

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF DURABLE MEDICAL
EQUIPMENT PROVIDERS' MEDICAID
CLAIMS FOR RESIDENTS OF
ASSISTED LIVING PROGRAMS**



**Daniel R. Levinson
Inspector General**

**SEPTEMBER 2006
A-02-05-01017**

Office of Inspector General

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.





DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

September 5, 2006

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Report Number: A-02-05-01017

Antonia C. Novello, M.D., M.P.H, Dr. P.H.
Commissioner
New York State Department of Health
Empire State Plaza
14th Floor, Room 1408
Corning Tower
Albany, New York 12237

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Durable Medical Equipment Providers' Medicaid Claims for Residents of Assisted Living Programs." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

To facilitate identification, please refer to report number A-02-05-01017 in all correspondence.

Sincerely yours,

A handwritten signature in cursive script that reads "James P. Edert".

James P. Edert
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
New York, New York 10278

EXECUTIVE SUMMARY

BACKGROUND

An Assisted Living Program (ALP) provides long-term residential care, room, board, housekeeping, personal care supervision, and home health services (either directly or under arrangements with other providers) to five or more adults. Services provided by ALPs are covered by New York's Medicaid State plan. The State's Medicaid program reimburses ALPs for nine services provided to Medicaid eligible residents via a per diem rate. The nine services included in the rate, for which no other Medicaid billing may occur, are: (1) personal care services, (2) home health aide services, (3) personal emergency response services, (4) nursing services, (5) physical therapy, (6) occupational therapy, (7) speech therapy, (8) medical supplies and equipment not requiring prior approval, and (9) adult day health care.

The Federal Office of Management and Budget Circular No. A-87 establishes principles and standards for determining allowable costs applicable to grants with State and local governments. Section C.,1.,c. of Attachment A of these principles states that in order to be allowable under a grant program, costs must be authorized or not prohibited under State or local laws or regulations. State regulations at New York Compilation of Codes, Rules and Regulations (NYCRR), Title 18, section 505.35(h)(1), require that ALPs receive a capitated (per diem) rate of payment for certain specified services furnished to their Medicaid-eligible residents. One of these services pertains to medical supplies and equipment not requiring prior approval. Pursuant to State regulations at 18 NYCRR 505.5(d)(1)(iii), payment will not be made to durable medical equipment (DME) providers for items furnished by a facility or organization when the cost of those items is already included in the rate.

OBJECTIVE

Our objective was to determine whether DME providers improperly received Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were already included in the per diem rates paid to ALPs. Our audit covered the period January 1, 1999, through February 29, 2004.

FINDINGS

The DME providers improperly received Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were furnished to ALP residents. The costs of these items were already included in the Medicaid per diem rates paid to the ALPs. Consequently, the Medicaid program paid twice for the items. We believe that the DME providers should have sought reimbursement for the medical supplies and equipment from the ALPs, not from Medicaid. As a result, we concluded that \$406,081 in Federal funds was improperly claimed under the Medicaid program.

The unallowable claims occurred because: (1) the State Medicaid Management Information System (MMIS)¹ lacked the necessary edits and controls to deny DME provider claims for medical supplies and equipment not requiring prior approval that were furnished to ALP residents, and (2) DME providers did not follow State regulations prohibiting Medicaid payment for items included in the ALPs' per diem rates.

RECOMMENDATIONS

We recommend that the State:

- refund \$406,081 to the Federal Government;
- establish eMedNY edits and controls necessary to deny DME provider claims for Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were furnished to ALP residents; and
- issue guidance to DME providers emphasizing that State regulations prohibit Medicaid payment for items included in the ALPs' per diem rates.

STATE'S COMMENTS

In its comments on our draft audit report, the State concurred with two of our recommendations, and generally agreed with the third recommendation to refund \$406,081 to the Federal Government. State officials commented that they would need to review a listing of the inappropriately paid claims identified in the report, and then pursue for recovery those claims validated as being overpayments. The State's comments are included in their entirety as an appendix to the report.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing applicable Federal and State laws, regulations, and other requirements and the State agency's comments on our draft report, we continue to believe that our findings and recommendations are valid.

¹Currently known as eMedNY

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INTRODUCTION

BACKGROUND

Federal Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program pays the health care costs of beneficiaries who qualify because of medical condition, economic condition, or other qualifying factors. Medicaid costs are shared between the Federal Government and participating States. Within the Federal Government, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program.

To participate in the Medicaid program, States must submit and receive CMS approval of a State plan. The State plan is a comprehensive document detailing the nature and scope of the State Medicaid program and the State's corresponding obligations to the Federal Government. The Medicaid program pays for medically necessary services, as specified in Medicaid law, provided they are included in the State plan and furnished to beneficiaries eligible under the State plan.

New York Medicaid Program

In New York State, the Department of Health is the State agency responsible for operating the Medicaid program. Within the Department of Health, the Office of Medicaid Management is responsible for administering the Medicaid program. The Department of Health uses the Medicaid Management Information System (MMIS),¹ a computerized payment and information reporting system, to process and pay Medicaid claims.

