STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

FINAL AUDIT REPORT

January 15, 2014

[redacted]
Beverly Mack, Inc.
738 Crown Street
Brooklyn, New York 11213

Re: Level II COPS Recoveries July 1, 2005 – June 30, 2008
Audit #: 12-4098
Provider ID #: [redacted]

Dear [redacted]

Pursuant to Section 517.3(g) of Title 18 of the Official Compilation of Codes, Rules and Regulations of the state of New York (NYCRR), the New York State Office of the Medicaid Inspector General (OMIG) and the New York State Office of Mental Health (OMH) performed a joint review of Beverly Mack, Inc. (the "Provider") Level II Comprehensive Outpatient Programs (Level II COPS) supplemental payments for the period July 1, 2005 through June 30, 2008 for its New York City program(s). **Please note that as of July 1, 2008, due to implementation of Clinic Ambulatory Patient Groupings, Clinic COPS will no longer be subject to reconciliations.** The Level II COPS reconciliations have been calculated as required by Section 592.10 of Title 14 NYCRR.

BACKGROUND

Since 1991, New York State has provided supplemental Medicaid Level I COPS payments to mental health providers for enhanced services to seriously and persistently mentally ill adults and seriously emotionally disturbed children. Since 2001, New York State has provided supplemental Medicaid Level II COPS payments to mental health providers for enhanced services to seriously and persistently mentally ill adults and seriously emotionally disturbed children. The supplemental payments for Level I COPS and Level II COPS are payments in addition to a provider's Medicaid rate, and serve as a deficit funding mechanism. The amount of Level I COPS and Level II COPS reimbursement that a provider can retain in any fiscal year is limited to a specific COPS threshold.

The Level I COPS and Level II COPS threshold is a provider and program specific amount. Level I COPS and Level II COPS received in excess of that year's threshold amount will be recouped by the State. CSP payments also fund community-based mental health programs that serve the severely and persistently mentally ill population. CSP payments in excess of the Provider's CSP threshold are subject to recovery by the State. In cases where recoveries are necessary, the State may adjust the CSP supplemental rate prospectively.

REGULATIONS

OMIG is responsible for reviewing payments made by Medicaid for medical care, services, and supplies/equipment provided to eligible persons. The OMIG audits are directed at ensuring provider compliance with applicable laws, regulations, rules and policies as set forth by the Departments of Health and Mental Hygiene (10 NYCRR, 14 NYCRR, & 18 NYCRR, respectively) and the Medicaid Provider Manuals. Level I COPS standards are established in 14 NYCRR Section 592.8, Level II COPS standards are established in 14 NYCRR Section 592.10 and CSP standards are established in 14 NYCRR Section 588.14.

In addition, 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 . . . (g) to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program, including patient histories, case files and patient-specific data...(i) to comply with the rules, regulations and official directives of the department." *18 NYCRR Section 504.3*
>
> 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)*
>
> Furthermore, according to regulations, all fiscal and statistical records and reports of a provider, used to establish rates of payment made pursuant to the Medicaid program, and all underlying books, records, documentation and reports which formed the basis for such statistical reports or payments are subject to audit. Additionally, cost-based providers must maintain said records in accordance with the requirements set forth in the regulation.
> *18 NYCRR Section 517.3(a)*

FINDINGS

Since you did not respond to our draft audit report dated June 25, 2012, the findings in the final audit report remain identical to the draft audit report.

The OMH has reviewed the data on the Provider's Level II COPS payments and have identified Level II COPS overpayments to the Provider in the amount of $4,910.55. We have attached for your review a reconciliation of the Provider's Level II COPS payments for said time period.

PROVIDER RIGHTS

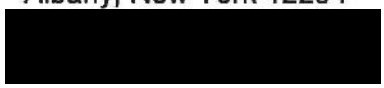
In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below.

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

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File # 12-4098
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 report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. Such interest charges are deemed by the Office of Mental Health to be ineligible for reimbursement. If the process of establishing the repayment agreement exceeds 20 days from the date of the final report, the OMIG will impose a 15% withhold after 20 days until the agreement is established. The OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. 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. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204



If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to secure payment and liquidate the overpayment amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

You have the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. 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.

