



**MEDI-CAL PROGRAM
COMPLIANCE REVIEW**

FOR PORTERVILLE DEVELOPMENTAL CENTER

Review Period: APRIL 1, 2007 through MARCH 31, 2008

**Client Financial Services
Department of Developmental Services**

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EXECUTIVE SUMMARY

In June 2008, Client Financial Services (CFS) completed Part I of a two-part compliance review of the Porterville Developmental Center (PDC) Trust Office and its administration of the Medi-Cal program. The purpose of Part I, the Medi-Cal compliance review, is to determine compliance with the requirements of the Medi-Cal program and the Medi-Cal standards set forth by the CFS manual, and ensure maximum reimbursement under the Medi-Cal program. This report addresses related findings from the Part I review.

Part II of the review, the Trust Office compliance portion, reviews Trust Office operations and compliance with other legal and policy issues. The Part II review will be conducted in Fiscal Year 2008-09 and discussed in a separate report. The delay is due to staffing issues and the necessity to redirect Trust Coordination efforts to the implementation of drug billing under Medicare Part D.

For the Medi-Cal Compliance Review, the CFS Review Team reviewed a sample of consumer files and ledger trust accounts for the period April 1, 2007 through March 31, 2008. This review checked for compliance with key federal Medicaid and state Medi-Cal regulations, and with federal and state licensing regulations, the State Administrative Manual (SAM), and the State Controller's Office procedures with regard to consumer funds and property.

The Review Team found that, overall, the PDC Trust Office complies with the Medi-Cal program requirements and the standards set forth by CFS with regard to consumer funds. Eleven of the areas reviewed were 100 percent compliant with Medi-Cal requirements, but the respective report sections contain discussion addressing circumstances related to the area or recommendations for maintaining 100 percent compliance. No corrective action is needed in these areas. However, the review revealed three other areas that were not 100 percent compliant, and where program adherence or administrative and operational controls should be improved. Corrective action on those related findings will help to prevent further issues from arising, including incorrect Medi-Cal reimbursements, penalties for noncompliance with Medi-Cal requirements, or loss of participation in the Medi-Cal program.

- Primary Insurance Queries
The Trust Office did not have documentation to show that annual insurance queries had been sent out during the last 12 months for 13 consumers.
- Share of Cost (SOC) – Calculating, Reporting, and Input
Four consumers' SOC amounts shown on CRS accounts receivables did not match the respective monthly SOC shown in the Medi-Cal Eligibility Data System (MEDS).
- Asset Limits
One consumers' ledger showed account balances in excess of \$2,000 for duration of 12 consecutive months before being spent down by the Trust Officer.

A Plan of Correction (POC) addressing the findings in these three areas is required to be submitted to CFS within 60 days of the date of the report's transmittal letter. Attention to these areas is considered essential to ensure the facility's ongoing compliance with important Medi-Cal program requirements, and ensure that these areas of concern are corrected prior to a Department of Health Care Services (DHCS) audit.

Please review the attached report and if you have any comments, questions, or wish to provide additional information that could impact the findings, please contact CFS Medi-Cal Auditors Lesli McClung-Coombs at (916) 657-0035, or Peggy Peter at (916) 654-3376.

The Review Team and CFS would like to take this opportunity to commend the Trust Office staff on their professionalism and expertise. The Trust Office staff demonstrates that it strives to put the consumer first, and is instrumental in providing quality service and maintaining the integrity of services provided to PDC consumers.

PURPOSE OF MEDI-CAL AND TRUST OFFICE COMPLIANCE REVIEW

The Department of Developmental Services (DDS) is committed to providing leadership that facilitates the provision of quality services to the people of California and assures the opportunity for individuals with developmental disabilities to exercise their right to make choices. DDS carries out this commitment in part through its developmental centers (DC) and through its state operated community facilities (SOCF). The DC's are licensed and certified acute care hospitals with distinct areas licensed and certified as Skilled Nursing Facility (SNF) and Intermediate Care Facility/Mentally Retarded (ICF/MR), while the SOCF's are licensed only as ICF/MR.

The DC's and SOCF's provide intensive 24-hour services and active treatment, including residential services, social skills training, activities-of-daily-living training, specialized healthcare, and specialized therapies. These services are supplemented, as needed, with medical, dental, nursing, and a wide variety of other specialized services such as physical therapy, occupational therapy, speech therapy, and language development. Individuals with medical conditions receive special supervision and medical and nursing care in SNF units.

Major funding for the DC's and SOCF's comes from reimbursement to the DDS budget by the Medi-Cal program. Eighty-five percent of the cost of operating the DC's and the SOCF's is paid by Medi-Cal. The Medi-Cal program is administered by DHCS, which is designated as the single state agency for this purpose as required by the federal Social Security Act (SSA). DDS is responsible for providing assurance to the DHCS and the federal Centers for Medicare and Medicaid Services (CMS) that DDS's bills for Medi-Cal program services are in accordance with the applicable sections of the California Welfare and Institutions Code (WIC), and with Title 19 of the federal SSA.