The State's Federal medical assistance percentage was 50 percent for claims paid from January 1, 1999, through March 31, 2003; and 52.95 percent for claims paid from April 1, 2003, through February 29, 2004.

New York Assisted Living Program

The New York assisted living program was established pursuant to Chapter 165 of the Laws of 1991, and was intended to serve Medicaid beneficiaries who are medically eligible for residential health care facility (nursing home) placement, but whose needs could be met in a less restrictive and lower cost residential setting than the highly structured medical environment of a nursing home. The assisted living program meets the needs of these beneficiaries by combining the residential services of an adult home, or an enriched housing program, with a licensed home care services agency, long term home health care program, or a certified home health agency furnishing supportive home care services.

An Assisted Living Program (ALP) furnishes long-term residential care, room, board, housekeeping, personal care supervision, and home health services (either directly or by arrangement with other providers) to five or more adults. The State's Medicaid program

¹ Currently known as eMedNY

reimburses ALPs for services furnished to Medicaid-eligible residents at a per diem rate. During our audit period, 61 ALPs received Medicaid reimbursement for 1,954,433 claims, totaling \$219,977,118 (\$109,961,975 Federal share).

Medicaid Coverage for Assisted Living Programs and Durable Medical Equipment Providers

The New York Medicaid State plan covers services furnished by ALPs and durable medical equipment (DME) providers. The Federal Office of Management and Budget Circular No. A-87 establishes principles and standards for determining allowable costs associated with State and local government grants. Section C.1.c. of Attachment A of these principles requires that these costs must either be authorized, or not prohibited, by State or local laws or regulations, to be allowable under a grant program.

New York State promulgated regulations expressly intended to govern Medicaid payment for services furnished by ALPs at New York Compilation of Codes, Rules and Regulations (NYCRR), Title 18, section 505.35. Pursuant to section 505.35(h)(1) of these regulations, the Medicaid program pays assisted living programs at a capitated (per diem) payment rate for services furnished to Medicaid-eligible ALP residents. The nine services included in the rate, for which no other Medicaid billing may occur, are: (1) personal care services, (2) home health aide services, (3) personal emergency response services, (4) nursing services, (5) physical therapy, (6) occupational therapy, (7) speech therapy, (8) medical supplies and equipment not requiring prior approval, and (9) adult day health care.

New York State promulgated regulations expressly intended to govern Medicaid payment for durable medical equipment, medical/surgical supplies, and orthotics at NYCRR, Title 18, section 505.5. Section 505.5(d)(1)(iii) of these regulations provides that Medicaid will not pay for any items furnished by a facility or organization when the cost of these items is included in the capitated rate.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether DME providers improperly received Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were already included in the per diem rates paid to ALPs.

Scope

Our audit period covered January 1, 1999, through February 29, 2004. During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed internal controls that were significant to the objective of our audit.

We conducted fieldwork at the State Department of Health in Albany, New York; the State's MMIS fiscal agent in Menands, New York; and at six ALPs in Far Rockaway, New York;

Lockport, New York; Rego Park, New York; Syracuse, New York; Troy, New York; and Utica, New York.

Methodology

To accomplish our objective, we:

- held discussions with CMS officials to identify all applicable Federal and State regulations and guidelines governing assisted living program services;
- obtained and reviewed Federal and State laws, regulations, and guidance applicable to assisted living facilities;
- held discussions with State officials concerning the objective of our audit;
- conducted survey site visits to six ALPs;
- ran computer programming applications at the MMIS fiscal agent, which identified 1,954,433 claims from 61 ALPs, totaling \$219,977,118 (\$109,961,975 Federal share);
- matched the ALPs' claims against the DME payment files at the MMIS fiscal agent, which identified 33,847 DME claims for medical supplies and equipment not requiring prior approval, submitted by 389 DME providers for residents of 60 ALPs;
- analyzed the 33,847 DME paid claims and determined that they represent 686 item codes, totaling \$802,541 (\$406,081 Federal share);
- used simple random sampling techniques to select a sample of 30 claims to validate that all 33,847 DME claims for medical supplies and equipment not requiring prior approval were improperly reimbursed by Medicaid, because the costs were already included in the ALPs' per diem rates;
- requested supporting documentation for the 30 sampled claims from the ALPs and the DME providers; and
- reviewed the supporting documentation for the 30 sampled claims to determine whether the DME providers were improperly reimbursed by Medicaid for medical supplies and equipment not requiring prior approval, that were already included in the ALPs' per diem rates.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The DME providers improperly received Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were furnished to ALP residents. As a result, we concluded that \$406,081 in Federal funds was improperly claimed under the Medicaid program.

