



# *Shifting Costs to Medicaid*

## The Case of Financing the OMRDD Comprehensive Case Management Program



NYS COMMISSION ON QUALITY OF CARE  
FOR THE MENTALLY DISABLED

DECEMBER 1995

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# Executive Summary

The New York Mental Hygiene Law authorizes the Commission on Quality of Care for the Mentally Disabled to "review the cost effect of mental hygiene programs and procedures provided for by law with particular attention to efficiency, effectiveness and economy in the management, supervision and delivery of such programs. Such review may include...determining reasons for rising costs and possible means of controlling them..." (Section 45.07 (b)).

During the course of a Commission investigation into complaints about the health, safety and welfare of developmentally disabled residents of a supportive apartment program in New York City operated by Project L.I.F.E., Inc., Commission fiscal staff — who were reviewing allegations that client food and spending allowances were not being remitted to residents — noted that the agency was placing one-half of Comprehensive Medicaid Case Management (CMCM) revenue into an escrow account instead of using it to offset State residential payments as required by regulation (see, *Crossing the Line from Empowerment to Neglect: The Case of Project L.I.F.E.*, July 1994). Concerned that other providers might be retaining money belonging to the State, the Commission sought to determine whether statewide implementation of the CMCM program resulted in similar unnecessary payments to providers.

## SCOPE OF THE REPORT

While this report examines the financing of the CMCM program, and in particular its implementation by the Office of Mental Retardation and Developmental Disabilities (OMRDD), the report should not be read as an overall assessment of the value of case management services — a task the Commission did not undertake.

The Commission recognizes that case management is a valuable and, in many cases, vital service, especially for developmentally disabled persons who live on their own, with their families or in settings which do not provide constant staff support. In these settings, case management provides an essential measure of both safeguards and quality assurance. Even in supervised settings, the availability of an independent case manager can provide an additional level of assistance to ensure effective access to needed community services and supports, without which such services and supports may remain effectively out of reach of many residents in need.

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## **EXPLANATION OF CMCM**

Case management is commonly understood to be a system under which responsibility for locating, coordinating and monitoring a group of services rests with a designated person or organization. While most Medicaid services are bound by a "statewideness" requirement, in 1985 Congress modified the law to include case management as a covered service when "targeted" to specific groups or categories of recipients in any area of the State. In approving the program, the intent was to allow case management to be provided as an additional service, not "solely" to reduce program costs.

OMRDD exercised the case management option in 1989 by establishing CMCM as a discrete and separately reimbursed service to a clinically-determined group of Medicaid-eligible consumers residing in community residences or family care homes, or living independently or with families anywhere in the State. It was envisioned in implementing this program that priority would be given to individuals living with their family and those transitioning into a community setting, and that the State could save money by shifting a portion of existing State-funded case management costs to Medicaid, which provides 50 percent matching funds.

As with all Medicaid-funded services, there is a potential for duplicate payments which can arise when the same or similar services are furnished by other programs or as an integral aspect of another covered Medicaid service. This recognition led OMRDD to adopt a regulation to require that CMCM payments be used to help reduce State payments to community residences, because the State was already funding many case management activities which were part of the routine day-to-day activities of direct care staff in community residences. In implementing CMCM, the State established a system for documenting contacts made on behalf of consumers and the nature of these contacts. It was obligated to ensure that these services did not duplicate other Medicaid services through its payment systems and that only eligible services were billed to Medicaid.

## **OBJECTIVES AND METHODOLOGY**

Since OMRDD is committed to using case management as the key coordinating activity for all developmentally disabled consumers living in the community, the Commission reviewed the implementation of the CMCM program, which expended \$18.8 million in 1994, to determine:

- (1) whether the shifting of expenditures for case management services for residents of community residential programs onto Medicaid has saved the State money;

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- (2) the extent to which services have actually been expanded;
  - (3) whether implementation of the CMCM philosophy of consumer choice and voluntary enrollment as a condition for service under New York's Medicaid Plan requires tighter controls; and,
  - (4) by auditing a sample of billings, whether services have been appropriately claimed for federal financial participation consistent with federal and State requirements.

The Commission examined CMCM fee development and OMRDD's policy for using Medicaid to offset State-funded costs of community residences. It also visited 13 programs across the State operated by voluntary agencies and by OMRDD developmental centers, and audited a statistically valid sample of CMCM Medicaid claims.

## **FINDINGS**

The principle findings of this study can be summarized as follows:

1. The fees for CMCM for voluntary agencies were set at a rate higher than justified by the actual cost data available. From 1991-1994, these fees were set 45 percent higher than their estimated costs, accounting for excess payments of approximately \$10.4 million to providers. (Report pp. 6, 17-19.)
2. CMCM payments to community residences duplicated payments they were already receiving from OMRDD for these services performed by their staff. Although an OMRDD regulation required that the State take an offset equal to 50 percent of the CMCM payments (approximately \$4 million) to partially compensate for this duplication, OMRDD has not recouped the offset and does not intend to do so. (Report pp. 1-3, 9, 18-19, 22.)
3. When a new fee methodology for community residences was implemented in 1993, these duplicative overpayments for CMCM services continued since the new fees apparently do not deduct the cost of Medicaid CMCM payments, amounting to approximately \$8.6 million annually. (Report pp. 19, 22-23.)
4. An audit of a statistically valid sample of 1992 Medicaid claims for CMCM services revealed that 21 percent of the claims lacked adequate documentation or were for unallowable costs. If this rate of improper billings was projected to the entire CMCM costs

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incurred from April 1989 to December 1994 (\$75 million), approximately \$15.8 million worth of claims were ineligible for reimbursement. (Report pp. 14-17, 21, 24-25.)

5. Finally, several of the federal statutory requirements governing the CMC program — such as requiring consumer choice in the selection of a case manager — were not complied with for residents of community residences. (Report pp. 11-12, 20, 26-27.)

## CONCLUSION

A draft report was sent to OMRDD on March 2, 1995. Its response is attached to this report (Attachment A). The Commission is concerned that while the OMRDD response cites numerous examples of OMRDD policies and procedures, it fails to address the central finding of the Commission's review — that the implementation of the CMC program has resulted in a substantial degree of improper billings to the Medicaid program, and duplicate payments to providers have resulted in millions of dollars of unnecessary costs (See, also, Commission's rebuttal letter, Attachment C).

The completion of this project, coupled with the State's continuing financial problems leads the Commission to conclude that this is an appropriate time for the Governor and the Legislature to commission a plenary review of the State's appropriate role in the delivery of services to persons with developmental disabilities, and of the adequacy and methods of financing services to this population.

The Commission makes this recommendation in light of the long history of unorthodox methods of financing and supplementing programs and services because of perceived inadequacies in funding. For example:

- In the 1970's, inadequacies in the methodology for financing the fledgling community residences led OMRDD to supplement their funding through purchase of service contracts. This practice resulted in widely disparate levels of payment among providers with no apparent rationale (see, *Willowbrook: From Institution to the Community; A Fiscal and Programmatic Review of Selected Community Residences in New York City*, August 1982).
- In the 1980's, the State embarked upon a massive program of converting community residences into intermediate care facilities for the mentally retarded (ICF/MR) for the primary purpose of obtaining federal Medicaid reimbursement to increase funding. While this conversion enabled many community residences to enrich their services, it also resulted in a significant increase in overall expenditures, much of it caused by the need to comply with detailed federal regulations which

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often did not specifically address the needs of residents (see, *Converting the Community Residences into Intermediate Care Facilities for the Mentally Retarded: Some Cautionary Notes (ICF-MR)*, October 1980).

- The policy decision to develop and expand the State's role in directly operating community residences and ICF/MRs, and more recently in operating individualized residential alternatives (IRAs) has added capacity to the service system but at a significant premium over the costs of similar programs operated by voluntary agencies. At a time when the State's work force is undergoing significant downsizing due to continued fiscal problems, it is appropriate to re-evaluate this policy decision and the appropriate role of the State in direct service delivery.
- A recent Commission study of OMRDD's rate appeal system identified significant flaws, including the granting of rate appeals for costs which had not been actually incurred by a provider, and the practice of permitting providers to retain and continue to receive increased reimbursements allowed by the rate appeals even if they had not spent the money for the purpose for which it was claimed (see, *Safeguarding Public Funds: A Review of Spending Practices in OMRDD Rate Appeals*, January 1995; *Missing Accountability: The Case of Community Living Alternative, Inc.*, June 1994).
- Finally, this study found that the costs of the CMC program are roughly twice as high for State-operated programs as they are for voluntary agency-operated programs (Report pp. 6-7). It notes that the duplication of costs permitted by this program was motivated largely by the desire to supplement the funding of community residences which have not received a cost of living increase in several years. (Report pp. 2, 9.)

The Commission believes that many of the decisions to supplement authorized rates of reimbursement, or to set fees above actual costs, were motivated by a perception that the overall level of funding for programs was inadequate and to compensate for this perceived inadequacy. However, these methods of circumventing the rate structure have weakened respect for the validity of decisions made about financing the system and have created a climate where circumvention is accepted and sanctioned.

The Commission believes that this environment is not conducive to reducing waste, fraud and abuse which have plagued the Medicaid program — a problem that accounts for one out of every 20 dollars spent nationally

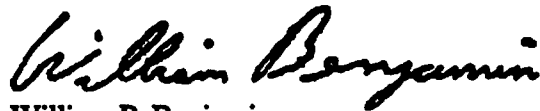
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on health care (Statement of Louis J. Freeh, Director, Federal Bureau of Investigation, before the Special Committee on Aging, United States Senate, March 21, 1995.) Thus, we believe that a forthright reassessment of the State's role in direct service delivery and of the adequacy of funding for services provided in the OMRDD service system will benefit both the recipients of services and the sound administration of the system.

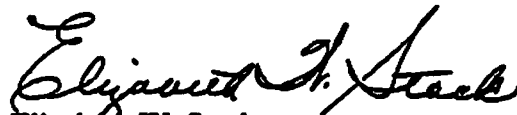
This report represents the unanimous opinion of the members of the Commission.



Clarence J. Sundram  
Chairman



William P. Benjamin  
Commissioner



Elizabeth W. Stack  
Commissioner

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# Introduction

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*Congress intended that case management be provided as an additional service, not "solely" to reduce program costs.*

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New York State's Medicaid program has long been one of the largest and most costly in the country. In 1993, New York spent \$18.2 billion on Medicaid, which is a 26 percent increase over the \$14.4 billion spent in 1991.<sup>1</sup> While historically much of the State's cost could be attributed to its heavy dependence on very costly institutional care and optional services, a recent study suggests that New York's current growth is more the result of policies and practices which have centered around the "shifting" of State-funded human service program costs onto Medicaid. Shifting previously State-funded programs to Medicaid helps to improve the State's financial condition, since Medicaid provides access to 50 percent federal matching funds. A byproduct of this policy is that there is reduced incentive to cut costs which are funded substantially from another source.<sup>2</sup>

This report examines one of these initiatives, the Comprehensive Medicaid Case Management (CMCM) program, which was implemented by the Office of Mental Retardation and Developmental Disabilities (OMRDD) to finance the coordination and linkage of consumers to support services in the community. It shows how cost shifting has ended up adding to and, in some instances, duplicating the cost of already-existing services at community residences.

The Commission first became concerned about the CMCM program in late 1993 when a team of fiscal analysts from the Commission conducted a survey of the finances of a programmatically deficient agency in New York City.<sup>3</sup> During the survey, fiscal staff found that since 1991 this agency was placing one-half of its CMCM revenue into an escrow account in the belief that these funds would be recouped as an offset against its community residence program funding.<sup>4</sup> However, OMRDD had neither offset its payments to this provider nor issued any directive to the agency clarifying the State's plan to recoup these monies in the future. Concerned that other providers may also have monies waiting to be recouped by the State, the Commission decided to take a closer look at the statewide implementation of the CMCM program and the related offset.

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<sup>1</sup> "Medicaid Reference Statistics," NYS Department of Social Services, August 1994.

<sup>2</sup> James W. Fossett, "Medicaid and Health Reform: The Case of New York," *Health Affairs*, Fall 1993, pp. 81-94.

<sup>3</sup> *Crossing the Line from Empowerment to Neglect: The Case of Project L.I.F.E.*, New York State Commission on Quality of Care for the Mentally Disabled, July 1994.

<sup>4</sup> State regulation (14 NYCRR 686.13 (h) (5)) required that "Effective January 1, 1991, community residence payments for certified CMCM providers shall be adjusted by a CMCM offset. Said offset shall be equal to fifty percent of the CMCM service hours billed per Medicaid eligible resident per month at the applicable CMCM rate." (Regulation rescinded effective February 28, 1993 with the adoption of a new community residence methodology which provided Medicaid funding for the non-"rent" portion of community residences.)

