



**A Study Of The Delays
In The Receipt Of Medicaid Cards
By Patients Discharged
From Mental Hygiene Facilities**

July, 1980

**A REPORT BY THE NEW YORK STATE COMMISSION
ON QUALITY OF CARE FOR THE MENTALLY DISABLED**

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Commissioners

The Commission wishes to acknowledge the efforts of Thomas Harmon, formerly a Program Analyst and now Assistant Director of the Quality Assurance Bureau, in the preparation of this report.

EXECUTIVE SUMMARY

Medicaid eligible individuals released from State psychiatric and developmental centers have experienced lengthy delays in the receipt of Medicaid cards which adversely affect their access to needed services in the community and, at the same time, inappropriately reduce federal financial participation in the cost of these services. This Commission initiated a study of the Medicaid card issuance process to determine the causes and effects of such delays. This report reflects conditions found to exist from 1976 through early 1979 -- the period in which the sample population experienced delays in the receipt of Medicaid cards.

Summary of Findings

The following findings are based on extensive interviews with officials of the various Federal, State and local agencies involved in the process of furnishing Medicaid coverage for deinstitutionalized mentally disabled individuals; a review of appropriate Federal and State laws, regulations and procedures; and an investigation of 113 sample cases of individuals released from Department of Mental Hygiene institutions.

1. Many clients released from State psychiatric and developmental centers experienced delays in the receipt of Medicaid cards ranging from one to three months from the time of discharge. Some individuals experienced delays of up to one year (Report, p. 9).

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2. There are major systemic problems which delay the issuance of Medicaid cards (Report, pp. 10-17).
 - A) The Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD) did not take advantage of existing opportunities to file applications for Public and Medical Assistance prior to an individual's release from their institutions.
 - B) The determination of Supplemental Security Income (SSI) eligibility, which is the category of Public Assistance which generates Medicaid coverage for a majority of individuals released from psychiatric and developmental centers, is a lengthy process contributing to the delayed issuance of Medicaid cards. Moreover, difficulty in properly documenting an individual's disability for the purpose of generating Public and Medical Assistance benefits further delays the determination of eligibility and the issuance of a Medicaid card.
3. The delays associated with initiating applications for Public and Medical Assistance, and subsequent delays in the receipt of Medicaid cards, result in a significant loss of Federal reimbursement, unnecessary State expense and considerable hardship for deinstitutionalized individuals and health care providers (Report, pp. 18-26).
 - A) Because psychiatric and developmental centers often did not take advantage of existing procedures which allow for filing of applications for

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assistance prior to an individual's release, the State loses Federal SSI reimbursement and is forced to advance payments to providers caring for released individuals in the State's Family Care Program. The advance payment of these funds presents a recovery problem.

- B) The absence of Medicaid cards for released individuals results in the loss of Federal financial participation in the cost of medical care and in unnecessary State expense.
- C) In the absence of Medicaid cards for deinstitutionalized mentally disabled individuals, the parties responsible for their care expend considerable time and effort in securing necessary medical services.
- D) The discharged individuals themselves experience considerable hardship in the absence of a Medicaid card, often traveling back to the institutions for medical care, or sometimes paying for Medicaid reimbursable services with their own limited personal funds.
- E) Finally, health care providers willing to provide medical care to individuals awaiting the receipt of a Medicaid care suffer the inconvenience of delayed remuneration.

4. The delayed issuance of Medicaid cards is symptomatic of the lack of coordination among the agencies involved. The absence of administrative coordination and control to ensure that the process actually works was evidenced in:
 - A) Eligible individuals never receiving Medicaid cards due to differing interpretations among State agencies of responsibility for furnishing Medicaid coverage.
 - B) Individuals receiving wrong Medicaid cards which resulted in local social services districts bearing undue expenses.
 - C) Individuals receiving State-issued Medicaid cards which were not accepted by many health providers in the local jurisdictions (Report, pp. 27-34).

Recommendations

The Commission, noting that the process of furnishing Medical Assistance to deinstitutionalized individuals is dependent upon a labyrinth of Federal, State and local agency procedures, believes that the timely issuance of Medicaid cards can be accomplished only by creating administrative controls to ensure effective coordination among the agencies, and recommends that:

1. Medicaid cards be issued to eligible individuals on the day of their release from State psychiatric and developmental centers. To this end, it is recommended that the OMH, OMRDD, Social Security Administration (SSA),

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New York State Department of Social Services (NYSDSS), and local social services districts establish written agreements and procedures ensuring that:

- A) Applications for assistance be submitted and processed prior to any individual's release from a psychiatric or developmental center;
- B) Application packages for Public Assistance be initiated by OMH and OMRDD facilities at the time that individuals are first identified as possible candidates for community placement;
- C) Completed application packages be submitted by Resource Agents at least 30 days prior to release;
- D) Resource Agents be designated as the first and last steps of the Medicaid card issuance process -- initiating the process by submitting applications prior to release and ending the process by handing individuals, on the day of their release, Medicaid cards issued by the appropriate jurisdiction upon determination of the client's eligibility.
- E) In light of the inherently lengthy Supplemental Security Income (SSI) eligibility determination process, clients be issued Medicaid cards on the basis of their eligibility for Home Relief or Medicaid only, pending the determination and transmission of SSI eligibility and the generation of a Medicaid card on that basis.