To ensure this outcome, CFS conducts regular and ongoing compliance reviews of the DC Trust Offices to identify federal program and other compliance issues, to determine training needs, to improve application of policies and procedures, and to maintain a close working relationship with the Trust Office staff. These reviews are conducted under the authority of Title 42, Volume 2, Chapter IV, Section 435.904 of the Code of Federal Regulations (CFR); WIC, Section 14157; and, SSA, Section 1902(a)(55). The criteria used for the reviews are cited in WIC, Section 14157; the California Code of Regulations (CCR), Title 17, Title 19, and Title 22; the Medi-Cal Provider Manual and related All-County Letters; the State Administrative Manual (SAM); the CFS Manual; and the Trust Accounting and Procedures Manual.

The overall goal of the reviews is to proactively identify problems before they lead to more serious issues that could result in adverse audit findings, citations, loss of program eligibility and federal funding, or monetary penalties as determined by federal agencies including the CMS, the Office of the Inspector General, the Department of Justice, and/or state agencies including the DHCS, Department of Finance, the Bureau of State Audits, and the Department of Industrial Relations.

The compliance reviews are conducted in two parts. Part I, the Medi-Cal compliance review, evaluates compliance with the requirements of the Medi-Cal program and the Medi-Cal standards set forth by the CFS manual to ensure maximum reimbursement under the Medi-Cal program. Part II, the Trust Office compliance portion, reviews Trust Office operations and compliance with other legal and policy issues. The results of the Part I and II reviews are reported to provide information for the DC's and SOCF's regarding areas the Review Team finds to be compliant with program requirements and trust operating procedures, and information where procedures are noncompliant or place the department and facility at risk.

Where deficiencies are discovered, recommendations to correct the deficiencies are included in the reports.

SCOPE AND METHODOLOGY

A) Review Period and Sample

For the Medi-Cal compliance review, the Medi-Cal Program Review Team reviewed a sample of the facility's consumer accounts for the period of April 1, 2007 through March 31, 2008. The sample consisted of 42 PDC consumers' Medi-Cal and related trust records, which is 10 percent of all consumers at PDC whose services are being billed to Medi-Cal. The 42 sampled consumers included two consumers newly admitted within 12 months of the date of the review; 38 consumers with ongoing residential status; and two consumers who had been discharged within six years of the review period. This was a stratified random sample that included consumers in proportion to the percentage of all consumers receiving Acute, SNF, and ICF/DD level of care services.

For the Trust Office compliance review, Trust Coordination staff will review a representative sample of trust accounts for a specified period. These accounts will include those identified as having trust balances below \$25 with an emphasis on those that show a negative balance, and those with balances above \$1,800 with emphasis on those above \$2,000, which would cause consumers on Medi-Cal to become ineligible for benefits.

B) Compliance Review Process

One of the goals of the CFS section at DDS headquarters (HQ) is to complete annual compliance reviews at each facility. The process is as follows:

1. Two and a half weeks prior to the intended review date, the CFS Review Team contacts the Trust Office to notify them of the upcoming review. The availability of the Trust Officer is discussed and the review date may be moved back an additional two weeks to accommodate availability and staffing needs of the Trust Office.
2. Two weeks prior to the actual review date, the following takes place in sequential order:
 - i. The CFS Review Team sends a letter to the facility's Executive Director and the Trust Officer advising them of the upcoming review and the review date.
 - ii. The Review Team contacts the Trust Officer and requests a copy of the Trust Account Balance Analysis report. Upon receipt of that report, the Review Team reviews it and selects consumers' records to be reviewed. The Review Team then contacts the Trust Officer to have copies of the ledgers for the selected group of consumers sent to HQ for preliminary review.
 - iii. The Review Team reviews the Medi-Cal billings for the review period and selects a stratified random sample of consumers' names from those billings. The Review Team then contacts the Trust Officer and requests the ledgers for the sample selected; copies of MEDS for the sample if the records cannot be obtained from MEDS directly at HQ; copies of Treatment Authorization Requests (TAR) for the sample selected for review; and, information regarding new admissions to the facility. Preliminary review of these documents is done at HQ prior to the actual visit to the facility. Any additional

documentation required for review will be requested upon arrival at the Trust Office.

3. Upon arrival at the facility, the CFS Review Team holds an entrance conference with the facility's Executive Staff. The Review Team outlines the items to be reviewed and answers any questions or concerns brought up by the Executive Staff.
4. The review is undertaken to include reviews of records, interviews with staff, and a review of consumer property. The Review Team reviews the documentation, work processes, and consumer property to check compliance with areas summarized in the table below.
5. At the end of the review, the CFS Review Team holds an exit conference and provides a verbal preliminary report to the Executive Staff regarding the team's findings.
6. Following the exit conference, the CFS sends a hard copy preliminary report to the Executive Staff at the facility.
7. For 45 days following the date of the transmittal letter accompanying the preliminary report, the Executive Staff has the opportunity to contact the Review Team, or the team's managers, to discuss any questions, make comments, or provide additional information pertinent to the findings and recommendations made in the preliminary report. As a result of that contact, the report may be revised.
8. After the preliminary report review period, or upon completion of CFS consideration of any additional comments and information, the report is considered final. The facility's Executive Staff then has 60 days from the date of the report transmittal letter to submit a Plan of Correction (POC) to CFS.
9. Once the POC is accepted by CFS, a final report package that includes the POC is assembled and sent to all concerned parties. This package is sent within 30 days of the CFS acceptance of the POC. Review of the findings and POC are included as part of the scope of the next compliance review of the facility.
10. Ninety (90) days after the date of the final report package transmittal letter, CFS follows up on the progress the facility has made in implementing the POC.
11. The CFS completes the 90 day follow-up by reviewing CRS transactions and contacting the Trust Office regarding POC status.