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Medicaid funding of case management has been authorized as an optional service since 1985 when the Consolidated Omnibus Budget Reconciliation Act (COBRA) amended the Social Security Act by adding Section 1915 (g). This section allows states to amend their state Medicaid plans to include case management when targeted to selected groups of Medicaid recipients. In authorizing this service, Congress intended that case management be provided *as an additional service, not "solely" to reduce program costs.*<sup>5</sup> Thus, while states were not prohibited from receiving federal matching funds for services they were already providing and paying for, the federal legislation clearly intended that services be expanded.

On April 1, 1989, OMRDD exercised the targeted case management option by establishing CMC as a discrete and separately reimbursed service to a clinically determined group of Medicaid-eligible individuals residing in community residences or family care homes, or living independently or with family anywhere in the State. It was envisioned that in implementing this program additional federal monies would be captured to offset expenses which were previously being paid entirely from State funds.

Initially, OMRDD expected to replace the 100 percent State-funded costs for case management in community residences with Medicaid funding. However, because providers saw little to be gained from helping the State shift its expenditures to federal funds, and because of the extensive paperwork required to support Medicaid billings, providers were reluctant to implement the program. To overcome this, a financial incentive was adopted whereby a provider could keep 50 percent of the reimbursement from Medicaid even though these costs were already funded by the State through their community residence rates.<sup>6</sup> The other 50 percent would be remitted to the State through an "offset" to community residence payments. In effect, this meant that community residences could receive additional funding at no cost to the State. At a time when community residence providers were receiving no cost of living adjustments (COLAs), the provider community began to view the 50 percent share of retained CMC billings as its COLA. However, as examined in this report, OMRDD has not implemented the regulatory requirement that half of the CMC revenues collected by providers be used to reduce community residence payments. The Commission estimates that, as of March 1, 1993, \$4 million is due and owing to the State as an offset pursuant to this OMRDD regulation.

Since OMRDD continues to be committed to using case management as the coordinating activity for all developmentally disabled consumers choosing

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*OMRDD has not implemented the regulatory requirement that half of the CMC revenues collected by providers be used to reduce community residence payments.*

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<sup>5</sup> Legislative History, Public Law 99-272, Optional Targeted Case Management Services, Effective October 1, 1985.

<sup>6</sup> Recognizing that individuals living independently or at home (including family care homes) did not have case management systems in place, OMRDD determined that there should be no offset for this group. On the other hand, a 30 percent offset was "negotiated" for sheltered workshops which presumably would have a mix of consumers from community residences and other unlicensed community settings.

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to live in the community within the Individualized Service Environment (ISE) structure,<sup>7</sup> there are important operational and fiscal questions that need to be answered about the implementation of the CMCM program and its fiscal impact on the State and localities which share the 50 percent non-federal portion of Medicaid costs. This study looks at these questions and examines:

- (1) if the shifting of expenditures onto Medicaid has saved the State money;
- (2) the extent to which services have actually been expanded;
- (3) whether implementation of the CMCM philosophy of consumer choice and voluntary enrollment as a condition for service under New York's State Medicaid Plan (hereinafter, State Plan) requires tighter controls; and,
- (4) by auditing a sample of billings, whether services have been appropriately claimed for federal financial participation (FFP) consistent with federal and State requirements (i.e., services were provided to a targeted group, consumer choice, providers were qualified, non-duplication of payments, and claims were appropriate and properly documented).

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*As of March 1, 1993, \$4 million is due and owing to the State as an offset pursuant to this OMRDD regulation.*

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In addressing these study objectives, the Commission examined CMCM fee development and the offset policy. It also visited 13 different programs across the State operated by voluntary agencies and by OMRDD developmental centers. The 11 voluntary agencies visited accounted for 23 percent of voluntary agency CMCM billings in 1992; the two State-run programs comprised 18 percent of developmental center billings for 1992-93. The Medicaid claims reviewed were randomly selected to be representative of total claims at these programs with a 90 percent level of confidence.

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<sup>7</sup> The proposed shift towards ISE moves away from limiting CMCM services based on a clinical assessment to a less restrictive standard where there is a presumptive need based on disability and residential status.

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# Background

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## CMCM Service Model

In a 1984 study, OMRDD assessed its system of delivering case management services and proposed a framework upon which to determine the future dimensions of the case management system.<sup>8</sup> By looking at actual practices, OMRDD determined that it had committed major staff resources to the program and that the success and stability of the community network was directly attributable to case management. It found that voluntary and State providers performed a wide range of case management functions. Consumers on average received about 44 hours of case management in a year, but the services were unevenly provided by placement setting, ranging from a high of 67 hours in a State-operated ICF to a low of 29 hours in a voluntary community residence.<sup>9</sup>

The study recommended that services be directed to those "most in need of services" with a clear priority to be given to individuals living with their family and those transitioning into a community setting who were having problems adjusting to their new living situation. Once transition was accomplished, residential program staff would assume responsibility for case management. Specialized organizational structures and a case manager title series and qualifications were recommended to clearly delineate the distinct case management function. An operational definition of case management was also to be adopted.

Building on the 1984 study and with particular attention to Medicaid requirements, OMRDD in May 1991 drafted a *Guide to Provider Delivered Comprehensive Medicaid Case Management*. To be eligible for CMCM services, an individual must be diagnosed as developmentally disabled, need assistance in acquiring services, be eligible for Medicaid, and be part of the targeted population.<sup>10</sup> Individuals could receive CMCM services from only one provider but could not be restricted in their choice of the provider or specific case manager. The Guide also broadly laid out the areas of CMCM services that were billable, including service planning and coordination, linkage/referral, and follow-up and monitoring.

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<sup>8</sup> *OMRDD Case Management Service Model, Case Management Time and Effort Study, Final Report*, Office of Mental Retardation and Developmental Disabilities, November 1984.

<sup>9</sup> Individuals living in the community as part of the Willowbrook Consent Decree received more case management services although how much was influenced by the type of residence. On average, 79 hours of case management were provided yearly with a high of 94 hours in a family care home setting, 78 hours in a State-operated ICF, and 72 hours in a voluntary-run community residence.

<sup>10</sup> Individuals residing in ICFs, specialty hospitals, skilled nursing facilities or a psychiatric center would not be eligible for CMCM services.

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Under the State Plan and an interagency agreement,<sup>11</sup> case management services are broadly defined as those which assist persons eligible for medical assistance in gaining access to needed medical, social, psychosocial, educational, and other services in accordance with goals contained in a written case management plan *mutually agreed to by the case manager and the individual*.

In June 1994, a new manual entitled *OMRDD's Comprehensive Medicaid Case Management (CMCM)* was published which places more emphasis on case management as a component of the new ISE model. While continuing the 1991 operational definition of case management, the revised manual provides more stringent staff certification requirements,<sup>12</sup> FFP for non-eligible settings within 30 days of resident discharge, guidelines for non-Medicaid recipient participation, a provider enrollment process including a character and competence requirement, and more comprehensive plans for services including monthly face-to-face contacts with consumers and semi-annual plan updates.

Eligibility for FFP is guided by the federal law and the State Plan which intended that CMCM not be used solely to reduce program costs or to duplicate services available from other funding sources. Congress, in authorizing states to offer targeted case management services, recognized that there was the potential for duplicate payments when the same or similar services were being furnished through other programs. Because of this, and in keeping with the longstanding policy of Medicaid being the payer of last resort, an explicit statement prohibiting the duplication of payments was included in federal program requirements.<sup>13</sup>

OMRDD also recognized the potential for duplicate payments when case management services were provided through its existing community residence (CR) program. Although not a discrete component of the CR reimbursement rate, OMRDD acknowledged that case management services were already an integral part of its CR program. Therefore, to preclude a duplication of payments (both through the CR reimbursement rate and Medicaid), OMRDD required an "offset" to that portion of CR payments which represented the cost of providing case management services. Pursuant to 14 NYCRR 686.13, an agency's CR payments would be offset by an amount equal to 50 percent of every dollar collected from Medicaid for CMCM services.<sup>14</sup>

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<sup>11</sup> Memorandum of Understanding (MOU) between the State Department of Social Services and OMRDD dated March 2, 1993.

<sup>12</sup> See, *infra*, Discussion at pp. 12-14.

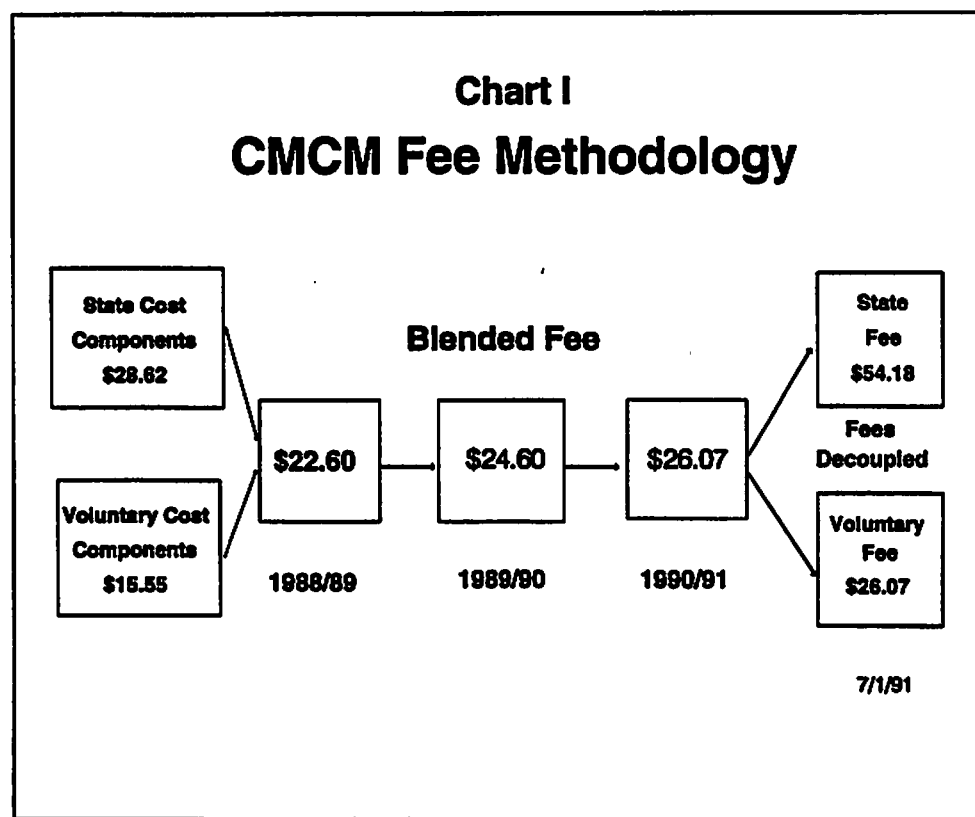
<sup>13</sup> *State Medicaid Manual*, Part 4 - Services, Transmittal No. 30, Department of Health and Human Services, Health Care Financing Administration (HCFA), January 1988.

<sup>14</sup> See, *supra*, Discussion at p.1, footnote 4.

## CMCM Fees and Reimbursement

Both State and voluntary providers are reimbursed for CMCM services through the normal Medicaid claiming process based upon approved hourly fees. Only allowable services delivered by certified staff to registered individuals are eligible for Medicaid reimbursement. Additionally, in the case of State-operated programs, only the federal share of the Medicaid fee is reimbursed.

Initially, all reimbursements were made using a single "cost-related" hourly fee which was a blend of cost components from both State and voluntary programs. These components included direct and indirect salaries, fringe benefits, travel costs, property costs, and administrative overhead. State cost components were based on OMRDD's 1986/87 cost finding, while the voluntary components were based on 1985 data. These costs were accumulated and trended forward for inflation to 1988 levels, resulting in the initial hourly reimbursement fee of \$22.60.<sup>15</sup> Since that time, the fee has been trended twice to its current (1995) level of \$26.07 per hour. Effective July 1, 1991, based on an amendment to the State Plan, the fee was split and State-operated programs began to receive a separate "cost-based" hourly fee of \$54.18 while the voluntary programs continued to receive the \$26.07 blended hourly fee (Chart I).



<sup>15</sup> CMCM services are billed to Medicaid in quarter-hour units of service. For billing purposes, 5 to 15 minutes equals one unit, 16 to 30 minutes equals two units, 31 to 45 minutes equals three units, etc.