2. To ensure that Medicaid eligible family care clients receive Medicaid cards and that these cards have been issued by the New York State Department of Social Services, it is recommended that:
 - A) Family care placement staff determine if clients have received Medicaid cards;
 - B) Family care placement staff, in coordination with Resource Agents, determine if the Medicaid card received by each client was in fact issued by the appropriate jurisdiction and duly report any errors;
 - C) Family care placement staff report to Resource Agents instances in which seemingly eligible individuals did not receive Medicaid cards.

3. An organized campaign be initiated to recruit health care providers willing to accept State-issued Medicaid cards. OMH and OMRDD should have as their objectives:
 - A) The pooling of information regarding health care providers within geographic areas known to accept State-issued Medicaid cards;
 - B) The identification of geographic areas where there are concentrations of family care clients, but an inadequate number of providers willing to accept State-issued Medicaid cards;
 - C) The identification of categories of health care providers (i.e., dentists, internists, gynecologists, etc.) needed within underserved areas; and

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- D) The delegation of responsibility for recruitment activities to develop the pool of available health care resources within geographic areas.
4. Training sessions be initiated for appropriate institutional staff routinely involved in the process of documenting individuals' disabilities for public assistance purposes, so that errors in this initial stage of generating Medicaid coverage might be reduced.
5. The jurisdictional responsibility for furnishing Medical Assistance to individuals released to State-operated community residences be clarified by the NYSDSS.

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In accordance with the Commission's policy of inviting the review and comments of agencies affected by Commission studies, this report was issued in draft form in January 1980 to the OMRDD, the OMH, NYSDSS and the Division of the Budget. The responses of these agencies (appended to the text in Appendix J and summarized in Chapter V) indicate that considerable progress has been made recently toward the more timely issuance of Medicaid cards to individuals released from Mental Hygiene facilities and that this progress is attributable to two factors: the enactment of Chapter 277 of the Laws of 1979 and the implementation of the Medicaid and Welfare Management Information Systems (MMIS and WMIS).

With the enactment of Chapter 277, NYSDSS assumed responsibility for the determination of public assistance

eligibility for individuals who are 621 eligible.* Such a shift in responsibility for determining eligibility from the local to the State level better enabled the two State agencies, the Department of Social Services and the Department of Mental Hygiene, to cooperatively implement a system for the timely issuance of Medicaid cards.

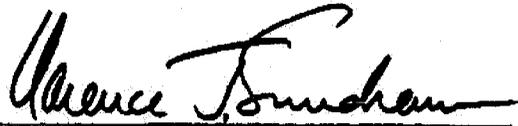
This realignment of responsibility coupled with the emergence of the Medicaid and Welfare Management Information Systems, which allow for the expedient exchange of eligibility data, has created a framework in which eligible individuals can receive their Medicaid cards on the day of their release; such a system was implemented in the New York City area in January 1980.

While considerable progress has been made toward the timely issuance of Medicaid cards, the cooperative endeavors of the various State agencies, although laudable, do not offer a comprehensive resolution to the problems identified in the report. Firstly, the implementation of Chapter 277 benefits only those individuals who are 621 eligible -- a significant number of individuals in OMH facilities are not 621 eligible. Secondly, MMIS and WMIS will not be operational Statewide for at least two years. Additionally, the success of the endeavors of the Department of Mental Hygiene and the Department of Social Services is contingent upon the appropriation of funds to purchase and install the necessary computer terminals at OMH and OMRDD facilities in order to access eligibility information.

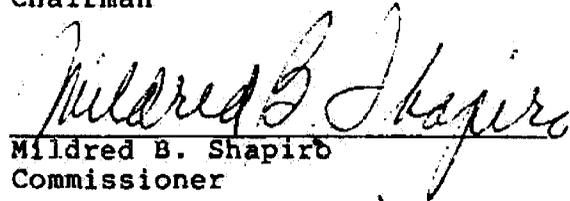
*621 eligible refers to those individuals who meet the criteria established by Chapter 621 of the Laws of 1974. This amendment to Social Services Law required that local Social Services districts be reimbursed 100 percent for services rendered to individuals released from mental hygiene facilities after inpatient stays of five or more consecutive years.

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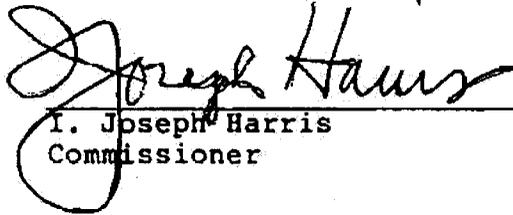
As such, in April 1980, at the direction of the Governor's Office, an interagency task force, consisting of representatives from OMH, the OMRDD, NYSDSS, the Division of the Budget and the Commission on Quality of Care, was created to address the problems identified in the report and to explore avenues for the comprehensive resolution of such problems and for the implementation of the Commission's recommendations.