The following Medi-Cal Program and Trust Office categories are reviewed:

Part I: Medi-Cal Program Review	
1.	Records Retention and Access
2.	Documentation in CRS Billing System
3.	Queries for Changes in Primary Insurance
4.	Medi-Cal Eligibility – Application and Monitoring
5.	Inter-County Transfers
6.	Share of Cost – Calculating, Reporting, and Input
7.	Asset Limits – Monitoring, Spend-Downs, and Reporting
8.	Aid Codes
9.	Legal Class
10.	Treatment Authorization Request (TAR) Requirements
11.	Leave Monitoring and Reporting
12.	Change in Medi-Cal Status Notification
13.	Use of Medi-Cal Indicator Reports
14.	Work Functions Funded by Medi-Cal

Part II: Trust Office Review	
15.	Records Retention and Access
16.	Interaction with CRS Billing System
17.	Queries for Changes in Primary Insurance (Non-Medi-Cal Consumers)
18.	Account Balances – Insufficient Funds
19.	Personal and Incidental (P&I) Funds for Medically Indigent
20.	Personal Property Audits
21.	Encumbrance Process
22.	Purchase Ordering Process
23.	Procedures for Discharged and Deceased Consumers' Accounts
24.	Cashiering Process
25.	Field Referral Process
26.	Authorization to Access and Use Consumer Funds
27.	Cost of Care

FINDINGS AND RECOMMENDATIONS

This section of the report discusses our findings and recommendations for each of the 14 Medi-Cal Program areas examined. For those areas showing 100 percent compliance, no corrective action is needed. However, the corresponding report sections may contain discussion addressing circumstances related to the area or recommendations for maintaining 100 percent compliance in the area. For the remaining areas where 100 percent compliance was not achieved, corrective action is needed. The format for the corrective action is specified on page 23 of this report.

Compliance Review Categories	Compliant (Percent of Sample)	Not Compliant (Percent of Sample)
Part I: Medi-Cal Program Review		
1. Records Retention and Access	100 %	0 %
2. Documentation in CRS Billing System	100 %	0 %
3. Queries for Changes in Primary Insurance	66 %	34 %
4. Medi-Cal Eligibility – Application and Monitoring	100 %	0 %
5. Inter-County Transfers	100 %	0 %
6. Share of Cost – Calculating, Reporting, and Input	89 %	11 %
7. Asset Limits – Monitoring, Spend-Downs, and Reporting	97 %	3 %
8. Aid Codes	100 %	0 %
9. Legal Class	100 %	0 %
10. Treatment Authorization Request (TAR) Requirements	100 %	0 %
11. Leave Monitoring and Reporting	100 %	0 %
12. Change in Medi-Cal Status Notification	100 %	0 %
13. Use of Medi-Cal Indicator Reports	100 %	0 %
14. Work Functions Funded by Medi-Cal	100 %	0 %

Part II: Trust Office Review	Findings will be discussed in a later report.	
15. Records Retention and Access		
16. Interaction with CRS Billing System		
17. Queries for Changes in Primary Insurance (Non-Medi-Cal Consumers)		
18. Account Balances – Insufficient Funds		
19. Personal and Incidental (P&I) Funds for Medically Indigent		
20. Personal Property Audits		
21. Encumbrance Process		
22. Purchase Ordering Process		
23. Procedures for Discharged and Deceased Consumers' Accounts		
24. Cashiering Process		
25. Field Referral Process		
26. Authorization to Access and Use Consumer Funds		
27. Cost of Care		

1. Records Retention and Access

Criteria

United States Code (USC) Title 31, Subtitle III, Chapter 37, Subchapter III, Section 3731(b), False Claims Procedure, states, "A civil action may not be brought...more than ten (10) years after the date on which the violation is committed."

Code of Federal Regulations (CFR), Chapter 42, Section 489.20(f), states, "The provider agrees to maintain a system that, during the admission process, identifies any payors other than Medicare, known as Medicare Secondary Payors (MSP), so that incorrect billing and Medicare overpayments can be prevented. Hospitals must document and maintain MSP information for Medicare beneficiaries. Since CMS may pursue providers, physicians, and other suppliers under the False Claims Act and the Federal Claims Collection Act for up to ten (10) years after a claim is paid, it is prudent for hospitals to retain all billing related records for ten (10) years."

WIC Section 14124.795, states, "It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has other available health coverage or insurance, the Medi-Cal program shall be the payor of last resort."

Condition

The Review Team reviewed 38 files of current residential consumers, and two files of consumers who had been discharged from PDC within six years of the review period. All 40 consumer files contained documentation of transactions processed by the Trust Office from the date of admission through the review period. There were no findings in this area.