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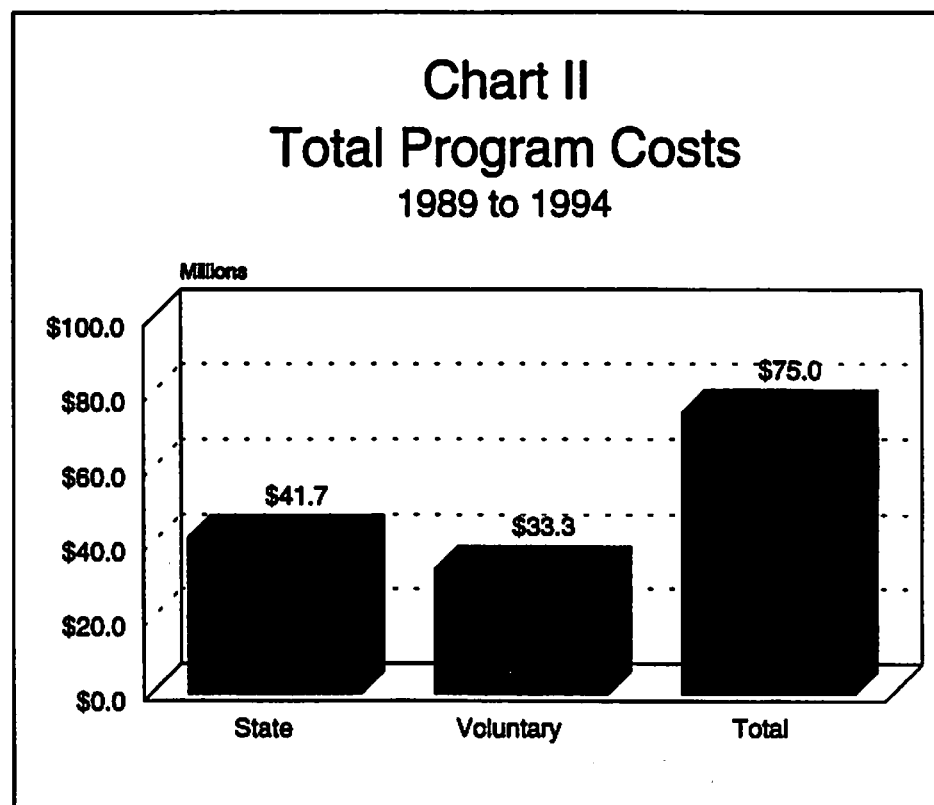
*Since exercising the targeted case management option in April 1989, Medicaid funding for case management services has increased dramatically. From 1989 to 1994, CMCM services increased by 403 percent from \$3.7 million to \$18.6 million annually*

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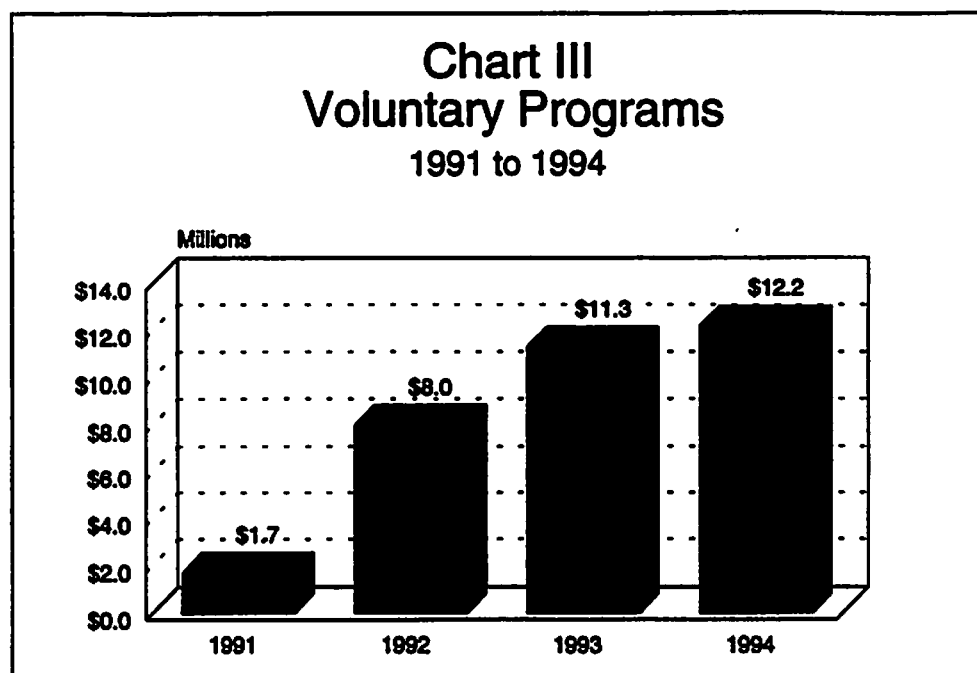
Since exercising the targeted case management option in April 1989, Medicaid funding for case management services has increased dramatically. From 1989 to 1994, CMCM services increased by 403 percent from \$3.7 million to \$18.6 million annually. During this period a total of \$75.0 million was claimed to Medicaid for CMCM services. Of this total, 56 percent was incurred in State-operated programs while the remaining 44 percent was incurred in voluntary programs (Chart II). During 1992, State-operated CMCM services cost approximately \$2,000 per client; voluntary agencies spent about \$875 for each client.

Although the State elected to provide CMCM as an optional service in 1989, the voluntary sector was slow to furnish these services. Several factors contributed to this delay. First, OMRDD was slow in developing the program. Pilot projects at only a couple of the larger agencies began in the latter part of 1991, with most agencies coming on board in 1992. Second,



when the program began, only 11,000 slots (recipients who could receive CMCM services) were approved by DSS; by the end of 1992, this number more than doubled to about 27,000. Third, providers were reluctant to develop the CMCM program. They saw little or no financial gain from providing CMCM services because OMRDD, in order to avoid a duplication of costs (already paid for through the CR rate), planned on recouping or "offsetting" 100 percent of the Medicaid revenues generated by CMCM. They resisted being burdened with more paperwork to comply with

Medicaid requirements without receiving increased reimbursement.<sup>16</sup> As a result, in 1991, when the CMCM program was implemented in the voluntary sector, only \$1.7 million was claimed by voluntary agencies. By 1994, the program experienced a 618 percent increase, bringing the total annual costs to \$12.2 million (Chart III).



<sup>16</sup> See, *supra*, Discussion at p.2.

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# Findings

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Although the goal of the CMCM program was to ensure that Medicaid recipients were assisted in making necessary decisions about the care they needed and in locating providers appropriate to their needs, the Commission's study has found that, for persons living in community residential programs, the CMCM program shifted mostly existing services onto Medicaid funding without any real change in focus or expansion of these services. At nine of 11 agencies visited, agency administrators stated and documentation supported that no new services were provided to CR residents after CMCM was implemented. At the remaining two agencies, services were provided in the community but not at CRs because agency administrators recognized that case management was already an integral part of the CR program. Among the explanations for implementing the program in this manner was the opportunity to reduce State costs by obtaining federal matching funds and to provide additional funds for voluntary community residences which had been denied COLA increases during the State's fiscal crisis of 1991-93.<sup>17</sup> However, the pressure to help voluntary agencies receive more funding has substantially driven up the overall cost of the program because fees have been set beyond what was supported by actual costs and because charges for case management services have been duplicating services paid for under another authority of the Medicaid program. Moreover, monies due the State to offset its payments to voluntary agencies for case management have not been recouped as required by regulation.

## Expansion of Services

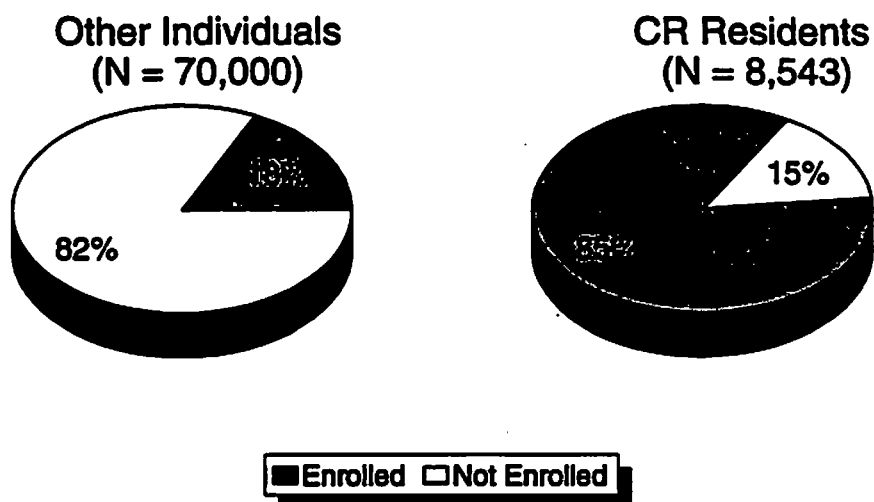
Under the State Plan and the interagency MOU, CMCM is defined as an activity to assist individuals in accessing services appropriate to their needs in accordance with a written case management plan *mutually agreed to by the case manager and the individual*. The federal intent, moreover, was to allow case management to be provided *as an additional service, not "solely" as a means to reduce program costs*.

In its 1984 study, OMRDD recommended that case management services be directed to the greatest unmet need; i.e., individuals living with their families or transitioning into community settings. The Commission's review found in 1992 that 13,000 of this population had been enrolled in the

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<sup>17</sup> Effective October 1, 1993 voluntary community residence providers received a four percent COLA. Effective January 1, 1995 another four percent COLA was granted but was rescinded on April 1, 1995.

## Chart IV 1992 CMCM Enrollment



CMCM program. At the same time, 85 percent of the estimated 8,543 residents living in CRs were enrolled (Chart IV), perhaps reflecting the greater ease with which the CR population could be made Medicaid-eligible.<sup>18</sup>

In the voluntary sector, even though CR residents comprised 43 percent of the individuals receiving CMCM services, they accounted for 70 percent of the 1992 costs (Chart V).<sup>19</sup>

This situation occurred because enrollment into the CMCM program, with few exceptions, was mandatory and CR residents usually had no choice in selecting their case manager or the types of services that would be provided. Instead, they received routine services which had been provided as part of their daily activity. As seen in Chart VI, based upon an audited sample of billings, nearly half of the services provided involved routine day-to-day "monitoring" of clients, rather than linkage and referral to support services.

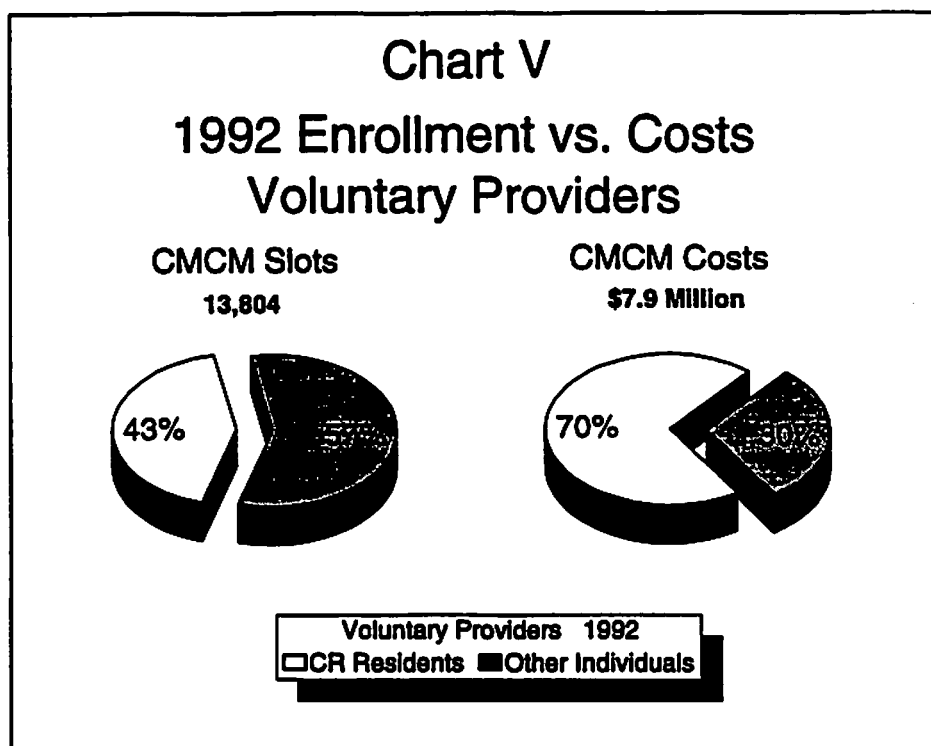
<sup>18</sup> OMRDD, in its response letter (Attachment A), states it recognizes that persons living at home need and want case management, but it often was unable to grant agency requests to serve these people because of DSS restrictions. The letter contends that, since 1990, DSS has limited the number of CMCM enrollment opportunities (slots) for persons living at home and has granted only two allocations of slots, one in 1991 and another in 1993. This restrictive measure is cited by OMRDD as a major reason for the limited enrollment of persons living at home and was not foreseen in the initial planning and goal setting for the CMCM program. Yet, DSS' letter (Attachment B) indicates that until late 1993 all OMRDD requests for allocation of slots were approved as constructed by OMRDD.