Clarence J. Sundram
Chairman



Mildred B. Shapiro
Commissioner



I. Joseph Harris
Commissioner

Chapter I

INTRODUCTION

1. Purpose

Last year over 26,000 people were released from facilities operated by the New York State Department of Mental Hygiene (DMH) (Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD)). Many of these individuals were eligible for Medical Assistance (Medicaid) while they were inpatients.¹ In fact, Medicaid funded their inpatient treatment. Others not eligible for Medicaid while they were inpatients, due to certain restrictions in Federal law on Medicaid coverage for inpatient psychiatric care, became Medicaid eligible upon discharge.

Despite their eligibility, few of these individuals were in possession of a Medicaid card upon release. In fact, based on reports received by this Commission, many eligible individuals experienced delays in the receipt of Medicaid cards ranging from two to twelve months from the date of discharge.

Concerned with the impact such delays might have on discharged mentally disabled individuals' access to health care services and on the financing of their health care needs, the Commission on Quality of Care for the Mentally Disabled initiated this study in order to:

- ° Verify that significant delays in the issuance of Medicaid cards to discharged patients is a widespread phenomenon;

- ° Identify significant factors impeding the timely issuance of Medicaid cards;
- ° Determine the financial ramifications as well as the burdens placed on deinstitutionalized individuals and health care providers resulting from a delayed issuance of Medicaid cards; and
- ° Formulate recommendations for corrective action.

2. Methodology

The findings and recommendations posited in this study are based on a review of the appropriate Federal and State laws, regulations, policies and procedures; numerous interviews with senior representatives of the Social Security Administration, Regional and District Offices, the New York State Department of Social Services (NYSDSS), and the OMH and OMRDD Central Offices and facilities; and a review of sample cases.

Sample Cases

The cases of 113 individuals released from psychiatric and developmental centers in the New York City and upstate regions to family care homes or community residences were selected for study to determine trends and problems associated with the process of Medicaid card issuance.² Family care and community residence placements were specifically chosen for study for the following reasons:

- i. Placements into family care and community residences, as illustrated in Appendix B, represent the two largest categories of placement activity, excluding releases to one's own home, family or relatives.
- ii. These two categories of placement activity reflect the two different realms of responsibility for the issuance of Medicaid cards; the State for family care and the locality for community residences.

Sixty-two individuals comprised the sample representing family care placements. Originally 100 individuals placed in family care during 1978 were randomly selected for study. However, 38 cases had to be eliminated from the review because the 1978 placement date was not the original placement into family care and:

- i. The individual's family care placement history was so complex that determining which Medicaid card was issued for a particular stay in family care was impossible; or
- ii. The original placement into family care was prior to 1976. This cutoff point was arbitrarily selected for the purpose of convenience in retrieving any necessary records or data.

The sample representing community residence placements consisted of 51 individuals who were discharged to community residences operated by eight voluntary agencies during the period ranging from late 1977 to early 1979.

A breakdown of the sample cases, by discharging institution and type of placement, is offered in Appendix C.

3. Organization of Report

The findings of this study are prefaced by a chapter which presents an overview of the Medicaid system. This general discussion of the process of securing Medicaid cards for deinstitutionalized mentally disabled individuals offers a background for the findings and recommendations presented in the following chapters.

The findings themselves are discussed in three chapters. "The Delays" presents a discussion of the major factors which contribute to the delayed issuance of Medicaid cards. "The Impact" discusses the financial effects of the delays and the burdens placed on clients and health care providers alike. The chapter entitled "The Confusion" addresses some major problems emanating from the Medicaid card issuance system which presently exists.

In the final chapter of the report, the Commission concludes the study with recommendations for corrective actions.

Chapter II

THE PROCESS: AN OVERVIEW

The issuance of a Medicaid card to an individual released from an OMH or OMRDD facility is a process affected by the category of assistance for which the individual is eligible and by the jurisdiction responsible for furnishing Medical Assistance.

1. Eligibility

Social Services Law section 366.1 describes the conditions under which a person is entitled to Medical Assistance. Generally, a person is eligible for Medicaid in either of two ways.

In the first case, a person is eligible to receive Public Assistance. The major categories of Public Assistance are:

- ° Supplemental Security Income (SSI). This is a federally administered program which grants cash assistance to needy aged, blind and disabled individuals. The size of the grant is dependent upon the individual's living arrangement and the size of the State supplement.
- ° Aid to Dependent Children (ADC). This is a locally administered program which has Federal financial participation and which provides assistance to needy households with dependent children.
- ° Home Relief (HR). This locally administered category of assistance provides cash grants to needy individuals who do not meet the eligibility requirements of a category of assistance that is federally administered or has Federal financial participation.

A person, however, may be eligible for Medicaid even if he or she is not eligible for Public Assistance. Such cases are usually referred to as "Medical Assistance Only (MA Only)" or "Medicaid Only." To be eligible for Medicaid Only, a person must meet certain income requirements, slightly higher than those of SSI and ADC. The person must also meet certain criteria regarding place of residence, public institutional care, transfer of property and:

- ° be under 21 or over 64 years of age, or
- ° with certain contingencies, be the spouse of a Public Assistance recipient, or
- ° for reasons other than income or resources, be eligible for ADC, Federal SSI benefits and/or additional State payments.