DURABLE MEDICAL EQUIPMENT PROVIDERS' IMPROPER CLAIMS

As detailed in the "Methodology" section of this report, we identified a universe of 33,847 claims submitted by 389 DME providers that we believe to have been improperly reimbursed by Medicaid. To validate our belief, we selected a random sample of 30 claims for review.

The DME providers improperly received Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were provided to residents of ALPs in all 30 claims in our random sample. The costs of these items were already included in the Medicaid per diem rates paid to the ALPs. Consequently, the Medicaid program paid twice for those items. We believe that the DME providers should have sought reimbursement for the medical supplies and equipment from the ALPs, not from Medicaid.

The 30 improper DME claims corresponded to the following items:

- 10 claims – sterile and nonsterile gloves;
- 5 claims – wheelchair rental and wheelchair accessories;
- 4 claims – oxygen concentrators and systems;
- 2 claims – nebulizers;
- 2 claims – blood glucose strips; and
- 7 claims – various items including sterile gauze, alcohol wipes, and batteries.

CAUSES OF UNALLOWABLE CLAIMS

As discussed below, we identified two main causes of the unallowable claims.

No State Controls

The State established MMIS Edit Number 01208 entitled "ALP RECIPIENT/SERVICE INCLUDED IN PER DIEM" which was designed to deny claims for eight of the nine types of services included in ALP per diem rates. However, the edit routines were not designed to deny claims from DME providers for medical supplies and equipment not requiring prior approval that were furnished to ALP residents.

Failure to Follow State Regulations

The DME providers did not follow State regulations at 18 NYCRR 505.5(d)(1)(iii) which required that payments will not be made to durable medical equipment providers for items furnished by a facility or organization when the cost of those items is already included in the per diem rate.

OVERPAYMENT AMOUNT

Based upon the results of the tests of the 30 randomly selected claims, together with Federal Office of Management and Budget Circular No. A-87 cost principles, and State regulations that prohibit Medicaid payment for items included in the ALPs' per diem rates, we concluded that all 33,847 DME claims, totaling \$802,541 (\$406,081 Federal share), were improperly reimbursed by Medicaid.

RECOMMENDATIONS

We recommend that the State:

- refund \$406,081 to the Federal Government;
- establish eMedNY edits and controls necessary to deny DME provider claims for Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were furnished to ALP residents; and
- issue guidance to DME providers emphasizing that State regulations prohibit Medicaid payment for items included in the ALPs' per diem rates.

STATE'S COMMENTS

In its comments on our draft audit report, the State concurred with two of our recommendations, and generally agreed with the third recommendation to refund \$406,081 to the Federal Government. State officials commented that they would need to review a listing of the inappropriately paid claims identified in the report, and then pursue for recovery those claims validated as being overpayments.

The State's comments are included in their entirety as an appendix to the report.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing applicable Federal and State laws, regulations, and other requirements and the State agency's comments on our draft report, we continue to believe that our findings and recommendations are valid.

APPENDIX

DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 15, 2006

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Report Number: A-02-05-01017

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS - OIG's Draft Audit (A-02-05-01017) on "Review of Durable Medical Equipment Providers' Medicaid Claims for Residents of Assisted Living Programs."

Thank you for the opportunity to comment.

Sincerely,



Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Charbonneau
Mr. Dougherty
Mr. Griffin
Mr. Howe
Ms. Napoli
Mr. Reed
Mr. Seward
Mr. Wing

**Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-05-01017 on
“Review of Durable Medical Equipment Providers’
Medicaid Claims for Residents
of Assisted Living Programs”**

The following are the Department of Health’s (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-05-01017) on “Review of Durable Medical Equipment Providers’ Medicaid Claims for Residents of Assisted Living Programs.”

Recommendation #1:

Refund \$406,081 to the Federal Government.

Response #1:

The Department agrees that there appears to be overpayments associated with durable medical equipment (DME) providers improperly receiving reimbursement for medical supplies and equipment provided to residents of assisted living facilities. The Department is currently reviewing the diskette submitted by DHHS that lists those inappropriate paid claims identified in the report. Those claims that are validated as being overpayments, and are within the statute of limitations for recovery, will be pursued.

Recommendation #2:

Establish eMedNY edits and controls necessary to deny DME provider claims for Medicaid reimbursement for medical supplies and equipment not requiring prior approval that were furnished to Assisted Living Program (ALP) residents.

Response #2:

The Department will develop necessary edits and controls to preclude inappropriate payments from occurring.

Recommendation #3:

Issue guidance to DME providers emphasizing that State regulations prohibit Medicaid payment for items included in the ALPs’ per diem rates.

Response #3:

Department staff will draft an article for the Medicaid Update directed to DME providers reminding them that Medicaid payment is prohibited for items in the ALP's per diem. The Department will also issue a direct mailing to providers on the subject.

ACKNOWLEDGMENTS

This report was prepared under the direction of James P. Edert, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

John Berbach, *Audit Manager*

Kevin Smith, *Senior Auditor*

Nicholas Halko, *Auditor*

Stephen Bugler, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.