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated May 20, 2015.

1. Services Performed by Unqualified Medicaid Service Coordinator Staff

For Services Prior to 10/1/2010:

The *Medicaid Service Coordination Vendor Manual* states, "MSC service coordinators must meet all of the following minimum educational, experiential, and training requirements:

Minimum Educational Level

- Associate's degree in a health or human service field, or an RN

...

Minimum Experiential Level

- One year experience working with people with a developmental disability, or
- One year experience as a service coordinator with any population.

...

Minimum Training Level

- Attendance at an OMRDD-approved Core service coordination training program within three months of assuming MSC responsibilities, unless the person can produce a certificate verifying past attendance at a Core training. "

Medicaid Service Coordination Vendor Manual, Chapter 2

For Services 10/1/2010 and After:

Medicaid Service Coordination Vendor Manual states, "MSC's must meet all of the following minimum educational, experiential, training and other requirements:

Minimum Educational Level

MSCs must possess the following minimum education:

- An associate's degree in a health or human services field (see text box) from an accredited college or university or a degree in nursing as a Registered Nurse (RN).
- An individual with credits toward a bachelor's degree may meet this educational requirement by providing a letter from his or her college verifying that he/she has completed course work equivalent to an associate's degree both in the total number of credits received and the number of credits earned in a health or human services field. An associate's degree is usually equal to 60 credits.

- An individual with an associate's degree or a bachelor's degree or who has a minimum of 60 credits toward a bachelor's degree in a field other than health or human services may meet this educational requirement if a minimum of 20 of his/her college credits are in health and human services. The vendor agency should review the individual's college transcript to verify that the educational requirements have been met and retain this documentation.

...

Minimum Experiential Level

At a minimum, MSCs must possess the following experience:

- One year experience working with people with developmental disabilities, or
- One year experience as a service coordinator/case manager with any population.

...

Minimum Required Training (Core MSC Training)

Once hired, in order to continue work as an MSC, the service coordinator must attend an OPWDD-approved Core (i.e., basic) service coordination training program within six months (180 days) of assuming MSC responsibilities, unless the person can produce a certificate verifying past attendance at a Core training.

Medicaid Service Coordination Vendor Manual, Chapter 2

OPWDD Administrative Memorandum #2010-03 states, "...the MSC Vendor must maintain the following documentation to support claims for payment:

- Evidence that the service coordinator attended basic (i.e., core) training or received instruction using an approved OPWDD curriculum. Evidence may include, but is not limited to, a training certificate or an attestation from OPWDD that the service coordinator attended training." *OPWDD Administrative Memorandum #2010-03, p. 5*

In 4 instances pertaining to 4 recipients, MSC services were provided by a person not meeting the MSC qualification standards. In 4 instances, 2 MSCs failed to meet the yearly 15 hour training requirement. This finding applies to Sample #'s 16, 44, 85, and 91.

2. Missing Documentation of Intermediate Care Facility/Mental Retardation (ICF/MR) Level of Care Eligibility Determination (LCED) Annual Redetermination

Regulations state, "In order to be approved for participation in the HCBS waiver . . . the application for participation approval shall document that the person: . . . is eligible for ICF/MR level of care . . ."

14 NYCRR Sections 635-10.3(a) and (b)(2)

Regulations also state, ". . . either a physician's authorization indicating that rehabilitative services are necessary to meet the person's medical, remedial or developmental needs or have an initial and annually redone ICF/MR level of care eligibility determination signed by a physician or, if the LCED is an annual renewal, it may be signed by a physician's assistant/nurse practitioner. . . ."

14 NYCRR Section 671.4(b)(1)(ii)

For Services Prior to 10/1/2010:

The *Medicaid Service Coordination Vendor Manual* states, "Persons enrolled in the HCBS Waiver need an annual level of care determination that documents their continued eligibility for an ICF level of care."

Medicaid Service Coordination Vendor Manual, Chapter 2

For Services 10/1/2010 and After:

The *Medicaid Service Coordination Vendor Manual* states, "Persons enrolled in the HCBS Waiver need an annual level of care determination that documents their continued eligibility for an ICF level of care. It is the responsibility of the service coordinator to ensure the timely completion of the level of care re-determinations."