Although there are no statistics available which indicate on a comprehensive statewide basis the number of clients released from OMH or OMRDD facilities who receive Medicaid on the basis of their eligibility (i.e. SSI, ADC, HR or Medicaid Only), there are indicators that SSI eligibility is a major avenue for securing Medicaid coverage for such discharged individuals.

Representatives of OMH and OMRDD estimate that of the total number of clients residing in community residences certified by these Offices, 80 to 90 percent, respectively, are in receipt of SSI. Statistics show that approximately 85 percent of the clients in family care homes certified by OMH, and 92 percent of those in OMRDD family care homes, are in receipt of SSI.³

SSI is intended to ensure, through the provision of Federal dollars, a uniform level of income for the needy aged, blind or disabled persons throughout the nation. Eligibility for SSI, which is determined at the Federal level, serves in this State as a concomitant determination of Medicaid eligibility.⁴ Notification of SSI eligibility is transmitted to states through the State Data Exchange (SDX), an electronic information sharing device which records and transmits data regarding SSI eligibility.

2. Responsibility for Furnishing Medical Assistance

For the purpose of administering the Public Assistance and Medicaid programs, section 61 of the Social Services Law divides the State into 58 county and city public welfare districts, referred to in this report as local social services districts. As designated in section 365 of the Social Services Law, each local social services district is responsible for providing Medicaid coverage for eligible individuals within its geographic jurisdiction, except in cases where an individual is the responsibility of another social services district, or the responsibility of the NYSDSS.

The NYSDSS is responsible for administering the Medical Assistance program on behalf of eligible individuals residing in OMH and OMRDD facilities⁵ as well as eligible individuals who are conditionally released from such facilities to family care.⁶

Recently, with the enactment and approval of Chapter 277 of the Laws of 1979, the Social Services Law was amended to expand NYSDSS's responsibility to also include determining eligibility and providing Medical Assistance on

behalf of individuals meeting the criteria of Chapter 621 of the Laws of 1974. Chapter 621 mandated the NYSDSS to reimburse local social services districts 100 percent for the cost of Public Assistance and care rendered to individuals who are released from State psychiatric and developmental centers after five or more continuous years of inpatient treatment. With the enactment of Chapter 277 of the Laws of 1979, which broadened the responsibility of NYSDSS to include furnishing Medicaid coverage for "621 eligible" clients, the process of Medicaid care issuance will be altered. In fact, section 4 of Chapter 277 requires that NYSDSS and DMH jointly prepare and submit a report to the Governor and the Legislature, by March 1, 1980, on the implementation of Chapter 277's provisions and the measures which will be undertaken to assure the timely issuance of Medicaid cards.

It should be noted, however, that this study's sample consisted of individuals released from State psychiatric and developmental centers prior to the enactment of Chapter 277 and, as such, the jurisdictional responsibility for furnishing their Medical Assistance was not affected by their 621 eligibility.

Chapter III

THE DELAYS

The review of 62 family care placements verified the fact that individuals released from OMH and OMRDD facilities experience delays in the receipt of Medicaid cards ranging from one to 12 months. As illustrated in the table below, two-thirds of the 48 family care clients who received Medicaid cards* received them within three months after the month of release; others experienced delays of up to 12 months or longer.

Analysis of Months Lapsed From Time of Family Care Placement Until Receipt of a Medicaid Card

Months Lapsed Since Placement	Number of Cases	Percentage of Total Cases
One to three months	32	66.6%
Four to eight months	10	20.8%
Nine to twelve months	5	10.5%
Over twelve months	1	2.1%
Total	48	100.0%

A number of factors contributed to the delayed issuance of Medicaid cards. In isolated cases, human error played a role. For example, Valarie Dobbs and Esther Frank** did not receive Medicaid cards for over six months. In Ms. Dobbs'

*Fourteen individuals did not receive NYSDSS Medicaid cards. This problem is discussed in Chapter V.

**All names in this report have been changed to protect the confidentiality of the individuals in the study's sample.

case a mis-coded Social Security number caused the delay; in Ms. Frank's case the application for SSI was lost in the mail. Compounding the problem of instances of human error, however, are major systemic problems which delay the issuance of Medicaid cards to most eligible individuals released from OMH and OMRDD facilities. These problems include:

- ° Delays inherent in the SSI determination process;
- ° Difficulty in documenting an individual's disability; and
- ° Delays in filing applications for assistance.

1. The Lengthy SSI Process

SSI, as a category of Public Assistance which generates Medicaid coverage, is a primary source of such coverage for individuals released from OMH or OMRDD facilities. In this study it was found that 91 percent of the individuals in the sample who received Medicaid cards received them on the basis of SSI eligibility. Determining and transmitting SSI eligibility, however, is a lengthy process which contributes to the delayed issuance of Medicaid cards.

Data collected by NYSDSS Program Operations, a unit responsible for transmitting SSI eligibility transactions from the Federal to county levels, reveal the time delays inherent in the SSI process.⁷

Of particular significance in the data collected by NYSDSS on 847 applicants is the time delay associated with determining SSI eligibility on the basis of disability.⁸

As illustrated in the chart below, the data on the 847 SSI applicants whose eligibility was determined and transmitted to NYSDSS during December 1978 indicate that:

- ° Of the 350 cases whose eligibility was based on age, 69 percent were determined and transmitted to the State in less than 38 days from the date of application; and
- ° Of the 497 cases whose eligibility was based on disability, only 16 percent were determined and transmitted to the State in less than 38 days from the date of application. A majority of the disability cases took over 69 days to determine and transmit.