2. Documentation in CRS Billing System

Criteria

CFS Manual Section 1000 states, "CFS determines need for and provides broad management review of Trust Office activities to ensure that overall obligations and objectives of the Department are met in accordance with provisions of WIC and other applicable laws and regulations." This function includes review of federal, state, and other programs to ensure that the Trust Office is meeting the requirements of those programs to maximize reimbursements and revenues. In addition, CFS' review of Trust Office activities minimizes the risk of audit findings that could lead to penalties for noncompliance, including fines and loss of participation in those programs.

In this regard, CFS requires that actions and contacts made by the Trust Office concerning consumers' cost of care and related billings are thoroughly documented on CRS. Contacts that require specific and detailed memos include discussions or work steps concerning liability, program eligibility, initial input, and changes affecting consumers' continued eligibility or billing, as well as any other information regarding the determination of consumers' ability to pay. Documentation is made on the CRS Post Third Party Payor Memo or Post Payor Memo screens, as applicable.

Condition

The Review Team reviewed CRS Third Party Payor Memo screens for 38 current residential consumers' files to determine whether notes were posted in each consumer's Third Party Payor Memo screen to clearly reflect actions, contacts, and significant circumstances regarding consumer accounts as they affect Medi-Cal billing. The Review Team also interviewed Trust Office staff regarding CRS note-posting policies and practices to determine whether their work flow included posting notes. Based on the selected sample and interviews with staff, the Review Team concluded that notes were posted appropriately in CRS to reflect circumstances affecting consumers' accounts related to Medi-Cal billing. There were no findings in this area.

3. Queries for Changes in Primary Insurance**Criteria**

CFR, Chapter 42, Section 489.20(f), states, "The provider agrees to maintain a system that, during the admission process, identifies any payors other than Medicare, known as Medicare Secondary Payors (MSP), so that incorrect billing and Medicare overpayments can be prevented. Hospitals must document and maintain MSP information for Medicare beneficiaries. Since CMS may pursue providers, physicians, and other suppliers under the False Claims Act and the Federal Claims Collection Act for up to ten (10) years after a claim is paid, it is prudent for hospitals to retain all billing related records for ten (10) years."

WIC Section 14023.7 states, "Any provider of services seeking payment for health care services for a person eligible for these services [Medi-Cal]...shall first seek to obtain payment from any private or public health insurance coverage to which the person is entitled, where the provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to the department for the payment of any unpaid balance for these services."

CCR Section 50185(a)(4), Applicants' and Beneficiaries' General Responsibilities, states, "As a condition of [Medi-Cal] eligibility, applicants and beneficiaries, and persons acting on behalf of applicants and beneficiaries, shall report the following facts to the county department that may affect the determination of eligibility: ...and, change in other health care coverage."

CFS Manual Section 1001 (2) states, "The Trust Officer shall secure for the consumers those benefits to which they may have entitlement."

CFS Manual Section 6125(A) 1-5, Third Party Liability, states, "Third party payors represent sources of payment for consumer services which may offset Medi-Cal payments. Every effort must be used to identify and bill all potential third party payors." Third party payors include Medicare, Veterans Administration, CHAMPUS, group insurance, and private insurance.

Condition

The Review Team reviewed 38 files of consumers with residential status for at least one year to determine whether the Trust Office queried parents, guardians, or conservators annually for updated third party insurance coverage apart from Medi-Cal. The review disclosed that 25 of the sampled consumers' files contained documentation of insurance queries sent out within a year of the review. The remaining 13 files did not contain any documentation of insurance queries sent out within the last year.

Cause

The Trust Office is not adequately monitoring that annual insurance queries are sent out to determine whether consumers are newly covered by insurances apart from Medi-Cal.

Effect

DDS risks overbilling Medi-Cal if the Trust Office is unaware of consumers' new insurance benefits. This would be a DHCS finding or a finding determined by CMS.

Recommendation

The Trust Officer should ensure that annual insurance queries are sent out and that every effort is made to secure consumers' eligibility for other insurances prior to billing Medi-Cal.

4. Medi-Cal Eligibility - Application and Monitoring**Criteria**

CCR Section 50147(a) states, "A person or family applying for Medi-Cal only shall submit a completed application form to the county department."

CCR Section 50148(a) states, "A person or family applying for retroactive Medi-Cal shall submit a completed application form to the county department, if the application is for retroactive coverage only. If the request for retroactive Medi-Cal is made in conjunction with, or after, an application for public assistance or Medi-Cal, the retroactive coverage request shall be submitted either on the application form, on the Statement of Facts, or by submitting a written request."

CCR Section 50148(b) states, "An application for retroactive Medi-Cal coverage must be submitted within one year of the month for which retroactive coverage is requested."

CCR Section 50197(b) states, "The request for retroactive Medi-Cal eligibility shall be made in accordance with Section 50148(a) and (b), and shall be treated as any other application, except that persons applying on the basis of disability shall have their disability determined prior to determining retroactive eligibility."