Medicaid Service Coordination Vendor Manual, Chapter 2

OPWDD Administrative Memorandum #2010-03 states, "Effective immediately, a Qualified Mental Retardation Professional (QMRP) who is familiar with the HCBS waiver participant's functional level may review and sign the annual LCED redetermination form in place of a physician (or physician's assistant or nurse practitioner if so authorized by a physician) for all individuals enrolled in the HCBS waiver except residents of Community Residences."

OPWDD Administrative Memorandum #2009-05

OPWDD Administrative Memorandum #2010-03 states, "...the MSC Vendor must maintain the following documentation to support claims for payment:

...

- If the individual is enrolled in the HCBS waiver, a copy of the individual's ICF/MR level of care eligibility determination (LCED) annual redetermination that has been completed and signed within 365 days from the prior review and authorized signature date."

OPWDD Administrative Memorandum #2010-03, p. 5

OPWDD Administrative Memorandum #2011-01 states, "A qualified person (e.g., A Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430 (a) or listed in the guidance memorandum dated March 2, 2010 which clarifies ADM #2009-05) is able to review the information on the form and, if there are no changes that impact the person's level of care, to complete the ICF/MR Level of Care Eligibility Redetermination section on the same form as the last redetermination. The redetermination must be completed and signed annually, i.e. within 365 days of the previous authorization (i.e. effective) date."

OPWDD Administrative Memorandum #2011-01

In 1 instance, the ICF/MR LCED was not completed and signed within 365 days of the prior review. This finding applies to Sample # 11.

3. **Distribution of the Individualized Service Plan (ISP) Exceeded 45 Days**

For Services Prior to 10/1/2010:

The *Medicaid Service Coordination Vendor Manual* states, "The service coordinator has 45 days from the date of the face-to-face ISP review meeting to send the full ISP or addendum and any revised habilitation plans to the consumer, advocate and major service providers. . . .

When the ISP review is **not a face-to-face meeting** . . . The service coordinator has 45 days from the official six-month review date to send the full ISP or addendum and any revised habilitation plans to the consumer, advocate and major service providers."

Medicaid Service Coordination Vendor Manual, Chapter 4, Section 3

For Services 10/1/2010 and After:

OPWDD Administrative Memorandum #2010-03 states, "If a service coordinator writes a new ISP, re-writes the ISP or writes an addendum to the ISP, and the new or rewritten ISP or the addendum reflects a new service or a change in service provider, the service coordinator must show evidence that the new or rewritten ISP or addendum was distributed within 60 days from the date of the ISP review or addendum or later if the 60 day timeframe cannot be met. If distribution exceeds the 60 day limit, the service coordinator must document the reason for the delay, and then sign and distribute the ISP or addendum. Evidence of distribution may include, but is not limited to, a sheet stating when the document was distributed, a monthly service note indicating that the documentation was distributed, a page attached to the ISP indicating when it was distributed, or a notation on the ISP or addendum indicating when it was distributed. Regardless of method of distribution used, documentation must include the parties to which the ISP was sent and the date(s) on which it was sent."

OPWDD Administrative Memorandum #2010-03, p. 6

In 1 instance, distribution of the ISP exceeded 45 days. For services prior to 10/1/2010, the *Medicaid Service Coordination Vendor Manual* specifies the services coordinator has 45 days to send the full ISP, with or without requisite signatures, to all parties. However, the OMIG disallowed claims for failure to distribute the ISP within 60 days. This is in keeping with OPWDD's redesign effective October 2010. For services 10/1/2010 and after, the requirement was changed to 60 days. This finding applies to Sample # 46.

4. **Missing Medicaid Service Coordination Agreement**

For Services Prior to 10/1/2010:

The *Medicaid Service Coordination Vendor Manual* states, "The Service Coordination Agreement has two sections, the Basic Agreement, and the Activity Plan.