Analysis of SSI Application Date in Relation to Date
On Which NYSDSS was Notified of Eligibility

Days Lapsed From Application	Eligible Aged Individuals		Eligible Disabled Individuals	
	Number of Cases	Percentage	Number of Cases	Percentage
Less than 38	240	69%	79	16%
39-69	71	20%	133	27%
More than 69	39	11%	285	57%
Total	350	100%	497	100%

The problems associated with the determination of eligibility on the basis of disability have not gone unnoticed. According to a representative of the Social Security Administration (SSA) Regional Office, Region II, the average amount of time, nationwide, for determining SSI eligibility on the basis of disability is approximately 44 days and, as such, improving the situation in New York State is a high priority of the SSA. In addition to the SSA's own internal goals for reducing delays in the determination of disability, the New York State Department of Social Services,

which by contract with the Federal government determines disability for Federal programs, has retained the Public Executive Project of the State University at Albany to conduct a management study of the disability determination system. Furthermore, concerned that information affecting the issuance of Medicaid cards was not being transmitted from the Federal to local levels in a timely and accurate fashion, the SSI Information Task Force, chaired by the Health Care Financing Administration of the United States Department of Health, Education and Welfare, and consisting of representatives from the Federal, State and local levels, was created to study problems associated with the determination and transmission of SSI eligibility data.

2. Difficulties in Documenting Disability

A majority of discharged mentally disabled clients qualified for Public Assistance and Medicaid on the basis of their disability, based on the sample under study. Many Resource Agents,* however, particularly in OMH facilities, indicated considerable difficulty in documenting disability, a problem which delays the submission of applications and determination of eligibility.

The determination of disability for SSI, as well as for Medicaid Only purposes, is based on the submission of medical evidence which proves that the applicant has a physical or mental impairment which has lasted or is expected to last 12 consecutive months or result in death, and which prohibits the person from engaging in significant gainful activity.⁹

*Resource Agents are staff of the Department of Mental Hygiene and are responsible for procuring all benefits due residents in psychiatric and developmental centers.

Resource Agents, who rely on facility treatment teams to gather the necessary medical evidence, many times receive documentation which, in their opinion, would not provide disability. In such instances Resource Agents return the documentation to the clinical teams and request information which more appropriately substantiates the claim of disability. Resource Agents attribute the difficulty in documenting disability to the following factors:

- ° At the time of community placement the general orientation is toward the patient's improved condition and the appropriateness of placement in a less restrictive environment, rather than toward the individual's continued disabling condition; and
- ° Although physicians sign the statements of disability, at times non-medical personnel gather the various medical documents which should support the claim of disability.

In the past, the NYSDSS Bureau of Disability Determinations, which is responsible for determining disability for SSI purposes, has conducted training sessions for DMH personnel on the appropriate documentation of disabilities. During the course of this study, representatives from both OMH and the NYSDSS Bureau of Disability Determinations indicated that additional training sessions are warranted.

3. Delays in Filing Applications

In light of the delays inherent in determining and transmitting a client's eligibility for Public and Medical Assistance, and the difficulty in documenting an individual's disability for eligibility purposes, the timely filing of applications becomes of utmost importance. During this study, however, it was found that neither OMH nor OMRDD are taking full advantage of the opportunity to file applications for the various categories of Public Assistance, including SSI, on behalf of clients prior to their release.

Section 12103.1 of the Social Security Administration Claims Manual outlines a procedure for the filing of SSI applications prior to an individual's release from a public institution. These procedures allow for the filing of SSI applications up to three months prior to discharge.¹⁰

NYSDSS regulations also allow for the filing of applications for Public Assistance and the determination of eligibility prior to an individual's placement in the community:

"Each local department of social services shall upon notification from a director of a state mental hygiene facility that a patient is about to be placed in the community and is, or is likely to become in need of public assistance and care, process appropriate applications and determine the applicant's eligibility." 11

The OMH and OMRDD policies and procedures regarding the preparation of clients for community placement, however, do not promote an aggressive prerelease application process. As a result, applications for Public Assistance and care, which could have been filed prior to release, are often filed on the day of release or after the client is already residing in the community.

In the case of family care placements, the Resource Agent is responsible for securing all appropriate funding for the client.¹² Resource Agents are staff of the Central Offices of OMH and OMRDD. Their primary function is procuring all benefits and entitlements due residents in OMH and OMRDD facilities; inasmuch as clients placed into family care homes are still carried on the rolls of facilities, Resource Agents are responsible for filing applications for assistance in their behalf.

According to a memorandum issued July 17, 1978 by the Deputy Commissioner for Administration of OMH, Resource Agents are to be notified of an impending family care placement two weeks prior to placement in order to prepare the appropriate applications. Resource Agents are then notified of the location and actual date of placement on or immediately following the date of placement.¹³ In discussions with Resource Agents, it was found that, in most cases, completed applications for assistance were filed only when this notification of actual placement had been received.