CCR Section 50189(a) states, "Persons or families determined to be eligible for Medi-Cal shall have their eligibility re-determined at least once every 12 months."

As a result of audit negotiations between DDS and DHCS, the CFS has agreed to monitor Medi-Cal eligibility monthly via DHCS MEDS.

Condition 1 – Initial Applications

The Review Team reviewed a sample of two files of consumers newly admitted to the PDC during the review period to determine whether county-generated Medi-Cal applications were on file. The Review Team also reviewed CRS entries to confirm that the consumer's statuses were correctly entered in CRS at the time of admission. The review revealed that the consumer files contained copies of the county-issued Medi-Cal application and documentation of the Medi-Cal eligibility start date. The review also showed that CRS entries for the newly admitted consumers showed accurate Medi-Cal eligibility status. Based on the selected sample, there were no findings in this area.

Condition 2 – Annual Redeterminations

The Review Team reviewed 36 files of ongoing residential consumers to determine whether the Trust Office performed an annual Redetermination for Medi-Cal Beneficiaries (Form MC 262) for assessing consumers' continued Medi-Cal eligibility. The review revealed that Form 262 had been sent out during the last 12 months for 27 consumers. However, the review revealed that redeterminations had not been sent out during the last 12 months for 11 consumers who receive Social Security Income (SSI).

Cause

The Trust Office did not send annual Medi-Cal redeterminations for the 11 consumers because no notification for a redetermination for these consumers had been received from the Social Security Administration. The Social Security Administration notifies the Trust Office when redeterminations are needed for specific consumers who receive SSI. According to the Trust Officer, the Social Security Administration does not request redeterminations for long-term residential consumers who have had no change in level of care. The Trust Office does not send redeterminations for consumers receiving SSI unless notified to do so by the Social Security Administration.

Effect

Due to the 11 consumers being SSI recipients, there is not effect.

Recommendation

The Trust Office should continue to complete annual redeterminations for consumers who do not receive SSI to maintain ongoing Medi-Cal eligibility. In addition, the Trust Office should continue to complete annual redeterminations for those consumers on SSI, as requested by the Social Security Administration.

Condition 3 – Medi-Cal Eligibility Monitoring

The Review Team also reviewed MEDS for the selected sample of two newly admitted consumers and 36 ongoing residential consumers to determine whether MEDS reflected Medi-Cal eligibility shown in CRS during each month of the review period. Based on the selected sample, the Review Team concluded that the Trust Office is monitoring consumers' ongoing eligibility for Medi-Cal on a monthly basis. There were no findings in this area.

5. Inter-County Transfers

Criteria

CCR Section 50136(a) states, "An inter-county transfer shall be initiated if persons or families receiving Medi-Cal-only become the responsibility of a new county." The section further specifies inter-county transfer responsibilities and procedures, and states the beneficiary's responsibility to apply for a re-determination in the new county of residence.

CCR Section 50185(a)(4)(11) states, "As a condition of eligibility, applicants and beneficiaries, and persons acting on behalf of such applicants or beneficiaries, shall... promptly notify the county department which initially established Medi-Cal eligibility of any changes in residence from one county to another within the state and apply for a redetermination of eligibility within the new county of residence. 'Apply for a redetermination of eligibility,' as used in this section, is defined as any clear expression to the county department, whether verbal or written, that the beneficiary is living in the county and wishes to continue receiving Medi-Cal."

CCR Section 50129 states, “The county of responsibility for determining Medi-Cal eligibility for persons placed in state hospitals after screening and referral by a county mental health agency or a regional center for the Developmentally Disabled shall be the county in which the state hospital is located, unless the person's eligibility is determined as part of a family or based on family income.”

CCR Section 50120(a) states, “The county of responsibility shall be the county whose county department is responsible for determining the initial and continuing Medi-Cal eligibility for a person or family.”

CCR Section 50127(a) and (b) state, respectively, “The county of responsibility for [Medi-Cal] persons with a county public guardian shall be the county in which the public guardian is located except that if the person is physically present in another county and the new county will accept a transfer of guardianship, the new county shall be the county of responsibility;” and, “The county of responsibility for persons with a private guardian or persons with a guardian employed by the state shall be established as if there were no guardian, provided the ward is a resident of the State.”

Condition

The Review Team reviewed 38 consumer records in MEDS to ensure that no consumers were assigned county codes apart from the county where the facility is located. The review disclosed that all of the consumers in the selected sample were assigned the appropriate county code, and no consumers were receiving Medi-Cal from a county other than the one in which the PDC is located. There were no findings in this area.

6. Share of Cost – Calculating, Reporting, and Input

Criteria

WIC Section 14005.7(d) states, “In the case of a medically needy person or state-only Medi-Cal person, monthly income in excess of the amount required for maintenance established pursuant to WIC section 14005.12...shall be the share of cost.”

WIC Section 14005.12(d)(1) defines the amount required for maintenance for a patient in a medical institution or nursing facility as “Personal and incidental needs in the amount of not less than thirty-five dollars (\$35) per month while a patient.”

WIC Section 14005.13 (a) and (b), respectively, state, “Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a share of cost for services under this chapter due to income which exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt; and, “The amount of earned income from therapeutic wages which shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level for a non-institutionalized person.”