The Basic Agreement:

- Identifies the MSC service coordinator and vendor selected by the person, the service coordinator's supervisor and the twelve-month period covered by the agreement.
- Recognizes the responsibilities of the MSC service coordinator and vendor in developing, implementing, and maintaining the person's ISP.
- . . .
- Identifies the frequency of the face-to-face service meetings . . ."

Medicaid Service Coordination Vendor Manual, Chapter 4, Section 3

For Services 10/1/2010 and After:

The *Medicaid Service Coordination Vendor Manual* states, "All people enrolled in MSC must have a signed Medicaid Service Coordination Agreement The Medicaid Service Coordination Agreement describes the responsibilities of the MSC service coordinator, the MSC Vendor and the person receiving MSC.

The MSC Agreement:

- States the rights and responsibilities of the person receiving MSC and the role of the MSC service coordinator in developing, implementing, and maintaining the person's ISP.
- Indicates that the person receiving MSC also has certain responsibilities and should actively participate in the attainment of his or her valued outcomes, to the extent possible.
- Provides information on how the person can withdraw from MSC or change his or her MSC service coordinator or MSC Vendor.

- States for non-Willowbrook Class members that they can choose to use an Activity Plan at any time
- States that Willowbrook Class members must have an Activity Plan."
Medicaid Service Coordination Vendor Manual, Chapter 4, Section 3

OPWDD Administrative Memorandum #2010-03 states, ". . . the MSC Vendor must maintain the following documentation to support claims for payment:

...

- Evidence that a Service Coordination Agreement was executed. Evidence may include, but is not limited to, a copy of the Service Coordination Agreement or a monthly service note indicating the agreement was reviewed.

OPWDD Administrative Memorandum #2010-03, p. 5

In 1 instance, the Medicaid Service Coordination agreement was missing from the recipient's record. This finding applies to Sample # 83.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$28,377, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-6327
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted point estimate of \$102,060. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED].

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

[REDACTED]
Clinton County Chapter NYSARC
P.O. Box 826
231 New York Road
Plattsburgh, New York 12903

PROVIDER ID # [REDACTED]

AUDIT #14-6327

AMOUNT DUE: \$28,377

AUDIT
TYPE

PROVIDER
 RATE
 PART B
 OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-6327
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #14-6327 was as follows:

- Universe - Medicaid claims for OPWDD MSC services paid during the period January 1, 2009, through December 31, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OPWDD MSC services paid during the period January 1, 2009, through December 31, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2009, through December 31, 2011.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services.

SAMPLE RESULTS AND ESTIMATES

Universe Size	8,059
Sample Size	100
Sample Value	\$ 25,577.84
Sample Overpayments	\$ 1,767.13
Net Financial Error Rate	6.91%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 1,767.13
Less Overpayments Not Extrapolated*	<u>(507.01)</u>
Sample Overpayments for Extrapolation Purposes	\$ 1,260.12
 Sample Size	 100
 Mean Dollars in Error for Extrapolation Purposes	 \$ 12.6012
 Universe Size	 8,059
 Point Estimate of Total Dollars	 \$ 101,553
Add Overpayments Not Extrapolated*	<u>507</u>
Adjusted Point Estimate of Totals Dollars	<u>\$ 102,060</u>
 Lower Confidence Limit	 \$ 27,870
Add Overpayments Not Extrapolated*	<u>507</u>
Adjusted Lower Confidence Limit	<u>\$ 28,377</u>

* The actual dollar disallowance for the following findings was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #3 – Distribution of the Individualized Service Plan (ISP) Exceeded 45 Days**
- **Finding #4 – Missing Medicaid Service Coordination Agreement**

The dollar disallowance associated with these findings was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim.