Despite the fact that planning for a family care placement should be in process long before the actual placement, and, in fact, 30 days prior to placement, the client's next of kin should be notified of the intent to release the client and even given an opportunity to visit the family care home,¹⁴ applications for assistance for the person being placed in family care are initiated only two weeks before placement and filed upon notification of actual placement. This lack of an aggressive prerelease application process for family care placements often results in applications for assistance being filed after the date of placement. In the sample of 62 family care placements, ten cases were found in which applications for SSI were filed one to five months after placement. Such delays (discussed in the next chapter) have serious financial implications.

The OMH and OMRDD policies and procedures regarding placements into residential settings other than family care share the same lack of an aggressive prerelease application process as do the policies and procedures regulating family care placements. Neither the OMH nor the OMRDD policies or procedures designate specific time frames for the submission of applications for assistance for clients placed in residential settings.

The OMRDD policies and procedures require that a Community Service Plan be developed 30 days prior to any client's conditional release or discharge.¹⁵ Although OMRDD requires that this plan address the economic as well as other needs and goals of the client, and requires the assignment of individuals to arrange for such services, the policies and procedures do not specify a time frame for the filing of applications for assistance.

The OMH policies and procedures similarly offer little explicit information on the timing of the submission of applications for assistance. OMH does, however, require that the process be initiated when the patient is ready or nearly ready for community placement.¹⁶

Using the SDX, it was possible to study the SSI history of 40 of the 51 cases comprising the sample of community residence placements. It was found that 17 of these individuals were on SSI while they were inpatients. Of the 23 individuals who became eligible for SSI upon release, however, applications were filed prior to release in only six instances. In these six cases the applications were filed only one to seven days prior to discharge. Applications for SSI on behalf of the majority of clients who were not on SSI while they were inpatients were filed either on the day of release or shortly thereafter.

In summary, the delays inherent in the process of determining eligibility, and the problems associated with documenting an individual's disability, highlight the need for an aggressive strategy of filing applications prior to an individual's release.

Chapter IV

THE IMPACT

Delays associated with the filing of applications and the issuance of Medicaid cards result in a loss of Federal reimbursement, unnecessary State expenses and inconvenience for clients and health providers alike.

1. Financial Impact

Roberta Chase and Frances Lewis were placed in family care in February 1978. It was not until August of that year that Ms. Lewis received her Medicaid card and her SSI benefits. Ms. Chase received hers in December. In neither case, however, were the monthly SSI benefits retroactive to the date of placement. Ms. Lewis' benefits were retroactive to March, the month in which her application was filed. Ms. Chase's benefits were retroactive to July, also the month in which her application was filed.

Roberta Chase and Frances Lewis are only two of the ten cases found in our review of 47 family care placements who were eligible for SSI and whose applications were filed anywhere from one to five months after their release. In these ten cases the delayed application resulted in: (a) a delayed issuance of Medicaid cards; and (b) a loss of \$3,083 of Federal funds.

Although the payment of SSI benefits is retroactive to the first day of the month of eligibility, it is the date of the filing of the SSI application which determines the month of eligibility.¹⁷ In the ten cases found during the review of sample placements and cited above, it was the failure to

file SSI applications during the month of placement which resulted in the lack of retroactivity of payments and the loss of Federal funds. This loss also had an impact on State financing.

When clients are in family care awaiting a determination of SSI eligibility, OMH and OMRDD advance monthly payments to the family care providers. These payments are to be recovered by OMH and OMRDD once eligibility is determined and retroactive SSI benefits are awarded to the clients. The failure to establish the date of retroactivity for SSI as the month of placement resulted in State expenditures which could not be recovered.

Projecting these findings onto the total number of clients placed in family care in 1978, it is estimated that the delayed filings of applications for SSI resulted in the loss of over \$185,000 in Federal funds.¹⁸

These findings are not unique. The failure to establish the retroactivity of SSI benefits for family care placements was also cited in a State Comptroller's audit report on the administration of family care programs at Newark and Suffolk Developmental Centers and Pilgrim and Middletown Psychiatric Centers.¹⁹ This audit also revealed delays of one to five months in the filing of SSI applications in 10 out of 40 sample family care cases. Additionally, the Comptroller's audit found that even when SSI payments were made retroactive to the date of placement, there was difficulty in recouping the State funds which were advanced to family care providers. The audit found that family care providers for 40 family care clients owed the State over \$24,500 in advanced funds which should have been repaid after the clients' SSI payments commenced.

The inability to recoup State funds advanced to family care providers, coupled with the financial losses incurred by delayed applications for SSI, highlight the need for institutions to utilize prerelease application procedures. Filing applications prior to an individual's release would maximize Federal reimbursement by ensuring the date of retroactivity. Additionally, initiating the eligibility determination process prior to placement would eventually reduce the amount of State funds advanced to family care providers and the scope of the recovery problem.

Delays in the issuance of Medicaid cards also result in unnecessary expenditures of State funds in that the absence of Medicaid cards fosters reliance on OMH and OMRDD inpatient facilities as providers of service for discharged clients' sundry health needs.