WIC Section 14110.8(e) states that the health care facility shall make a reasonable attempt to contact the county to obtain an estimate of the correct share of cost for Medi-Cal coverage.

CFS Manual Section 1000 states, “CFS determines need for and provides broad management review of Trust Office activities to assure that overall obligations and objectives of the Department are met in accordance with provisions of WIC and other applicable laws and regulations.” In this regard, CFS requires that changes to consumer share of cost be documented in the CRS Post Third Party Memo screen, including but not limited to, the effective date of change to the share of cost, the previous share of cost being replaced, and the reason for the change.

Condition 1

The Review Team reviewed the consumers’ ledgers for 38 sampled cases to determine that the SOC had been calculated correctly based on consumer income for each month of the review period. The Review Team determined that all consumers’ ledgers showed SOC calculated correctly. There were no findings in this area.

Condition 2

The Review Team reviewed the CRS accounts receivable records for 38 sampled cases to determine that the correct SOC had been billed for each month of the review period. The SOC shown on each receivable was compared to the SOC shown on corresponding monthly MEDS. The Review Team determined that four consumers in the sample had receivables that showed a SOC that did not agree with the approved SOC shown in MEDS.

Cause

The Trust Office is not consistently monitoring the consumers’ monthly SOC in MEDS and updating SOC amounts in CRS as changes occur.

Effect

The four consumers were incorrectly billed for the SOC, which required manual adjustments by HQ staff.

Recommendation

The Trust Office should consistently monitor monthly MEDS data for SOC changes, and update CRS when changes occur.

7. Asset Limits – Monitoring, Spend-Downs, and Reporting

Criteria

CFR, Title 20, Section 416, Supplemental Security Income for the Aged, Blind, and Disabled, subd.1205, Limitation on Resources, states, “An aged, blind, or disabled individual with no spouse is eligible for benefits under Title 21 of the Social Security Act if his or her non-excludable resources do not exceed \$2,000 after January 1, 1985. “

WIC Section 14006.4 states, “An unmarried resident is financially eligible for Medi-Cal benefits if he or she has less than \$2,000 in available resources.”

CFS Manual Section 1150 states, “It may be necessary to reduce [spend down] a consumer’s assets to establish or maintain Medi-Cal eligibility.”

Social Security Legislative Bulletin No 108-10R, effective March 4, 2004, states that representative payees “shall not count funds due for back payments as a consumer’s resources for a period of nine months.” This essentially means that a consumer’s funds must be spent down within nine months before those funds are considered assets for the purpose of Medi-Cal eligibility.

CCR, Title 22, Section 50185(a)(4)(B), Applicants’ and Beneficiaries’ General responsibilities, states, “As a condition of eligibility, applicants and beneficiaries, and persons acting of behalf of such applicants and beneficiaries, shall report [change in property or income] to the county department that may affect the determination of eligibility and share of cost within ten (10) calendar days following the date the change occurred.”

CFS Manual Section 12001 states, “It shall be the function of the Trust Officer to locate, protect, and preserve assets of the consumers, and administer those assets received at the facility in a fiduciary capacity implying great confidence, trust, and good faith.”

Condition

The Review Team reviewed 38 consumers’ account ledgers to determine whether monthly balances exceeded \$2,000. The review disclosed that 37 consumers’ ledgers showed balances within the \$2,000 limit, but one consumer’s assets exceeded \$2,000 for a 12-month period from March 30, 2007 to March 24, 2008.

Cause

The following occurred from August 2006 to March 2007:

- August 2006: The Trust Office received correspondence from the Social Security Administration, dated August 10, 2006, stating that \$3,860 in SSI benefits had been overpaid to the consumer and needed to be repaid. Trust Office staff believed the letter was sent in error because the consumer’s ledger showed assets below \$2,000. At this time, the Trust Officer was on an extended leave and staff placed the letter in the consumer’s file rather than on the Trust Officer’s desk for monitoring.
- March 2007: The Trust Office received the consumer’s March 30, 2007 bank statement that showed two SSI deposits for \$3,060 and \$800, respectively, which totaled the \$3,860 that the Social Security Administration claimed as overpayment in August 2006. The consumer’s bank statements did not show any SSI deposits for \$3,860 from August 2006 to February 2007.
- April 2007: The Trust Office posted the \$3,860 deposit to the consumer’s ledger on April 13, 2007.
- May 2007: The Trust Office transferred \$3,060 of the \$3,860 from the ledger’s current balance to the encumbered balance on May 23, 2007, to reduce the ledger’s available balance. On May 24, 2007, the Trust Office reversed the transaction and the \$3,060 was transferred back to the ledger’s current balance.
- June 2007: The Trust Office transferred \$2,500 from the ledger’s main balance into the encumbered balance, where it remained until March 24, 2008. Although the ledger’s available balance showed less than \$2,000, the consumer’s assets continued to exceed \$2,000.

- March 2008: The Trust Office paid \$1,132 in excess assets on behalf of the consumer to the Social Security Administration on March 24, 2008, and reduced the consumer's assets to below \$2,000 for the first time since March 30, 2007.