<sup>19</sup> Similar information is not available for individuals receiving services from State-operated programs because OMRDD did not maintain discrete data distinguishing between State CR residents and individuals living in the community.

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*The consensus among providers visited was that there was no difference in services, no new services were being provided, and/or there was no impact on their program or the consumers.*

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Indeed, when asked how the implementation of the CMCM program affected service delivery for residents in CRs, the consensus among providers visited was that there was no difference in services, no new services were being provided, and/or there was no impact on their program or the consumers. A few providers equivocated by saying that the program allowed them to “focus” more on the needs of the individual client.

Reflecting provider assertions that no additional services had been provided to CR residents, the Commission in comparing “individual annual plans” with newly required CMCM plans, which were intended to “outline [of] the person’s service needs and the actions to be taken to access these services,” found the written CMCM plans were a continuation of pre-existing annual plans with notations reflecting the status quo of residential, day and recreational services (e.g., “maintain placement...,” “maintain contact...,” “monitor status...”). Thus, although “redefined” and billed to Medicaid as CMCM, services remained essentially unchanged.

## Freedom of Choice

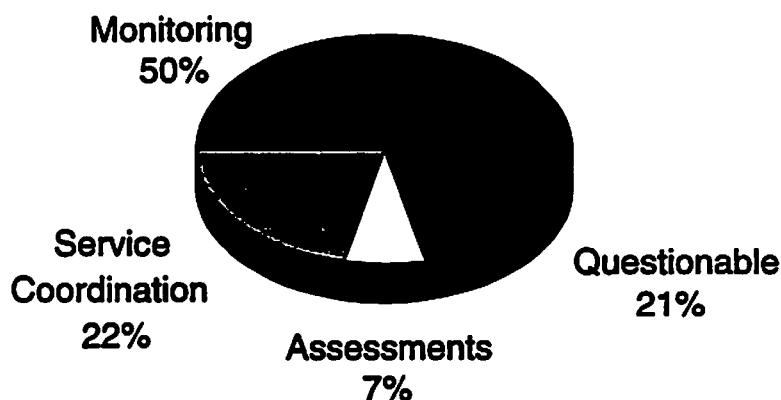
Section 1915 (g) (1) of the Social Security Act specifies that there shall be no restriction on free choice of qualified providers, i.e., the receipt of case management must be at the option of the individual, an individual must be free to receive services from any qualified provider, and there must be unrestricted provider participation and access of clients to other services

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*Recipients residing in CRs were generally not given the freedom to choose whether they wanted to enroll in the program or who would be their case manager.*

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Chart VI  
1992 CMCM Services  
Voluntary & State Providers



under the State Plan. To ensure that consumers understood their rights to choice, case managers were required to sign a written verification that the recipients had been informed of the right to request an alternate provider of services. Additionally, the recipient and case manager were required to sign an individual's CMCM annual plan to verify that the plan was "appropriate and comprehensive."

The Commission's review, however, found that, despite these provisions in the State Plan and the procedures adopted to ensure compliance, recipients residing in CRs were generally not given the freedom to choose whether they wanted to enroll in the program or who would be their case manager. Rather, there was a *de facto* requirement that all community residence consumers be enrolled and that the resident manager be assigned as their "primary" case manager. Additionally, recipients did not have the choice as to the type of services that they were to receive. Instead, as noted above, consumers continued to receive the same services they had always been receiving prior to being enrolled into the CMCM program.

## Case Manager Qualifications

Section 1915(g)(1) further provides that states may limit case managers to those capable of ensuring that individuals with developmental disabilities receive needed services. However, this does not restrict the recipient's freedom of choice, as they may receive case management services from any of the qualified providers. The federal statute does not set minimum standards for the provision of case management services; therefore, states were given the

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*It seemed clear that many case managers did not have the requisite experience in a substantial number of case management functions, such as intake and screening, assessment and reassessment, or writing and coordinating the case management plan.*

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flexibility to establish reasonable qualifications to ensure that case managers are capable of providing services of acceptable quality.

According to the State Plan and DSS regulation (18 NYCRR 505.16(e)(2)), case managers must have two years of experience in a substantial number of case management functions, including the performance of assessments and development of case management plans. The following qualifications may be substituted for this requirement:

- one year of case management experience and a degree in a health or human services field; or
- one year of case management experience and an additional year of experience in other activities with the target population; or
- a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under case management functions, including the performance of assessments and development of case management plans; or,
- the individual meets the regulatory requirements for a case manager of a State department within New York State.

Although these requirements identify minimum qualifications and emphasize *substantive case management* experience, OMRDD in its May 1991 provider manual deviated from the regulations by reducing the qualifications. OMRDD eliminated the requirement to have any case management experience and replaced it with the broader standard of having experience in "performing/participating in assessments and service plan development for people with developmental disabilities *and/or other populations*" such as a hospital or school (emphasis added). Thus, almost anyone with two years of experience in serving dependent populations could have been certified as a CCM case manager. This allowed CR providers to certify direct care workers as "case managers," thereby facilitating the billing of services that are an integral part of a community residence to the CCM program. Therefore, even though the DSS regulation is specific on the qualifications of case managers, OMRDD's guidelines allowed direct care workers who did not meet the minimum requirements to become "case managers."

Typically, these "case managers" conducted "monitoring and follow-up" activities such as transporting clients to medical appointments, picking up a client's prescription at a pharmacy, contacting a family member about a doctor's visit, or accompanying clients on a variety of social or recreational activities. Through interviews and examination of personnel files and staff certification records, it seemed clear that many case managers did not have the requisite experience in a substantial number of case management functions, such as intake and screening, assessment and reassessment, or writing and coordinating the case management plan. Of over 300 certification records examined, 70 percent of case managers qualified solely on the

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*The Commission estimates that almost \$10 million was improperly reimbursed because providers were claiming services that did not comply with DSS regulation and the OMRDD guidelines.*

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basis of having two years of general experience working with developmentally disabled individuals. During one interview with a "certified" CMCM case manager, the manager was asked if she had any experience performing any of the case management functions as outlined in DSS regulation (18 NYCRR 505.16(c)). The worker stated, "no, that was the job of a case manager." Apparently, this worker was unaware of the fact that she was a certified CMCM case manager.<sup>20</sup>

OMRDD's weakened standards posed other problems. For instance, although OMRDD specified that a case manager be assigned to each individual, their guidelines also allowed other staff who were certified under the program to assist in providing CMCM services. These assistants were commonly referred to as "secondary" case managers. Therefore, it was not unusual to find several case managers providing services to one client during the week or even in some instances on the same day. For example, at one agency, there were 183 certified case managers for 97 consumers, or approximately 1.9 managers per individual. At this agency, one community residence with six residents had 24 separate case managers, or a ratio of four managers per resident. At another community residence, one resident received 2 1/2 hours of case management services from three different managers on the same day. In this case, one manager brought the consumer to a podiatrist to inspect his infected foot; this manager later called the individual's aunt to discuss the doctor's visit. A second case manager then contacted his uncle to discuss the doctor's visit, and a third manager again contacted the doctor to discuss the visit.

## **Unallowable Services**

The Commission found that due to a lack of monitoring and vigilant oversight by OMRDD, 21 percent of the claims reviewed should not have been billed to Medicaid. Applying this rate to the \$75 million billed from April 1, 1989 to December 1994 by the State and voluntary agencies, the Commission estimates that \$15.8 million was improperly reimbursed because providers were claiming services that did not comply with DSS regulation and the OMRDD guidelines.

DSS regulation (18 NYCRR 505.16 (c)) establishes seven different case management functions which are eligible for reimbursement. They are:

- intake and screening
- assessment and reassessment
- case management plan and coordination

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<sup>20</sup> In June 1994, OMRDD revised its CMCM manual. The updated manual moves closer but stops short of the original requirements of having "case management" experience in order to qualify as a CMCM manager. How these new guidelines will affect the hundreds of managers performing CMCM services that do not meet the new requirements for "case management type" activities is unclear.



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- implementation of the case management plan
  - crisis intervention
  - monitoring and follow-up, and
  - counseling and exit planning

However, in implementing the CMCM program, OMRDD's May 1991 provider manual reduced these seven functions into three broad categories: service planning/coordination, linkage/referral, and follow-up/monitoring. Although the manual provided some examples as to what was allowable, it lacked clear criteria on billable activities. This led to confusion in the provider community and a lack of consistency in what was being claimed because providers interpreted the guidelines differently. For example, one agency said others were seeking its advice as to what should be billed; a second provider asked the Commission to conduct an in-service training on CMCM billing rules and regulations.

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*At one agency, a case manager billed Medicaid for 72 hours of CMCM services in one day.*

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The Commission found that 21 percent of the total claims reviewed in its sample were improperly billed to Medicaid. A large percentage (24%) were unallowable because documentation did not fully support the claim. In most cases, providers either failed to document contacts with recipients or the nature of these contacts. In other cases, there was documentation but no way of knowing what service was furnished because case records copied progress notes from one record to the next. For example, at one State-operated program, a case manager photocopied the same progress note for each of his 20 clients over a three-year period. The note stated: "observed \_\_\_\_\_; reviewed IPP notes to monitor progress at SOCR and Day Treatment." For each person in his caseload, the manager simply filled in the blank with a recipient's name, the date of the reported contact, and that each service lasted exactly 50 minutes each day. Chart VII summarizes some of the activities improperly billed to the CMCM program.

Finally, the Commission documented instances where case managers were charging the CMCM program for more hours than the actual number of hours of service provided. At one agency, a case manager billed Medicaid for 72 hours of CMCM services in one day. This occurred because the manager simultaneously provided 12 hours of CMCM services to six different consumers. However, instead of allocating the 12 hours of time among the six individuals (billing two hours per person), 72 hours were billed to Medicaid. In another example, a case manager accompanied three individuals on a "self-advocacy" trip that lasted nine hours. Instead of billing Medicaid for three hours per person (9 hours in total), 27 hours of service were billed.

A related problem was the routine rounding of brief contacts to one-quarter hour increments. Program guidelines require case notes to record the actual duration of the service, but often any contact with a recipient, no

## Chart VII

# CMCM SERVICES



A case manager accompanied 6 clients to self-advocacy training and billed **72 hours in one day.**

8 clients accompanied by 3 case managers traveled to Disney World at a **cost of \$5,000** to the CMCM program. Progress notes stated: "Monitoring Allen while on bus to Magic Kingdom." "Monitoring Allen while at Magic Kingdom."

**No documentation** was available to support the claimed expense in almost one-quarter of the questionable services.

Planned **leisure time activities prohibited by OMRDD**: such as trips to the Bronx Zoo, Atlantic City Casinos, weddings and night clubs.

"Beth was asleep in a recliner as this worker entered the home. She awoke and asked if I had "ice cream." Next she asked for a ride, then she went back to sleep. **Billed 30 minutes.**

"Phone call, not in, left message, 1 minute." **Billed 15 minutes.**

One case manager **xeroxed the same progress note** for 20 clients over a 3 year period.

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matter how brief, was recorded as 15 minutes or one billable unit. Longer contacts were similarly rounded into quarter-hour increments, (e.g., 16 minutes would be recorded as 30 minutes or two billable units). Although 16 minutes can be billed as two service units, this should occur only after the time has been aggregated on a daily basis not rounded after each contact. For example:

On a given day, a CMCM case manager spends 10 minutes in the morning and 5 minutes in the afternoon providing billable case management services to a person. The billable units of service are calculated by adding the daily minutes (10 + 5) for a total of 15 minutes. Fifteen minutes equals one unit of service. An agency may bill for only one unit of service for this day.<sup>21</sup>

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*From January 1, 1991 to December 1994, the Commission found that OMRDD overreimbursed voluntary CR providers close to \$22.1 million.*

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By rounding at the time of each contact, providers inappropriately increased the units of service charged to Medicaid. Virtually all of the case notes examined were recorded in this fashion. Several case managers said this type of rounding was standard practice.

Most of the above problems occurred because case management monitoring and program evaluation have been inadequate.

## **Overpayments to Voluntary Community Residence Providers**

From January 1, 1991 to December 1994, the Commission found that OMRDD overreimbursed voluntary CR providers close to \$22.1 million. This occurred for a couple of reasons: first, through a liberal fee methodology, OMRDD developed a CMCM fee which reimbursed CR providers at 45 percent above their identified costs; second, although providers began to receive additional funds through the CMCM fee, OMRDD continued to fund these same costs through its existing CR payment process without taking an offset for these duplicate payments. This resulted in reimbursement to CR providers for case management services at more than double what OMRDD calculated to be their cost of providing services.