OFFICE OF THE MEDICAID INSPECTOR GENERAL
OMRDD/CLINTON CO CHAP NYSARC
REVIEW OF OPWDD-MSC SERVICES
PROJECT NUMBER: 14-6327
REVIEW PERIOD: 1/1/2009 - 12/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS 1. Services Performed by Unqualified Medicaid Service Coordinator Staff 2. Missing Documentation of Intermediate Care Facility/Mental Retardation (ICF/MR) Level of Care Eligibility Determination (LCED) Annual Redetermination 3. Distribution of the Individualized Service Plan (ISP) Exceeded 45 Days 4. Missing Medicaid Service Coordination Agreement			
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated				
26	09/01/09	5212	5212	\$ 231.62	\$ 231.62	\$ -	\$ -				
27	05/01/11	5211	5211	252.98	252.98	-	-				
28	07/01/11	5211	5211	252.98	252.98	-	-				
29	04/01/10	5213	5213	286.56	286.56	-	-				
30	02/01/11	5211	5211	252.98	252.98	-	-				
31	05/01/11	5211	5211	252.98	252.98	-	-				
32	11/01/10	5211	5211	252.98	252.98	-	-				
33	08/01/11	5211	5211	252.98	252.98	-	-				
34	05/01/09	5213	5213	275.39	275.39	-	-				
35	03/01/09	5213	5213	267.21	267.21	-	-				
36	02/01/10	5211	5211	204.84	204.84	-	-				
37	01/01/11	5211	5211	252.98	252.98	-	-				
38	11/01/09	5213	5213	275.39	275.39	-	-				
39	07/01/09	5212	5212	231.62	231.62	-	-				
40	01/01/11	5211	5211	252.98	252.98	-	-				
41	01/01/11	5211	5211	252.98	252.98	-	-				
42	09/01/09	5213	5213	275.39	275.39	-	-				
43	07/01/11	5211	5211	252.98	252.98	-	-				
44	05/01/09	5213	5213	275.39	-	275.39	-	X			
45	09/01/09	5213	5213	275.39	275.39	-	-				
46	07/01/09	5213	5213	275.39	-	-	275.39			X	
47	10/01/11	5211	5211	252.98	252.98	-	-				
48	08/01/11	5211	5211	252.98	252.98	-	-				
49	06/01/11	5211	5211	252.98	252.98	-	-				
50	03/01/11	5211	5211	252.98	252.98	-	-				

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Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS 1. Services Performed by Unqualified Medicaid Service Coordinator Staff 2. Missing Documentation of Intermediate Care Facility/Mental Retardation (ICF/MR) Level of Care Eligibility Determination (LCED) Annual Redetermination 3. Distribution of the Individualized Service Plan (ISP) Exceeded 45 Days 4. Missing Medicaid Service Coordination Agreement				
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated					
76	06/01/11	5211	5211	\$ 252.98	\$ 252.98	\$ -	\$ -					
77	01/01/09	5213	5213	267.21	267.21	-	-					
78	07/01/09	5212	5212	231.62	231.62	-	-					
79	04/01/09	5212	5212	224.74	224.74	-	-					
80	10/01/09	5212	5212	231.62	231.62	-	-					
81	06/01/11	5211	5211	252.98	252.98	-	-					
82	12/01/11	5211	5211	252.98	252.98	-	-					
83	09/01/09	5212	5212	231.62	-	-	231.62					X
84	04/01/11	5211	5211	252.98	252.98	-	-					
85	01/01/09	5212	5212	224.74	-	224.74	-	X				
86	09/01/10	5211	5211	211.19	211.19	-	-					
87	08/01/09	5213	5213	275.39	275.39	-	-					
88	07/01/09	5212	5212	231.62	231.62	-	-					
89	12/01/10	5211	5211	252.98	252.98	-	-					
90	12/01/11	5211	5211	252.98	252.98	-	-					
91	09/01/09	5212	5212	231.62	-	231.62	-	X				
92	12/01/10	5211	5211	252.98	252.98	-	-					
93	07/01/09	5212	5212	231.62	231.62	-	-					
94	04/01/11	5211	5211	252.98	252.98	-	-					
95	07/01/10	5213	5213	295.45	295.45	-	-					
96	03/01/11	5211	5211	252.98	252.98	-	-					
97	05/01/10	5213	5213	295.45	295.45	-	-					
98	06/01/10	5213	5213	295.45	295.45	-	-					
99	03/01/10	5213	5213	286.56	286.56	-	-					
100	08/01/10	5211	5211	211.19	211.19	-	-					
Totals				\$ 25,577.84	\$ 23,810.71	\$ 1,260.12	\$ 507.01	4	1	1	1	