As will be discussed in the next section, individuals released from OMH or OMRDD facilities without Medicaid cards can use community-based health care providers. However, community residence operators and OMH and OMRDD staff involved with family care placements have indicated that, in the absence of Medicaid cards, the State facility often becomes the provider of non-emergency health services such as the renewal of medications.

In addition to placing a burden on State facilities which are budgeted and supplied primarily to serve the inpatient population, the reliance on inpatient facilities as providers of non-emergency health services by clients placed in the community results in a loss of Federal reimbursement. Representatives of the OMH and OMRDD Bureau of Patient Resources interviewed during this study indicated

that inasmuch as the costs of these services cannot be properly charged to inpatient cost centers and therefore recovered through the facility's per diem Medicaid reimbursement rate, Federal reimbursement for 50 percent of the cost of these services is lost.

Although the amount of Federal reimbursement lost due to this reliance on inpatient facilities for sundry health needs has never been quantified, OMRDD, which operates community residences for 750 individuals, estimates that the total cost of providing medical care for these individuals is approximately \$100 a month per person.²⁰ In providing medical services to individuals without Medicaid cards residing in these State-operated residences, OMRDD estimates that approximately \$50 a month per client of Federal reimbursement is lost.

In summary, the untimely filing of applications for assistance and the delayed and, in certain cases, the non-issuance of Medicaid cards to clients discharged from psychiatric and developmental centers, results in a significant loss of Federal reimbursement and unnecessary State expenditures.

2. Impact on Clients and Health Providers

During the course of this study, in interviews with OMH and OMRDD staff, community residence operators and family care providers, no instance was found in which an individual without a Medicaid card did not receive necessary medical services. In the cases studied, the lack of a Medicaid card did not lead to such dramatic consequences as the denial of medical attention; rather it was found that the absence of a

Medicaid card had a more subtle impact on clients and health care providers, an impact which influenced where clients received health services and how such services were reimbursed.

The absence of a Medicaid card does not prohibit health care providers from treating patients and subsequently billing Medicaid for reimbursement. As specified in Part 540.6(a) NYCRR Title 18, health care providers participating in the Medicaid program are required to submit claims for Medicaid reimbursement within 90 days of the date of service. Claims, however, may be submitted after 90 days if the delay was due to circumstances beyond the control of the health care provider. One such circumstance, described in Part 540.6 of the Social Services regulations, is the determination of eligibility. Services rendered to a person discharged from an OMH or OMRDD facility, who is awaiting the receipt of a Medicaid card, will be reimbursed once that person receives his or her Medicaid card and the health care provider submits the claim, complete with the client's Medicaid identification number and a statement explaining the reason for the delayed submission.

Despite the fact that health care providers eventually will be reimbursed, the lack of a Medicaid card causes considerable inconvenience to community residence operators, facility staff, clients and health care providers.

Community residence operators and OMH and OMRDD staff spend time cajoling and recruiting health care providers to treat clients who do not as yet have a Medicaid card. In one case it was found that facility staff were actually completing health care providers' billing forms in order to ensure the continued treatment of clients.

In many instances, the OMH or OMRDD facility becomes the provider of the more routine health services required by clients in family care and community residences. During one interview, a facility representative even indicated that in order to facilitate the medical treatment of clients without Medicaid cards, a "paper" admission back into the OMRDD facility is sometimes effected and clients are then treated by the local health institution with which the facility has a cooperative agreement as if they were an inpatient in the OMRDD facility.

In addition to resulting in a drain on the resources of OMH and OMRDD facilities and, as discussed in the previous section a loss of Federal reimbursement, the reliance on OMH and OMRDD facilities fostered by the delayed issuance of a Medicaid card creates an inconvenience for clients and their caretakers who, unable to conveniently avail themselves of neighborhood health providers, must travel back to the institution for services. It is also inconsistent with one of the purposes of community placement, that is, the integration of clients into the community.

Where cajoling fails and travel becomes inconvenient, clients sometimes pay for medical services which should have been reimbursed by Medicaid. The case of Jane Levin is a good example of this situation.

When Ms. Levin was placed in family care she waited six months to receive a Medicaid card. Because of her severe physical disability, which required the routine use of surgical supplies, Ms. Levin and her family care providers opted to use a neighborhood surgical supply store, and to pay for services with their own funds. This practice continued even after the receipt of a Medicaid card, since the

location of the nearest surgical supply store which would honor this State-issued card was 40 minutes away by car, or one and one-half hours by public transportation.* At the time of the Commission interview, 20 months after Ms. Levin's placement, she and her family care providers had paid \$1,192 out of their own funds for surgical supplies which were Medicaid reimbursable.

The cash flow problems experienced by health providers who render services to clients awaiting the receipt of Medicaid cards are exemplified in the cases of Pharmacy M. and Doctor G., who, in 1978, treated a number of clients in this study's sample of community residence placements.

In April 1978, Pharmacy M. agreed to provide pharmaceutical supplies to two clients who had just been released from an OMRDD facility to a local community residence. The clients did not have Medicaid cards as they had just applied for SSI.

Eventually the clients received their Medicaid cards, the claims for Medicaid reimbursement were submitted, and the pharmacy received payment. However, the process took ten months from the time the clients first started generating the \$230 claim.