If you wish to request a hearing, the request must be submitted in writing to:

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

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

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply a signed authorization permitting that person to represent you along with your hearing request. At the hearing, you may call witnesses and present documentary evidence on your behalf.

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.

Should you have any questions, please contact [redacted] or through email at [redacted] Please refer to audit number 12-4098 in all correspondence.

Sincerely,

[redacted]

Audit Manager
Division of Medicaid Audit
Office of the Medicaid Inspector General

[redacted]
Enclosures

CERTIFIED MAIL [redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

[redacted]

Beverly Mack, Inc.
738 Crown Street
Brooklyn, New York 11213

AMOUNT DUE: $4,910.55

PROVIDER [redacted]

AUDIT # 12-4098

AUDIT TYPE	[X] 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 # 12-4098
Albany, New York 12237-0048

5. If the provider number shown above is incorrect, please enter the correct number below.

CORRECT PROVIDER NUMBER

NYS Office of Mental Health
Aid to Localities Financial Systems

Provider	OMH Code	MMIS No.	County	Article	Expense	Program	[1] 2005-2006 Threshold	[2] 2005-2006 Paid	[3] 2005-2006 Recovery	[4] 2006-2007 Threshold	[5] 2006-2007 Paid	[6] 2006-2007 Recovery	[7] 2007-2008 Threshold	[8] 2007-2008 Paid	[9] 2007-2008 Recovery	[10] Combined Threshold	[11] Combined Paid	[12] Combined Recovery
Beverley Mack, Inc	[redacted]		NYC	31	Level II	Clinic	$ 3,928.00	$ 9,450.15	$ 5,522.15	$ 47,999.00	$ 43,815.56	$ -	$ 49,702.00	$ 53,273.44	$ 3,571.44	$ 101,629.00	$ 106,539.55	$ 4,910.55

COPS and CSP Revenue Reconciliation Report
Narrative Explanation

General Information

The OMH regulations that pertain to COPS (14 NYCRR Part 592) can be viewed on the OMH web page at www.omh.ny.gov/omhweb/policy_and_regulations.

The OMH regulations that pertain to CSP Medicaid (14 NYCRR Part 588.14) can be viewed on the OMH web page at www.omh.ny.gov/omhweb/policy_and_regulations.

The regulations that pertain to base Medicaid fees for Article 31 providers (14 NYCRR Part 588) can be viewed on the OMH web page at www.omh.ny.gov/omhweb/policy_and_regulations.

Appendix DD of the CBR manual (the appendix that addresses Level I, Level II COPS and CSP fiscal reporting) can be viewed on the OMH web page at www.omh.ny.gov/omhweb/cbr.

Revenue Reconciliation Report

Below are explanations for the columns of the report that merit more explanation than is provided in the column headers.

Column (1): Represents the 2006 Level I, Level II COPS and/or CSP threshold for your agency.

Column (2): Represents Level I, Level II COPS and/or CSP paid to your agency for the corresponding year (data source MMIS).

Column (3): Represents the Level I, Level II COPS and/or CSP recovery amount for the corresponding year.

Column (4): Represents the 2007 Level I, Level II COPS and/or CSP threshold for your agency.

Column (5): Same explanation as for column (2).

Column (6): Same explanation as for column (3).

Column (7): Represents the 2008 Level I, Level II COPS and/or CSP threshold for your agency.

Column (8): Same explanation as for column (2).

Column (9): Same explanation as for column (3).

Column (10): Combined Level I, Level II COPS and/or CSP thresholds for 2006 – 2008 for each supplemental category.

Column (11): Combined Level I, Level II COPS, and/or CSP revenue generated for 2006 – 2008 for each supplemental category.

Column (12): Combined Level I, Level II COPS, and/or CSP recovery amount for 2006 – 2008 for each supplemental category.