### **Fee Methodology**

As discussed earlier, beginning in 1988/89, CMCM services could be reimbursed using a single "cost-related" hourly fee which was a blend of both State and voluntary cost components.<sup>22</sup> According to the MOU with DSS, OMRDD would "develop a rate based on CMCM cost experience within twelve months of OMRDD's receipt of a representative sample of

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<sup>21</sup> OMRDD's Comprehensive Case Management Manual (CMCM), June 1994, p. 16. *See, also.* Discussion at p. 6, footnote 15.

<sup>22</sup> *See, supra*, Discussion at p 6.

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*The Commission estimates that from 1991 to 1994 the inflated fee has resulted in voluntary agencies receiving payments in excess of costs totalling approximately \$10.4 million*

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both State and voluntary agencies' actual CMCM costs over a twelve-month period." In July 1991, HCFA approved a State Plan Amendment which established a "cost-based" fee for State-operated programs only.<sup>23</sup> Voluntary-operated programs continued to be reimbursed using the original blended fee which is inflated by the higher State cost components that were not removed when the State fees were split-off in 1991. As a result, voluntary agencies continued to be reimbursed through a fee that is 45 percent higher than their estimated costs (Chart VIII).

When asked why only the State fee was updated, OMRDD officials said they did not have sufficient expenditure data to update the voluntary fee. Yet, the data used to develop the initial blended fee were based on actual cost data and, since the fee was established in 1989, OMRDD has accumulated three additional years of cost data from consolidated fiscal reports (CFRs) which could be used to develop a cost-based fee. The development of a cost-based fee would very likely result in reduced payments to voluntary providers.

Assuming that the differential between the actual costs of State agency and voluntary providers in delivering CMCM services remains relatively the same as when the fees were first calculated, the Commission estimates that from 1991 to 1994 the inflated fee has resulted in voluntary agencies receiving payments in excess of costs totalling approximately \$10.4 million.

## **Duplicate Payments to Community Residence Providers**

Federal program requirements and HCFA's billing manual specifically prohibit duplicative payments for case management services which are an "integral and inseparable part of another Medicaid covered service" or are paid through other programs. OMRDD recognized that this situation occurred when case management services were provided through its existing CR program and paid for by both existing CR payments and CMCM funds.

To address the federal requirement that precludes duplicate payments for case management services, OMRDD developed an "offset" to existing CR payments. According to State regulation (14 NYCRR Part 686.13), an agency's CR payments would be offset by an amount equal to 50 percent of every dollar collected from Medicaid for CMCM services. The Commission's review, however, found that the required offset has not been taken. From

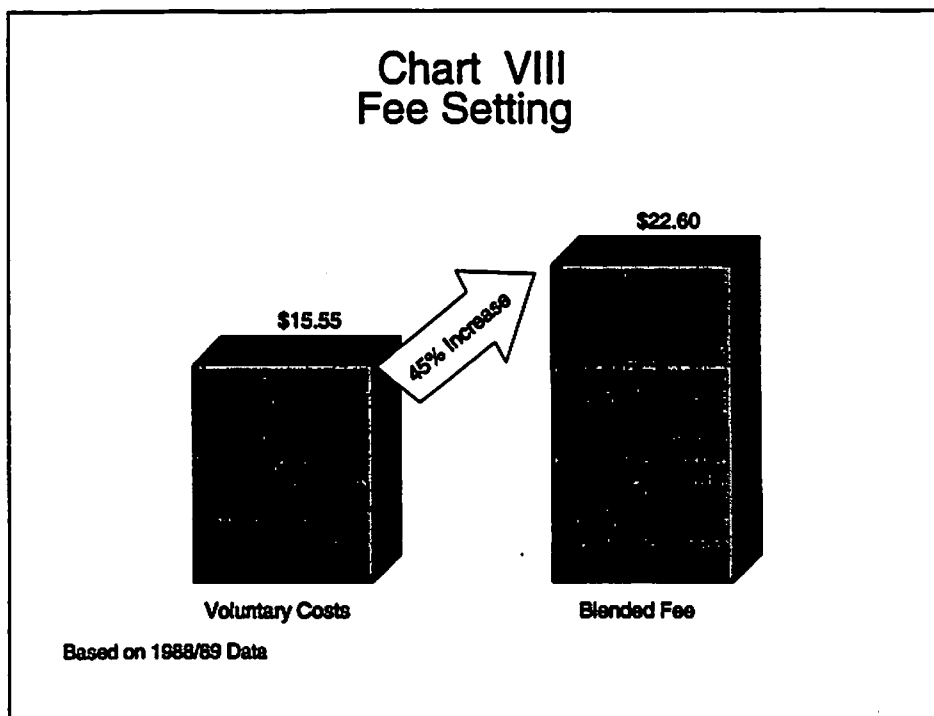
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<sup>23</sup> In developing the cost-based fee for State-operated programs, OMRDD calculated a cost of \$30.26 per hour. OMRDD then adjusted this hourly fee by the number of hours (1,326) a full-time case manager would spend on billable case management in a standard work year (2,080). This calculation increased the fee by 57 percent to \$47.47. This was then trended to 1990/91 levels resulting in a \$54.18 hourly fee. Even though the State plan must specify the methodology by which payments will be made, this change was never included in the 1991 amendment submitted to HCFA. So long as the State plan is amended and duplication of funding is avoided (i.e., activities are not an integral component of another Medicaid covered service), OMRDD's fee is appropriate for covered services.

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*Without a corresponding reduction in the CR fee, voluntary providers continue to receive duplicate payments to provide case management services. The Commission estimates this has resulted in the Medicaid program being overcharged \$8.6 million annually.*

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January 1, 1991 to February 28, 1993, the Commission estimates that OMRDD has failed to reduce CR payments by approximately \$4 million. While OMRDD officials claim that this is due to their inability to get "adjudicated claim files" from DSS to identify the offset amounts, the Commission was able to gather most of the necessary data to calculate the offset from the CFRs that providers submit annually to OMRDD. These cost reports generally identify the amount of CMCM revenue that an agency has received. In cases where the information was missing, the Commission contacted the agency and obtained the necessary cost information to calculate the offset.

On March 1, 1993, when funding for the rehabilitation portion of the CR program was shifted to Medicaid, the 50 percent offset provision was inexplicably removed from regulation. However, without a corresponding reduction in the CR fee, voluntary providers continue to receive duplicate payments to provide case management services. This duplication now is entirely Medicaid funded; once through the CMCM fee and again through the new Medicaid CR fee. The Commission estimates this has resulted in the Medicaid program being overcharged \$8.6 million annually based on 1994 costs (70 percent of \$12.2 million).

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# Conclusion

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*While the Commission applauds the consumer driven philosophy of choosing and pursuing integration and independence in the community, the end result of CMCM has been that these laudable program objectives have been subordinated to revenue objectives.*

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By initiating the Comprehensive Medicaid Case Management program OMRDD expected to preserve and strengthen its system of community care by providing individuals living in "least restrictive" community residential settings with access to appropriate services. In achieving this goal and following the State's practice of shifting programs onto Medicaid, CMCM offered an opportunity to receive matching federal dollars to support ongoing case management activities—particularly at State- and voluntary-operated community residences—and to support new services where there were unmet needs. Consistent with federal program requirements, the State provided assurances in its State Plan that Medicaid payments for case management services would not duplicate payments made under another program authority for this same purpose and would not restrict an individual's free choice of providers or services.

While the Commission applauds the consumer driven philosophy of choosing and pursuing integration and independence in the community, the end result of CMCM has been that these laudable program objectives have been subordinated to revenue objectives. The Commission also found that the rapid implementation of the program, coupled with weaknesses in policy direction to providers and in ongoing monitoring of the implementation of this program, hindered the achievement of these objectives. For example:

- There was a *de facto* requirement that all community residence consumers be enrolled into CMCM as a way of reducing the State share of costs in voluntary community residences and to provide additional revenue to CR providers which had not been receiving cost of living increases through the State's appropriation process. The result was that there were largely no differences in services provided, no new "focus" on the individualized needs of the consumers and, thus, little free choice by consumers of a case manager.
- Even the money objective of reduced State payments for community residences was not achieved as OMRDD failed to offset community residence payments by an estimated \$4 million from January 1, 1991 to February 28, 1993, which represents 50 percent of the CMCM revenues collected by providers. Indeed, because the State matches 25 percent of Medicaid costs, implementation of the voluntary program has resulted in an additional cost to the State for virtually the same services it had been paying for through the regular CR rate. Moreover, the conversion of State-funded operating expenses to 50 percent

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federal dollars was done without articulating its impact on local social services budgets.

- On March 1, 1993, when the non-"rent" portion of voluntary community residence funding was converted to Medicaid funding, the newly established fees were not reduced by the amount of CMM services, even though Medicaid-funded CR direct care staff provide and bill for the majority of these services. This oversight could result in OMRDD being found out of compliance with the federal requirements restricting duplication of payments.
- To determine whether voluntary providers were complying with federal requirements on documenting contacts with recipients or on behalf of recipients and the nature of the contacts, the Commission audited a statistically valid sample of claims for 1992. It found that 21 percent of the claims lacked adequate documentation or were for unallowable services. If this pattern is representative of statewide billings, it would mean that some \$15.8 million of the \$75.0 million claimed between April 1989 to December 1994 would be ineligible for reimbursement. Much of the problem occurs because case management monitoring and program evaluation have been inadequate.

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# Recommendations

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1. **OMRDD should enforce its regulation requiring that community residence payments for CMCN providers be adjusted by the 50 percent CMCN offset. The Commission estimates that for the period January 1, 1991 to February 28, 1993 (when the regulation was rescinded) community residences payments should be adjusted by approximately \$4 million.**

## **OMRDD Response**

OMRDD was always open about the fact that, as a deficit reduction program action, the recoupment of CMCN funds from community residences would not occur until OMRDD was comfortable with the claiming and billing data being provided by DSS. As time passed, a policy decision was made to delay the recoupments because the savings were generated in other ways and because of the cash flow difficulties that community residence providers were facing. This was the result of the lack of trend factors in 1991 and 1992 and the loss of the trend factor between January and October 1993. OMRDD does not plan to recoup the monies at this point in time. If this decision necessitates a regulatory change, OMRDD will make the required revisions.

2. **Federal requirements specifically state that separate payment cannot be made for case management services which are an integral and inseparable part of another Medicaid covered service. Since March 1, 1993, the non-"rent" portion of community residences which includes case management services has been Medicaid funded. These same services are also funded under the CMCN fee. The Commission recommends that community residences no longer be permitted to separately bill Medicaid for case management services under the CMCN program for costs of services provided by direct care staff which are already covered under the basic community residence fee. The elimination of these duplicate payments will reduce annual Medicaid costs by approximately \$8.6 million (70 percent of the \$12.2 million incurred in 1994).**

## **OMRDD Response**

This statement is absolutely untrue. The community residence methodology was revised effective March 1, 1993 to a fee methodology. When the methodology was developed, costs associated with case management services



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were excluded from total costs for fee development purposes. Therefore, community residence payments for services provided after March 1, 1993 are not inclusive of case management. Because of that, no offset is necessary when community residence providers bill for CMCM services after March 1, 1993.

### **CQC Rebuttal**

OMRDD's assertion that the CMCM costs were excluded from the new CR fee methodology contradicts its statement that it has been unable to determine the actual costs of CMCM services (see response to Recommendation 3 below). An OMRDD official defended its position at a June 14, 1995 meeting with Commission staff by maintaining that an OMRDD consultant had been "instructed" to reduce the CR Medicaid fee for a CMCM offset. However, despite a promise by OMRDD to produce supporting documentation to enable the Commission to verify this assertion, OMRDD has not provided any evidence despite repeated Commission requests to examine any such data. The Commission must conclude that either such evidence does not exist or that it would not support the assertions being made. Federal instructions are clear about CMCM not being billed as a discrete service when it is an integral and inseparable part of another Medicaid covered service. Accordingly, the Commission stands by its recommendation to eliminate separate and duplicative CMCM billings for CRs and urges OMRDD to implement CMCM in a way that it can be properly monitored to assure fiscal integrity.

- 3. In accordance with the State plan, OMRDD should establish a new cost-based fee for voluntary providers which reflects the true cost of providing CMCM services. The fee should be based on the most recent cost reports filed with OMRDD and (assuming Recommendation 2 is adopted) would apply to individuals living independently or with their family.**

### **OMRDD Response**

The data cited by CQC as cost data for CMCM is data which was gathered three years before the program began and would be totally inappropriate for establishing a cost-based fee. OMRDD has not had sufficient cost data to update fees. Most community residence providers did not even start providing CMCM until 1992. The first and second year expenditures in a new program are not good fiscal foundations upon which to base fee calculations. There are often data aberrations associated with program start-up. The cost reports for calendar year 1994 were not even due to OMRDD until April 30, 1995. Obviously, we have had no time to analyze

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1994 case management cost information. This finding by CQC is clearly without merit.