Effect

A DHCS audit conducted at the time a consumer's account balance exceeds \$2,000 for longer than the allowable nine-month spend down period puts the consumer at risk for losing Medi-Cal eligibility.

Recommendation

The Trust Office should continue to monitor consumers' monthly account balances to ensure that consumers' assets do not exceed \$2,000 for longer than nine months, and spend down assets within a nine-month period. In addition, the Trust Officer should ensure that Trust Office staff is trained to closely monitor consumers' bank accounts and ledger balances when overpayment notices are received from the Social Security Administration.

8. Aid Codes

Criteria

Aid codes identify the scope of benefits for which consumers are eligible, and applicable levels of federal financial participation (FFP) in payments for services provided. Some aid codes only provide for a limited scope of benefits, while other aid codes indicate that services are reimbursable with state-only funding. By monitoring consumers' aid codes, the Trust Office ensures that CRS does not bill for services to which a beneficiary is not Medi-Cal entitled, and prevents generating claims that would fall under the False Claims Act. Monitoring also ensures that the state maximizes federal funds by reasonably requesting aid codes with FFP in lieu of state-only funded aid codes.

Condition

The Review Team reviewed 38 consumers' aid codes recorded in MEDS and compared them to the aid codes recorded in CRS to determine whether the aid codes were appropriately assigned to each consumer. The Review Team determined that all 38 consumers' aid codes were accurately recorded in CRS and matched the aid codes shown in MEDS. There were no findings in this area.

9. Legal Class

Criteria

CFS Manual Section 850 states, "The Legal Class Code Chart contains all legal class codes that may possibly be encountered...and is used to determine how to bill for consumers based on their legal class...and whether the legal class is Medi-Cal billable. The legal class codes are also divided between those which may be used only for mental health facilities or developmental centers."

CFS Manual Section 6150 (A), Legal Class Codes, states, "CRS legal class codes are utilized to determine Medi-Cal eligibility...these codes may be consulted if a question of legal status arises during the application process."

CFS Manual Section 6150 (B) states, "CRS does not automatically stop billing when a legal class code is changed to a non-eligible code, and change from a non-eligible code to an eligible code may require action by the Trust Office staff. These actions may include requests for TAR approval, application for Medi-Cal, and initiation of billing. Further, appropriate entries to the CRS Insurance Verification screen must also be made and noted in the CRS Post Third Party Payor Notes screen."

Condition

The Review Team reviewed 38 consumers' legal classes recorded in CRS to determine whether the legal classes were appropriately assigned to each consumer as Medi-Cal billable. Based on the selected sample, the Review Team determined that the consumers' legal classes posted to CRS were Medi-Cal billable. There were no findings in this area.

10. Treatment Authorization Request (TAR) Requirements

Criteria

CCR Title 22, Section 51003 requires that "Prior authorization be granted by a designated Medi-Cal consultant in advance of rendering a service after appropriate medical, dental, or other review." The prior authorization is documented on a Treatment Authorization Request (TAR) for treatments provided by an Acute Care Facility, Intermediate Care Facility, and Skilled Nursing Facility.

CFS Manual Section 6226 (A) (1), Prior Authorization, states that all Medi-Cal billing is subject to prior authorization, and that a "TAR will be initiated by the hospital program directors or designee." Section 6226 further states, "The Trust Office staff is responsible for reporting the accuracy of the Medi-Cal billing days" and "Efforts will be made by the Trust Office to follow each program for TAR documentation so that Medi-Cal can be billed or for current billing."

Condition

The Review Team reviewed 38 consumer files to ensure there was TAR documentation for the level of care billed to Medi-Cal during the review period. The Review Team compared TAR documentation for each consumer with room occupancy records in CRS Medical Abstract Screens. The review disclosed that all 38 consumers had TAR documentation to support the level of care billed to Medi-Cal during the review period. There were no findings in this area

11. Leave Monitoring and Reporting

Criteria

CCR Section 51335(i), Skilled Nursing Facility (SNF) Services, states, "Leave of absence from SNF is covered [by Medi-Cal] for a maximum of 73 days per calendar year for developmentally disabled patients."

CCR Section 51353(o), Intermediate Care Facility (ICF) Services for the Developmentally Disabled, states, "Leave of absence from ICF for the developmentally disabled is covered up to a maximum of 73 days in a calendar year for developmentally disabled Medi-Cal inpatients."

CCR Section 52535(c) states, "The patient's records maintained in SNF and ICF shall show...the inclusive dates of leave." Therefore, it is essential for the Trust Office to maintain ongoing tracking of all consumers' leave dates to ensure that each consumer's leave period in a single calendar year does not exceed 73 days.

CCR Section 50185(a)(3), Applicants' and Beneficiaries' General Responsibilities, states, "As a condition of Medi-Cal eligibility, applicants and beneficiaries, and persons acting on behalf of applicants and beneficiaries, shall report all facts [to the county department] that are pertinent to the determination of eligibility." Therefore, the Trust Office must report to the county department those consumers whose leave exceeds 73 days in a calendar year as a factor affecting Medi-Cal eligibility.