The following information may be accessed at OMH's website:
http://www.omh.ny.gov/omhweb/spguidelines/HTML/cops_level_1.html

Level I COPS / Level II COPS / CSP Revenue Reconciliation

OMH maintains a Medicaid payment database that reflects payments made to providers consistent with the information contained in the Medicaid remittance statements which accompany each Medicaid check. **Providers must keep track of any Level I COPS / Level II COPS / CSP revenue receipts. Any Level I COPS / Level II COPS / CSP revenue received in excess of the Level I COPS / Level II COPS / CSP threshold must be kept in a reserve account for future recovery by the OMH.**

Any Level I COPS / Level II COPS / CSP received in excess of that year's Level I COPS / Level II COPS / CSP threshold will be recouped by the State through MMIS. A Level I COPS / Level II COPS / CSP payment report will be sent to each provider detailing the amount of Level I COPS / Level II COPS / CSP that OMH has determined the provider received, as compared to their threshold for the program for the particular year, during the reconciliation process. Included in any notice of recovery of overpayment will be a description of the recovery process.

Medicare/Medicaid Crossover Payment Methodology

In order to determine the individual Medicaid components (base Medicaid, Level I COPS, CSP and/or Level II Level I COPS) of a Medicaid payment made on a Medicare/Medicaid Crossover (crossover) paid claim you will need to know the following information:

- the crossover logic – Medicaid payment on a crossover paid claim is limited to the difference between either the Medicare approved amount and Medicare paid amount, or the Medicaid rate and Medicare paid amount, whichever is greater;
- the Medicare approved amount associated with the particular rate code the crossover logic is being applied against – please be aware that Medicare approved, and Medicare allowed, are synonymous;
- the Medicare paid amount for the particular rate code in question;
- the base Medicaid rate/fee – all Article 28 providers, and some D&TC providers, have base Medicaid rates for clinic, CDT, and day treatment; all Article 31 providers, and some Diagnostic & Treatment Center (D&TC) providers, have base Medicaid fees for clinic, CDT, and day treatment; all providers have base Medicaid fees for partial hospitalization (PH) and intensive psychiatric rehabilitation treatment programs (IPRT) – although for the purpose of this explanation, base rates and base fees will both be referred to as base Medicaid rates (see Part 588.13);
- the Level I COPS rate, if applicable;
- the CSP rate, if applicable;
- the Level II Level I COPS fee supplement, if applicable;
- the total Medicaid rate for a particular outpatient program; and
- the total amount paid (Medicare plus Medicaid),

Then apply the following logic to calculate the component parts of your Medicaid payment:

For providers who receive Level I COPS and CSP on the same rate code

- Determine the Medicaid payment by subtracting Medicare paid from the total amount paid.
- Determine the base Medicaid component:
- If the base Medicaid rate is greater than or equal to Medicare approved, then the base Medicaid component is equal to the difference between the base Medicaid rate, and Medicare paid.
- In all other cases, the base Medicaid component is equal to the difference between Medicare approved, and Medicare paid.
- Determine the base Medicaid plus Level I COPS component:
- If the sum of the base Medicaid rate and the Level I COPS rate is greater than or equal to Medicare approved, then the base Medicaid plus Level I COPS component is equal to the difference between the sum of the base Medicaid rate and the Level I COPS rate, and Medicare paid.
- In all other cases, the base Medicaid plus Level I COPS component is equal to the difference between Medicare approved and Medicare paid.
- Determine the Level I COPS component by subtracting the base Medicaid component from the base Medicaid plus Level I COPS component.
- Determine the CSP component by subtracting the base Medicaid plus Level I COPS component from the Medicaid payment.

For providers who receive CSP and Level II Level I COPS on the same rate code, apply the same logic as above, substituting Level II COPS for Level I COPS.

For providers who receive just Level I COPS, CSP, or Level II COPS on a particular rate code apply the same logic as above, assuming all unused rate components are equal to $0.

Please note:

In no instance can the Level I COPS, CSP, or Level II COPS payment credited through the application of this logic be less than $0.