### **CQC Rebuttal**

OMRDD's response is an attempt to evade the issue. OMRDD claims it has not had sufficient cost data to update fees and that using first and second year data of a new program is not a reliable foundation for the purpose of fee calculation. Yet, the Commission is simply recommending that a *new* fee be established using the most recent reports available. To state that first and second year data is not reliable to establish a fee is disingenuous, as OMRDD did exactly this when establishing the State-operated fee. Additionally, it seems inconsistent for OMRDD to claim it has cost data to exclude CMCM costs from the 1993 CR fee (see response to Recommendation 2), but no such information is available to establish a new CMCM fee. The Commission continues to recommend that OMRDD develop a cost-efficient fee for individuals living with their families or transitioning into community settings.

4. **OMRDD should revise its case management manual to better clarify allowable services and provide training to voluntary agencies and DDSO staff to ensure compliance with the appropriate billing regulations and guidelines. Given the 21 percent error rate in documenting and claiming of CMCM services, better guidelines and training could reduce inappropriate annual billings by as much as \$3.9 million based on 1994 costs.**

### **OMRDD Response**

OMRDD has, as cited throughout this response, revised its CMCM manual to more clearly explain billable services and to give even more examples of the type of activities not appropriate for billing. This revised manual was distributed to all State and voluntary providers in June 1994. At that time training sessions were held at each DDSO for the CMCM coordinator and Quality Assurance staff. Sessions were also held at each DDSO for all providers of CMCM. These training sessions focused primarily on the clarifications of billable services and the billing guidelines. OMRDD will continue its practice of providing CMCM training sessions at varying locations around the State. Technical assistance continues to be available from both DDSO CMCM coordinators and Central Office staff.

In September 1994, OMRDD instituted a policy of more careful scrutiny of agencies applying to become CMCM providers. Upon acceptance, each provider must ensure, and verify to OMRDD Central Office, that agency staff have attended CMCM training. Only upon receipt of written verification of attendance at training will OMRDD designate an agency to DSS as a CMCM provider.

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Finally, OMRDD contends that since August 1994, the program review process was expanded to include a more thorough review of the services claimed. Program surveyors must review one month's claimed services for every case sampled, to assure that documentation is appropriate, and that the services claimed are in fact "allowable" CMCM services. Statements of deficiency are issued when claims are not in compliance. Providers must respond with a plan of corrective action. When the service billed is found to be a non-allowable service for Medicaid billing, the plan of correction must address the filing of an adjusted claim with MMIS.

OMRDD anticipates that the increased vigilance in the survey process and the clarifications given in the manual and in training sessions, will result in improved compliance and service quality in the CMCM program.

### **CQC Rebuttal**

Although OMRDD in its response states that the Commission's suggestion of vague billing guidelines is "absurd" and that training and oversight had always been provided, DSS in its response letter points out that in December 1993 it froze additional development until OMRDD had committed sufficient resources for the operational function of training and monitoring. Moreover, as indicated above, OMRDD has taken steps to revise its CMCM manual to establish clear criteria on billable activities and to expand its training and monitoring activities.

- 5. OMRDD should require "case management" experience in order to qualify as a CMCM case manager consistent with the State Plan and DSS regulation.**

### **OMRDD Response**

As stated in the response to the findings, OMRDD does not agree with the position taken by the Commission regarding the qualifications, as written, in the CMCM manuals. OMRDD believes that it always has required case management experience as a qualification for the position of CMCM case manager.

### **CQC Rebuttal**

OMRDD claims its certification standards were substantively the same as those required in 18 NYCRR 505.16. Yet, until June 1994 when OMRDD revised its CMCM manual, the standards were substantially lower and allowed providers to certify virtually all direct care staff.

18 NYCRR 505.16(2) states: Case managers. The case manager must have two years experience in a *substantial number of activities* outlined in

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subdivision (c) of this section, including the performance of assessments and development of case management plans.

These activities are as follows:

1. Intake and screening.
2. Assessment and reassessment.
3. Case management plan and coordination.
4. Implementation of the case management plan.
5. Crisis intervention.
6. Monitoring and follow-up of case management services.
7. Counseling and exit planning.

The OMRDD staff certification form used by all providers visited by the Commission used the following as the basic criteria for staff certification:

*Two years of experience performing/participating in assessments and service plan development.*

This clearly did not encompass a substantial number of the case management functions outlined above. In fact, in most cases direct care staff qualified as case managers simply by virtue of having worked for two years at the provider agency. The Commission conducted interviews with many of the direct care workers who were certified as case managers and found they had little or no experience in a substantial number of the areas listed above.

6. OMRDD should strengthen its monitoring and oversight of the CCM program to ensure that there are no restrictions on a recipient's free choice of provider or services and that only qualified providers are certified as case managers.

### **OMRDD Response**

OMRDD has, through regulation (14 NYCRR 671) and statements in the June 1994 CCM manual, addressed the issues of choice of providers and services in the CCM program. As part of its ongoing initiative to improve the quality of the CCM program, OMRDD will add to the program review check list indicator(s) to monitor compliance with the freedom of choice issues.

OMRDD initiated in September 1994 more stringent training requirements for new CCM providers. OMRDD will also add to the program review an indicator to assure that providers are distributing the manual and training all new case managers in the CCM requirements.

OMRDD will continue to encourage all CCM case managers to attend the OMRDD CORE Case Management training and will consider making this a mandatory requirement for certification as a CCM case manager.

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### **CQC Rebuttal**

The Commission's finding on mandatory enrollment was based on visits to providers across the State. In discussions regarding the program and its implementation, providers said there were mass enrollments of CR residents with little or no choice in the assignment of a case manager. OMRDD responded saying that "neither mandatory enrollment nor mandatory assignment of the residence manager as case manager was ever OMRDD policy." This, however, does not address the finding. Providers routinely enrolled all CR residents in their programs, with the exception of those who were not Medicaid eligible, and assigned the residence manager as case manager since this has "always been an individual agency/DDSO choice" (emphasis added).

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# Attachment A

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Executive Deputy Commissioner

May 17, 1995

Clarence J. Sundram, Chairman  
State of New York  
Commission on Quality of Care  
for the Mentally Disabled  
99 Washington Avenue, Suite 1002  
Albany, NY 12210-2895

Dear Mr. Sundram:

Attached is the Office of Mental Retardation and Developmental Disabilities' (OMRDD) response to the draft report on Comprehensive Medicaid Case Management (CMCM) prepared by the Commission on Quality of Care.

Clearly, as you review OMRDD's response, you will see that numerous findings and recommendations by CQC are either misleading or have no factual basis. We will continue to recommend that CQC adopt accepted audit protocol employed by all other state, federal and private auditors. This would lead to more effective and productive audits, findings and recommendations by CQC.

I would hope that you and the other commission members will consider our recommendations.

Sincerely,

  
Thomas A. Maul  
Commissioner

TAM:AK/SOR  
Attachment

Right at home. Right in the neighborhood.







**Response To  
Commission on Quality of Care**

**Review of the OMRDD Comprehensive Medicaid Case Management System**

**INTRODUCTION**

**Comprehensive Medicaid Case Management Service Model**

The Office of Mental Retardation and Developmental Disabilities introduced Comprehensive Medicaid Case Management (CMCM) into its service delivery system in 1989. This program of Medicaid reimbursed case management was established under the authority granted to states in the federal Consolidated Omnibus Reconciliation Act (COBRA) of 1985. This federal action gave states the authority to offer case management to targeted populations as a discrete and independently reimbursed item of service under Medicaid. The New York State (NYS) Department of Social Services (DSS) established targeted case management as a Medicaid program in NYS governed by regulations 18 NYCRR 505.16. In accordance with those regulations, OMRDD filed a proposal with DSS designating a targeted population of individuals with developmental disabilities for case management services. This proposal was accepted and became the basis for a State Plan amendment allowing the provision of Medicaid reimbursed case management services to persons with developmental disabilities.

The CMCM program was first implemented solely through the Developmental Disabilities Services Offices (DDSOs) and was provided to persons living in state operated community residences and family care homes. In 1990, CMCM was introduced into the voluntary sector. Voluntary providers of services to persons with developmental disabilities were authorized to provide Medicaid reimbursed case management services to persons living in community residences or in the community, either independently or with family or friends.

The program grew rapidly since case management services are essential for assisting individuals to develop and maintain a life in the community. Many persons who might otherwise be living in expensive certified living situations have been able to successfully move into and maintain residence in non-certified community settings. Often the support and assistance of the case manager in identifying, accessing and coordinating services is the foundation on which successful community integration and inclusion is built. At a time when managed care environments are being established to control health care utilization and financing, DSS recognizes OMRDD's case management network as a form of managed care.

The Commission on Quality of Care for the Mentally Disabled (CQC) began a review of the CMCM program's fiscal and service components in 1993. The results of the CQC review have been presented to OMRDD in a draft report. The following is OMRDD's response to the findings, conclusions and recommendations in this report.

## **RESPONSE TO FINDINGS**

### **Minimal Expansion of Services**

CQC contends that OMRDD did not expand services to persons living at home with family, as was their stated goal, but rather that CMCM was used to fund existing services performed by direct care workers in community residences. It is the position of CQC that there was in fact minimal expansion of services.

CQC's assertion is very misleading. OMRDD clearly intended that CMCM be a service available to people living independently or with families as well as to those individuals residing in the certified community residential and family care settings. Both the State Plan amendment and the Memorandum of Understanding (MOU) between DSS and OMRDD state that the CMCM eligibility criteria will encompass both groups.

Initially, the community residence and family care population clearly outnumbered the "living at home" population enrolled in CMCM. At that time the DDSOs, whose major focus of service provision is to the state operated residential population, were the only authorized CMCM providers. However, as the CMCM program was expanded to the voluntary sector, the delivery of CMCM services to persons "living at home" significantly increased. In fact, agencies continually request authorization to enroll more persons living at home.

OMRDD recognizes that persons living at home need and want case management, but we are often unable to grant agency requests to serve these people because of DSS restrictions. Since 1990 DSS has limited the number of CMCM enrollment opportunities (slots) for persons living at home. In fact, DSS has granted only two allocations of slots for living at home persons, one in 1991 and another in 1993. This restrictive measure is a major reason for the limited enrollment of persons living at home. Such a limitation was not foreseen in the initial planning and goal setting for the CMCM program. CQC chooses to ignore this restriction in stating its finding. Thus, CR residents were not enrolled in CMCM because their Medicaid eligibility was easier to determine (page 9, CQC report) but rather because DSS does not restrict their enrollment as it does with persons living at home.

This restriction on CMCM enrollment has caused many providers to concentrate their case management effort on those persons residing in the community residence program. These people, although not identified in the 1984 study as the most in need of case management services, are most certainly in need of, and in a

position to benefit from the assistance and support of a case manager. At no time however, contrary to the statement in the CQC report (page 10), was CMCM enrollment mandatory for all CR residents; nor was there a mandate that all CR residents were to be assigned the residence manager as case manager (this will be addressed in more detail in the section on freedom of choice).

CQC further implies that the provision of monitoring as a case management service in the CR program was, in some way, out of compliance with the intent of the CMCM program (page 10, CQC report). OMRDD would like to point out that monitoring is a generally recognized and accepted case management service. Particularly, when the population in question is challenged by cognitive and judgmental deficits, it is of extreme importance that someone (case manager) be available to monitor and advocate for service quality and quantity. Although linkage, referral and coordination may be the more visible case management services, monitoring and advocacy are recognized as acceptable, allowable case management services in the NYS regulations governing the targeted case management program (NYCRR 18,505.16 (c) (6)). Therefore, OMRDD contends that the billing for monitoring services was justified and in compliance with all the Medicaid requirements for targeted case management.

CQC further states that services, for persons residing in CRs, were not expanded as evidenced by the comparison of individual plans before and after the implementation of CMCM. It is OMRDD's position that for some the need was to assure that the residential, vocational and medical status be maintained through monitoring. For many others, however, the CMCM program did allow for the introduction of new services and opportunities in their life. It was and continues to be OMRDD's policy that the case manager should look beyond the existing service network, educate the individual about service choice, and assist the individual to access those services required and desired by the individual.

### **Freedom of Choice**

"The Commission's review found that recipients residing in CRs were generally not given the freedom to choose whether they wanted to enroll in the program (CMCM) or who their case manager would be." (Page 12, CQC report).