Condition

The Review Team interviewed Trust Office staff to determine the type of tracking system in place for monitoring consumers' leave periods and reviewed the 38 consumers' tracking logs for days in excess of 73 days. The Review Team determined that the Trust Office has a leave tracking system in place for monitoring consumers' cumulative leave days, and none of the sample consumers had exceeded 73 leave days at the time of the review. Based on the selected sample, the review disclosed that the Trust Office is adequately monitoring consumers' annual leave periods. There were no findings in this area.

12. Change in Medi-Cal Status Notification

Criteria

CCR Section 72527 "Patients' Rights" states, "a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right: ...2) To be fully informed, prior to or at the time of admission and during stay, or services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act." In light of this requirement, procedures should be in place to notify patients who are moved between certified and uncertified units within the facility, or to notify patients whose stay is denied for coverage by the Medi-Cal program, that the Medi-Cal program is not paying for their cost of care.

Condition

The Review Team interviewed the Trust Office staff to determine whether the facility has notification procedures in place, and whether appropriate notifications were made for any instances of changes to consumer Medi-Cal eligibility or any periods of ineligibility for the sampled 38 consumers. The Review Team determined that none of the selected consumers had any changes or interruptions to their Medi-Cal eligibility during the review period. Based on the selected sample, there were no findings in this area.

13. Use of Medi-Cal Indicator Reports

Criteria

Indicator reports are generated by the CRS. These reports reflect many aspects of consumer eligibility and billing as they relate to the Medi-Cal program and CRS where the potential for missed or incorrect billings exists. Many reports are designed to isolate potential problems that are the subject of this compliance review such as: consumers not rated or verified for Medi-Cal billing; incorrect county, aid, and legal class codes; and, consumers whose insurance is expiring. These reports are provided to the Trust Office as tools to maintain the integrity of the claims to the Medi-Cal program. The Trust Officer and Trust Office staff should be familiar with these reports, understand the information presented, and know how to resolve the issue specific to the report for each consumer appearing on it.

Condition

The Review Team interviewed the Trust Officer to determine whether eight CRS indicator reports are reviewed on an ongoing basis to maintain adequate management of consumer accounts. The Review Team also reviewed one of the indicator reports, the Medi-Cal Beneficiary ID Verification Report (Report CP775BC), generated on March 10, 2008, and determined that four of the 38 sampled consumers were listed on the report. The Review Team reviewed CRS screens for the four consumers and determined that all four of the consumers' Beneficiary IDs had been corrected in CRS. Based on the interviews and selected sample, the Review Team determined that the Trust Office made adjustments or corrections shown on the indicator reports. There were no findings in this area.

14. Work Functions Funded by Medi-Cal

Criteria

DDS has entered into a contract (Standard Agreement) with DHCS to perform certain county functions for consumers in the DC's and SOCF's. These functions are reimbursed by the Medi-Cal program at 50 percent FFP. The "Scope of Work" Section in the contract states,

"DDS will perform Title 19 eligibility and administrative functions relating to the facilitation of the Medicaid eligibility program in compliance with the Social Security Act for those developmentally disabled residents or their families potentially eligible for Medi-Cal in DDS state owned or operated facilities. The services shall be provided at applicable statewide DDS owned or operated facilities...and at other locations including the residences of the potential Medi-Cal eligible individuals or their families. The services shall be provided during normal working hours 8:00 a.m. to 5:00 p.m., Monday through Friday, or additional hours and days as needed to facilitate the collection of necessary eligibility information except on official holidays."

This scope of work defines those activities that are allowable under this contract and for which DHCS will reimburse DDS. All staff funded by this contract must perform only those Medi-Cal duties as outlined in the scope of work to the extent that their position is listed as funded in the contract.

Condition

The Review Team reviewed duty statements for three Trust Office staff whose positions are funded by the Medi-Cal Contract, and interviewed Medi-Cal funded employees. Based on the interviews, the Review Team determined that each employee funded by the Medi-Cal contract is performing Medi-Cal related work tasks. There were no findings in this area.

NEXT STEPS

This report is submitted to Porterville Developmental Center for review and response. Please provide any comments, questions, or additional information which would change the findings or recommendations for Part I of the review within 45 days of the date of the letter transmitting this report to Medi-Cal Auditors Lesli McClung-Coombs, at (916) 657-0035, or Peggy Peter, at (916) 654-3376. If there are no additional comments or questions regarding this review, please submit a written POC to CFS within 60 days of the date of the transmittal letter.

The POC should address the negative findings that did not achieve 100 percent compliance and corresponding recommendations concerning those areas addressed in this report. These areas, shown in the Findings and Recommendations Section on page 10, include Primary Insurance Queries; Share of Cost Calculating, Reporting, and Input; and, Asset Limits.

The format of the POC should include:

- A. Summary of the deficiencies;
- B. The corrective action that will be taken, or has already been taken;
- C. The person who is responsible for ensuring that the corrective action is implemented; and,
- D. A timeline by which the corrective actions will be accomplished.

The Medi-Cal Review Team and CFS would like to thank your Trust Office staff for accommodating our requests for Medi-Cal information timely and efficiently, as well as for their cooperation and professionalism during our review at your facility.