Again, CQC's assertion is misleading. OMRDD has maintained from the outset of the CMCM program that each individual had the right to choose both program participation and the provider of the CMCM service. In fact, that is why the CMCM Individual Registration form has always included a verification that such information has been shared with the potential enrollee.

OMRDD further clarified this in an addendum to the original "Guide To Provider Delivered Comprehensive Medicaid Case Management", the "Provider Delivered Comprehensive Medicaid Case Management Questions and Answers". On page 2 of that addendum question 9:

**Question:** "May a resident of a CR refuse CMCM services?"

**Answer:** "Yes, individuals in all programs absolutely have the right to refuse CMCM services."

Neither mandatory enrollment nor mandatory assignment of the residence manager as case manager was ever OMRDD policy. For many CR providers the residence manager, who is skilled in case management service delivery and is also familiar with the needs and desires of the persons living in the CR, is a logical choice. This has always been an individual agency/DDSO choice. Some providers chose to do so, others do not, preferring to use other professional staff, such as social workers.

With the implementation of the Residential Habilitation services in the CR program the choice of case manager became a regulatory stipulation. "Every person approved for receipt of community residential habilitation services shall be assisted by a specific case manager chosen by him or herself or his/her advocate ----" (14 NYCRR, Part 671.2 (1). This further reinforces that the individual shall have the right to choose his/her case manager. CQC also contends that individuals were not given a choice of services but rather that "consumers continued to receive the same services they had always been receiving prior to being enrolled in the CMCM program". OMRDD replies that the continuance of services does not prove that a choice of services was not given to the consumer. Other reasons may be proposed as well: the consumer may be satisfied with current services and not wish to change; or, there may be a lack of available new services at this time and, the consumer has no choice but to continue with current services.

OMRDD has always emphasized in the CMCM training sessions that CMCM must offer consumers the opportunity to access new services, and in fact, OMRDD in its own reviews of case records has found evidence that this does happen. To state, as CQC does (page 12) that "recipients did not have the choice as to type of services that they were to receive" is to generalize to an entire population some examples found in a segment of the population. OMRDD staff have found evidence in case records that reflects that service choices have been given to CR residents.

To reinforce the need to provide individuals with choice and new opportunities the revised CMCM manual, "OMRDD's Comprehensive Medicaid Case Management Manual" (June, 1994) clearly states on page 12 that:

"The CMCM agency must inform participants of their right to select a case manager."

Further, on page 13 of the referenced manual OMRDD states the following regarding choice of services:

"A Plan of Services must be developed for all persons enrolled in CMCM within 30 days of the CMCM registration date. This should be an evolving document that is reviewed and modified at least semi-annually, or more frequently as the individual's goals and priorities change, and as growth, accomplishments and setbacks occur.

The Plan of Services must be based in part on the information gathered in the assessment. A written assessment must be completed within 15 days of the person's enrollment in CMCM. In developing the assessment, the case manager, together with the person and person's advocate, if desired, identifies that person's service needs, preferences, valued outcomes, strengths, and challenges. This is accomplished by interviewing the person, the person's advocate, if desired; reviewing existing clinical and social assessments; and evaluating current supports and services.

Once the assessment is completed and goals are identified, the person, person's advocate, if desired and case manager continue to work together to decide what actions need to be taken to realize the selected goals. The case manager assists the person in choosing available resources and opportunities that will provide the desired

supports and services. Options offered to persons should not be limited to those supports and services primarily designed to meet the needs of individuals with a developmental disability. Natural supports and community resources need to be explored."

OMRDD responds to the CQC that we have always been cognizant of the Medicaid principle of freedom of choice and have tried to assure that providers are in compliance with this principle.

#### **Case Manager Qualifications**

CQC states on page 13 of their report that OMRDD in its May 1991 CCM provider manual deviated from the regulations by reducing the qualifications as defined in 18 NYCRR 505.16 (e) (2).

CQC is absolutely wrong. OMRDD did not intend, nor do we agree, that we deviated from the regulations regarding the qualifications for case managers in CCM. The use of the term "performing/participating in assessments and service plan development" was intended to clearly define what is meant by experience in case management functions. It is our position that the assessment and service plan development experience is, in fact, case management experience. That OMRDD never intended to minimize or deviate from the qualification as stated in Part 505.16 is evidenced in the revised provider manual (June 1994) where OMRDD states the qualifications as follows:

"Two years experience performing/participating in case management type activities including assessment and plan development;--".

The Commission also states that OMRDD has reduced the standards by allowing persons with experience working with populations other than the targeted population to become case managers. In fact NYCRR 18, 505.16 (2) states:

**Case Managers.** The case manager must have two years experience in a substantial number of activities outlined in subdivision (c) of this section, including the performance of assessments and development of case management plans.

Nowhere in the above is it stated that the potential case manager for CCM must have experience with the targeted population.

The DSS requirements further state that the following may be substituted for the 2 years of experience in a substantial number of activities outlined in subdivision (c).

"One year of case management experience and a degree in a health or human service field; or

One year of case management experience and an additional year of experience in other activities with the target population; or

A bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined in subdivision (c) of this section, including the performance of assessments and development of case management plans."

OMRDD believes that its certification requirements (see below) are substantively the same as that required in Part 505.16.

The staff certification requirements for CMCM are:

Two years experience performing/participating in case management type activities including assessment and plan development; or

One year experience performing/participating in case management type activities, including assessment and plan development, and an additional year of experience in other activities with persons with developmental disabilities; or

One year experience performing/participating in case management type activities, including assessment and plan development, and a degree in a health or human services field; or

A bachelor's or master's degree in a health or human services field which included a practicum or internship offering experience in case management type activities, including assessment and plan development.

(OMRDD's Comprehensive Medicaid Case Management Manual, June 1994).



It is OMRDD's position that the above are also substantively the same as the requirements as stated in the original "Provider Guide to Comprehensive Medicaid Case Management", and therefore would have no effect on the certification status of persons certified prior to June 1994.

A related issue raised by CQC is that of the use of CR direct care staff as case managers. This was an acceptable procedure, when the person met the certification requirements. In specific instances, OMRDD allowed for a "CMCM team", and this team could have included direct care staff. A CMCM team is comprised of agency staff who provide case management services as directed by the "primary" case manager. All staff on the team must meet the qualifications for a CMCM case manager. The "primary" case manager is the person selected by the individual as his/her case manager, and is the person responsible for the development and implementation of the case management service plan.

The "team" approach was used in the early years of CMCM. At that time DSS approved the use of such an option in the CR program. DDSO and agency staff were trained in the use of the CMCM team and its requirements in all the training sessions prior to September 1993.

The use of the CMCM team has been virtually eliminated in recent years. In September 1993, OMRDD implemented residential habilitation services into the CR program. This regulation based initiative (14 NYCRR Part 671) requires that "every person approved for receipt of community residential habilitation services shall be assisted by a specific case manager chosen by him or herself ---" (14 NYCRR, 671.2 (1)). Further, Part 671.2 (1) (1), requires that "---To the extent possible, providers of case management services shall attempt to ensure the avoidance of a conflict of interest between the provision of case management services and other services in which the person is participating or receiving." This regulatory requirement has virtually eliminated the use of the CMCM team process, including the role of CR direct care staff as assisting case managers.

Additionally, in January 1995 the state operated CR program transferred its case management funding from State Plan Medicaid funding (CMCM) to the HCBS waiver based Medicaid funding. This transfer reduced the CR population enrolled in CMCM by over 1500 participants.

One other issue cited in this section by CQC must be addressed. CQC states that the certification of direct care staff from the CR sometimes resulted in ratios of up to 4 case managers per consumer. Had CQC taken the time and effort to understand staffing ratios, they would not have made that assertion. To the

casual observer their conclusion may appear to be correct, but anyone familiar with staffing and staffing ratios recognizes that ratios are determined by full time equivalents (FTEs) not individual staff involved. A calculation of the actual FTEs assigned and/or certified to case management would yield a much more realistic ratio.

Finally, CQC's attribution to OMRDD concerning individual ignorance of the team process, (page 14, CQC report) is incredibly misleading. Regular and comprehensive training in CMCM requirements and procedures has been and continues to be available to all agencies. Additionally, efforts are made at the time of program reviews to educate providers. Agencies with program deficiencies are referred to the DDSO CMCM coordinator for continuing training and technical assistance.

#### **Unallowable Services**

The Commission found that due to vague billing guidelines, inadequate training and a lack of vigilant oversight by OMRDD, over one-fifth of the claims reviewed should not have been billed to Medicaid.

The suggestion by CQC of "vague guidelines" is absurd. OMRDD responds that constant and ongoing efforts have been made to assure that providers understand exactly what services are "billable" to Medicaid. OMRDD has done this in the following ways:

1. Two manuals defining case management, case management services and CMCM requirements have been written and distributed to all CMCM providers. Additionally, OMRDD in its Activity Reporting Manual (ARM), has devoted an entire section to instructions regarding the recording of case management services.

The manuals: The Provider Guide to Comprehensive Medicaid Case Management (November 1991-first draft), (May 1991) and the OMRDD's Comprehensive Medicaid Case Management Manual (June 1994) contain sections defining the case management activities with examples. The May 1991 manual also has an appendix which specifically addresses billable and non billable services. This appendix lists examples of billable and non billable services for each broad function of case management.

The addendum to the May 1991 edition of the manual, the "Provider Delivered Comprehensive Medicaid Case Management Questions and Answers" answers ten questions regarding billable services and an additional four questions specifically about the validity of billing for any kind of transportation.

The manuals also provide very specific detail regarding the case note requirements for supporting documentation of the claims made.

2. Training in the requirements of CMCM, using the Manual as the curriculum base was provided to all providers. The first "round" of training sessions was held in November-December 1990. Ten sessions were conducted by the same Central Office staff at 8 sites around the state. All voluntary agency providers were invited to attend. A second "round" of training sessions was held in May 1991, again all voluntary agencies providing or planning to provide CMCM were invited to attend. The 3 hour sessions were held at 7 sites throughout the state and were conducted by the Central Office staff responsible for CMCM.

In addition to these formal statewide sessions, training was provided by both Central Office and DDSO staff on an ongoing basis, as new agencies enrolled in the program. Several sessions were presented in the New York City region and Long Island throughout 1992 and 1993. During the Summer of 1993, Central Office staff conducted seminars with voluntary CMCM providers at all Upstate DDSOS.

In 1994, with a new manual to be distributed, Central Office staff once again conducted training sessions at 7 sites statewide. These sessions targeted the DDSO Quality Assurance staff and CMCM Coordinators. The goal was to assure that they understood all the clarifications in the revised manual. DDSO coordinators distributed the revised manuals to all providers at follow up training sessions. These provider sessions were presented by both the DDSO CMCM coordinator and Central Office staff assigned to the CMCM program. Special attention was given to the New York City region. A Central Office staff member relocated to the New York City Regional Office for four weeks during the Summer of 1994 in order to hold seminar groups with CMCM providers so that they would receive individual instruction in the CMCM requirements.

3. Ongoing technical assistance has been available both from OMRDD Central Office staff and the DDSO. Each DDSO has a designated CMCM coordinator. They are available to answer questions and provide technical assistance. The instance cited in the Commission's report where an agency staff member asked for training in billing procedures was found to be the naive question of a novice case manager. OMRDD's investigation shows that the agency employing this individual had been trained on at least 3 different occasions. The failure of staff at this agency to

provide ongoing information to new case managers cannot be the fault of OMRDD. However, OMRDD Central Office staff did speak to the case manager and advised her of the name and phone number of her DDSO CMCM coordinator.

Despite the above training and technical assistance, both OMRDD and DSS were aware that there were instances where providers were billing inappropriately for CMCM services. Working together DSS and OMRDD addressed the areas most frequently found to be a problem for CMCM providers. This clarification of transportation, clinical services, habilitation and social services as billable or not billable services is included in the June 1994 manual.

The CQC report cites instances of inappropriate billings. OMRDD agrees that while there may have been some inappropriate and non allowable services; the issues had been addressed by OMRDD and the providers have been informed, since the inception of this program exactly what the requirements are. Some examples of specific OMRDD prohibitions against the activities cited are shown in the following:

**Citation:** A case manager accompanied 6 (consumers) to self-advocacy training and billed 72 hours for one day.

**OMRDD Response:** May 1991 edition of the CMCM manual-P.42.

"If you take more than one person to the doctor, and advocate for each person, prorate the time".

P.44 of the same manual addresses the issue of taking consumers to an activity and not providing a case management service. This too is clearly stated as not billable.

**Citation:** 8 clients accompanied by 3 case managers traveled to Disney World.

**OMRDD Response:** May 1991 edition P. 42.

"You are not performing Case Management services when you are supervising recreational activities.

P.44.

Not Billable - Taking a group of persons residing in a CR, bowling.

June 1994 edition, P.10.

"Accompanying a person to the movies to assist in purchasing a ticket, or accompanying a person on a trip to assist with hotel and transportation matters are not reimbursable.

**Citation:** No documentation was available to support the claimed expense in almost one-quarter of the questionable services.

**OMRDD Response:** Documentation requirements are clearly stated in all editions of the manuals. (May 1991, P.35, June 1994, P. 15.).

The Commission also states that a related problem has been the routine rounding of service time to quarter hour units of service. OMRDD agrees that there was some misunderstanding about the billing calculations. Instructions for the calculation of Medicaid claims, including those for CCM, are contained in the MMIS Provider Manual prepared and distributed by DSS. Since the MMIS Provider Manual was the source for claiming information, OMRDD did not issue any instructions, regarding the calculation of units of service for MMIS claims, prior to the June 1994 CCM manual. In that edition, at the request of DSS, instructions for billing are given. These instructions for the calculation of the units of service were written for OMRDD by DSS staff, and are accurately quoted in the Commission's report.

Although OMRDD does not challenge that there are occurrences of inappropriate billing and that billing calculations may have been erroneously calculated by some providers, we do challenge the Commission's assumption that these problems "occurred because there were few instructions or meaningful monitoring --". CQC has clearly ignored and omitted the facts.

As evidenced by the statements above, training, instruction and technical assistance have always been available to CCM providers. Monitoring also has been ongoing in this program. Program reviews are done every six months, in accordance with the DSS requirements. The failure of the reviewers to find the errors that the Commission found may have to do with the sampling of cases. OMRDD has, however, prior to the issuance of the Commission's report, taken steps to improve the monitoring process. This will be addressed in more detail further on in this document.

### Overpayment to Voluntary Community Residence Providers

CQC stated the following: "...OMRDD developed a CMCM fee which reimbursed CR providers at 45 percent above their actual costs... Voluntary Operated programs continued to be reimbursed using the original blended fee which is inflated by the higher state cost components which were not removed when the state fees were split-off. As a result, voluntary agencies continued to be reimbursed through a fee that is 45 percent higher than their actual costs." This statement is inaccurate and misleading. The CMCM fee is based on information gathered prior to the inception of the CMCM program. Without reviewing current cost reports, OMRDD and CQC, for that matter, could not state that the current voluntary CMCM fee provides funds in excess of provider costs.

### Recommendations

1. CQC states that "OMRDD should enforce its regulation requiring that community residence payments for CMCM providers be adjusted by the 50 percent CMCM offset. OMRDD was always open about the fact that, as a deficit reduction program action, the recoupment of CMCM funds from community residences would not occur until OMRDD was comfortable with the claiming and billing data being provided by DSS. Initially, OMRDD did not have the DSS adjudicated claim information necessary to recoup the provider monies. As time passed, a policy decision was made to delay the recoupments because the savings were generated in other ways and because of the cash flow difficulties that community residence providers were facing. This was the result of the lack of trend factors in 1991 and 1992 and the loss of the trend factor between January and October 1993. OMRDD does not plan to recoup the monies at this point in time. If this decision necessitates a regulatory change, OMRDD will make the required revisions.
2. CQC states that "Federal requirements specifically state that separate payment cannot be made for case management services which are an integral and inseparable part of another Medicaid covered service. Since March 1, 1993, the non-'rent' portion of community residences which include case management services have been Medicaid funded. These same services are also funded under the CMCM fee. The Commission recommends that community residences no longer be permitted to separately bill Medicaid for case management services under the CMCM program."

This statement is absolutely untrue. The community residence methodology was revised effective March 1, 1993 to a fee methodology. When the methodology was developed, costs associated with case management services were excluded from total costs for fee development purposes. Therefore, community residence payments for services provided after March 1, 1993 are not inclusive of case management. Because of that, no offset is necessary when community residence providers bill for CMCM services after March 1, 1993.

3. CQC states that "In accordance with the State Plan, OMRDD should establish a new cost-based fee for voluntary providers which reflects the true cost of providing CMCM services. The fee should be based on the most recent cost reports filed with OMRDD ..."

The data cited by CQC as cost data for CMCM is data which was gathered three years before the program began and would be totally inappropriate for establishing a cost-based fee. OMRDD has not had sufficient cost data to update fees. Most community residence providers did not even start providing CMCM until 1992. The first and second year expenditures in a new program are not good fiscal foundations upon which to base fee calculations. There are often data aberrations associated with program start-up. The cost reports for calendar year 1994 were not even due to OMRDD until April 30, 1995. Obviously, we have had no time to analyze 1994 case management cost information. This finding by CQC is clearly without merit.

4. OMRDD has, as cited throughout this response, revised its CMCM manual to more clearly explain billable services and to give even more examples of the type of activities not appropriate for billing. This revised manual was distributed to all state and voluntary providers in June 1994. At that time training sessions were held at each DDSO for the CMCM coordinator and Quality Assurance staff. Sessions were also held at each DDSO for all providers of CMCM. These training sessions focused primarily on the clarifications of billable services and the billing guidelines. OMRDD will continue its practice of providing CMCM training sessions at varying locations around the state. Technical assistance continues to be available from both DDSO CMCM coordinators and Central Office staff.

In September 1994, OMRDD instituted a policy of more careful scrutiny of agencies applying to become CMCM providers. Upon acceptance, each provider must insure,

and verify to OMRDD Central Office, that agency staff have attended CMCM training. Only upon receipt of written verification of attendance at training will OMRDD designate an agency to DSS as a CMCM provider.

5. As stated in the response to the findings, OMRDD does not agree with the position taken by the Commission regarding the qualifications, as written, in the CMCM manuals. OMRDD believes that we always have required case management experience as a qualification for the position of CMCM case manager. Our position on this was stated in the section entitled "Case Manager Qualifications". However OMRDD has a strong commitment to training for all case managers. Although case management training is not a requirement for CMCM case managers at this time, OMRDD encourages all its case managers (CMCM included) to attend the CORE Case Management training program. This is a 2 day training program developed and presented by OMRDD which focuses on consumer based case management practices and the role and function of the case manager in the OMRDD service system. We believe that this two day training session provides our case managers with a strong foundation in the consumer based philosophy, as well as providing strategies for accessing and linking community supports and services for our consumers.
6. OMRDD has, through regulation (14 NYCRR, 671) and statements in the June 1994 CMCM manual, addressed the issues of choice of providers and services in the CMCM program. As part of our ongoing initiative to improve the quality of the CMCM program, we will add to the program review check list indicator(s) to monitor compliance with the freedom of choice issues.

As noted above, we did initiate in September 1994 more stringent training requirements for new CMCM providers. OMRDD will also add to the program review an indicator to assure that providers are distributing the manual and training all new case managers in the CMCM requirements.

OMRDD will continue to encourage all CMCM case managers to attend the OMRDD CORE Case Management training and will consider making this a mandatory requirement for certification as a CMCM case manager.

Finally, we want to point out that since August 1994, the program review process was expanded to include a more thorough review of the services claimed. Program surveyors must now review one month's claimed services for every case sampled, to assure that documentation is appropriate, and that the services claimed are in



fact "allowable" CMCM services. Statements of deficiency are issued when claims are not in compliance. Providers must respond with a plan of corrective action. When the service billed is found to be a non allowable service for Medicaid billing, the plan of correction must address the filing of an adjusted claim with MMIS.

OMRDD anticipates that the increased vigilance in the survey process and the clarifications given in the manual and in training sessions, will result in improved compliance and service quality in the CMCM program.

In conclusion, numerous findings and recommendations by CQC are either misleading or erroneous. It is recommended that CQC adopt accepted audit protocol similar to this methodology employed by staff, for state and private auditors. This would lead to more productive and effective audits and recommendations.

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# Attachment B

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NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

Brian J. Wing  
Acting Commissioner



Richard T. Cody  
Deputy Commissioner  
Division of  
Health and Long Term Care

SEP 25 1995

Mr. Clarence J. Sundram  
Chairman  
Commission on Quality of Care  
For The Mentally Disabled  
99 Washington Avenue, Suite 1002  
Albany, New York 12210-2895

Dear Mr. Sundram:

Thank you for the opportunity to comment on the March 1995 draft report "A Review of the OMRDD Comprehensive Medicaid Case Management System". For the most part, the observations were useful and support the ongoing efforts undertaken by this agency and OMRDD to configure the service in an efficient and efficacious manner. My comments are restricted to those interpretations that are not consistent with our knowledge of events.

The intention of the original proposal and State Plan Amendment was always to include, as potential case managed clientele, individuals living in the community in all settings including Community Residences, Family Care and "at home". The intention was to assess each client's need and determine a case management plan appropriate to that need irrespective of living arrangement. The conclusion of "minimal expansion" presumes that the clients in congregate care settings were not part of the original target for the service. This is not the case. This Department does agree with the position implied in your report that a reexamination of both target and level of service attached to individuals in congregate care settings should be undertaken. OMRDD has agreed to the reexamination and the issue will be a major activity of the Service Coordination Consolidation Task Force on which SDSS staff will serve.

On the issues of restriction of client choice, use of unqualified case managers, payment for unallowable services and duplicative billing: based on SDSS staff review and anecdotal reports from the field, SDSS and OMRDD staff undertook a review and revision of the policy and procedure manual to assure appropriate instruction to providers and OMRDD DDSO monitoring staff. Using the revised manual, OMRDD undertook provider and monitoring retraining in the autumn and winter of 1994. The retraining focused on the issues identified above.

SDSS has stated a position relative to the use of assisting staff in the performance of case management functions. Although it is not prohibited by federal rule, it is a policy that may allow for misuse and is difficult to monitor. This too will be an issue for discussion in the Task Force.

As to SDSS' contribution to "the development problems": all requests for allocation of slots were constructed by OMRDD. SDSS approved all requests until December 1993 when we denied the November 12th request and asked for demonstration of assurances that:

- o OMRDD's operation of CMCM was in compliance with the federally approved SPA relative to the assessment of need vs receipt of service based solely on a DD diagnosis.
- o OMRDD had committed sufficient resources for the operational function of training and monitoring CMCM.

Following the denial, OMRDD and SDSS instituted the review and monitoring actions described above and OMRDD has formed the task force on consolidation. No requests for additional slots have been received. Your staff have copies of the letters and correspondence mentioned above.

I feel confident that your final report will reflect an accurate interpretation of events.

Sincerely,



Richard T. Cody  
Deputy Commissioner  
Division of Health & Long Term Care

/BMc:clt

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# Attachment C

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STATE OF NEW YORK  
COMMISSION ON QUALITY OF CARE  
FOR THE MENTALLY DISABLED  
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COMMISSIONERS

December 8, 1995

Commissioner Thomas Maul  
Office of Mental Retardation  
and Developmental Disabilities  
44 Holland Avenue  
Albany, NY 12229

Dear Mr. Maul:

I am enclosing the final report of the Commission on Quality of Care into its study of the CMCM program. As you know, a draft of this report was shared with OMRDD on March 2, 1995. In your response of May 17, 1995, you expressed disagreement with several of the findings and made a number of factual assertions to the contrary.

As is the Commission's policy, we will append your letter of May 17, 1995 to the report so that readers may have the benefit of your views. I would be remiss in my duty, however, if I failed to note that the conclusory criticisms and assertions contained in your letter are unsupported by any factual evidence. They are also inconsistent with statements made by the Department of Social Services in its response letter. The Commission's specific comments on the points made in your letter are contained in the body of the final report.

In an attempt to verify the accuracy of the assertions made in your letter that CMCM costs were excluded in the development of community residence fees, CQC staff have requested supporting information from OMRDD. However, in the months since your letter, we have met with delays, evasions, promises and, ultimately, a failure to provide the substantiation requested. The Commission is forced to conclude that the requested information has not been provided either because there is no substantiation for the



position you have asserted, or that the available information would not support the claim you have made.

Overall, while your letter cites numerous examples of OMRDD policies and procedures, it fails to address the central finding of the Commission's review -- that the implementation of the CMCM program has resulted in a substantial degree of improper billings to the Medicaid program, and that duplicate payments to providers have resulted in several millions of dollars of unnecessary costs to taxpayers.

Finally, although you recommend that the CQC adopt "accepted audit protocols" employed by other auditing agencies, I note that despite specific requests to provide examples of such protocols, OMRDD has not provided the Commission with any for consideration.

This report is being filed pursuant to Article 6 of the Public Officers Law and is considered a public document.

Sincerely,

A handwritten signature in cursive script, appearing to read "Clarence J. Sundram".

Clarence J. Sundram  
Chairman

Enclosure