Doctor G.'s situation is slightly different. At the time of the Commission interview, after six months of treating a client released from an OMH facility to a community residence in his neighborhood, Doctor G. had not yet been able to submit the \$180 claim as the client had not yet

*The nonacceptance of State-issued Medicaid cards is addressed in the next chapter.

received her Medicaid card. According to Doctor G., this patient had already had enough problems in her life and as such he was willing to treat her and wait for payment. However, according to Doctor G., "if this were a private paying patient, the matter would be in the hands of my attorney."

The delayed issuance of Medicaid cards, in summary, results in inconvenience for all concerned: State facilities' resources are inappropriately used; valuable staff time is lost in arranging for necessary medical services; clients are faced with a limited choice of health providers and, at times, a drain on their own limited resources; and health providers are burdened with extensive delays in reimbursement. The fact that the absence of a Medicaid card did not result in the denial of medical services for the clients in the sample does not diminish the gravity of this problem. Rather it speaks of the diligent efforts and sacrifices made by staff, caretakers and health care providers alike.

It should be noted, however, that the clients in the sample, clients who had been placed in either family care homes or community residences, were placed in living arrangements which received the support of agencies dedicated to serve as advocates on behalf of the mentally disabled.²¹ In light of the subtle consequences and inconveniences suffered by these individuals who resided in environments sustained and supported by a dedicated network of agencies, one wonders about the fate of the Medicaid eligible clients among the 4,500 individuals who, last year, were discharged to SRO's, boarding homes, their own homes or other living arrangements where, alone, they had to negotiate the health care system without a Medicaid card.²²

Chapter V

THE CONFUSION

The issuance of Medicaid cards to deinstitutionalized individuals is dependent upon a labyrinth of procedures involving Federal, State and local agencies. In certain cases, eligibility is determined at the Federal level (e.g., SSI). The determination of disability for SSI purposes, however, is made at the State level through a contract with the Federal government. In other cases, the determination of eligibility occurs on either the State or local level. Finally, as defined in Social Services Law, the responsibility for issuing a Medicaid card rests with either the State or a local social services district.

Noticeably lacking within this maze of agencies sharing a role in the process of providing Medicaid coverage for deinstitutionalized individuals is a designation of overall responsibility and administrative procedures for ensuring the effective coordination of agencies' efforts.

The fact that the policies of certain agencies allow for the filing of applications for assistance prior to an individual's release, yet in its policies and procedures another agency fails to take advantage of this opportunity, is only one manifestation of the lack of coordination among the agencies. During the course of this study, the confusion which results from the absence of administrative controls to ensure that this multifaceted system actually works was also determined to manifest in:

- ° Clients not receiving Medicaid cards;
- ° Local social services districts bearing undue costs because clients received the wrong Medicaid cards; and

- ° Clients receiving Medicaid cards which are not acceptable to most health providers within local jurisdictions.

1. Who Issues the Card?

One example of the lack of effective coordination among the agencies participating in the process of Medicaid card issuance is the non-issuance of Medicaid cards to individuals discharged to publicly operated community residences alluded to earlier.

OMH and OMRDD operate approximately 58 community residences for mentally disabled individuals. Prior to 1976, individuals in such publicly operated residences were ineligible for SSI due to restrictions placed on SSI benefits for persons in public institutions. In October of 1976, however, section 1382(e) of the United States Code, Title 42, was amended and individuals in publicly operated community residences serving no more than 16 residents became eligible for SSI benefits.²³

Insomuch as SSI eligibility is a concomitant determination of Medicaid eligibility, many of the individuals in State-operated community residences are also eligible for Medicaid. However, as a result of different interpretations of section 365 of the Social Services Law which defines State and local responsibility for furnishing Medicaid coverage, many eligible individuals in the State-operated community residences in various parts of the State do not receive Medicaid cards from either NYSDSS or local social services districts.

State-operated community residences in four social services districts were polled to determine which jurisdiction, if any, issued Medicaid cards to the eligible

clients in these residences. In two of the districts, it was found that the clients in the residences received Medicaid cards issued by the districts. In the other two districts it was found that, despite the fact that the clients were in receipt of SSI, neither NYSDSS nor the local social services districts issued Medicaid cards.

These findings indicate that a number of eligible clients in State-operated community residences are not consistently issued Medicaid cards by either NYSDSS or local social services districts. This non-issuance of Medicaid cards, as mentioned in the previous chapter, has serious financial consequences.

The recent amendment of section 365 of the Social Services Law by Chapter 277 of the Laws of 1979 will alleviate this problem to some degree. As NYSDSS becomes responsible for furnishing Medicaid coverage to all 621 eligible individuals, many clients in State-operated community residences will fall within NYSDSS's jurisdiction. However, to the extent that a significant minority of individuals in State psychiatric and developmental centers are not 621 eligible, as illustrated in Appendix H, Chapter 277 does not completely resolve the problem of responsibility for providing Medical Assistance to individuals released to State-operated community residences.

2. Who is Paying for Whose Care?

The absence of administrative procedures to ensure the overall coordination in the process of providing Medicaid coverage to individuals released from OMH or OMRDD facilities was also evidenced in clients receiving the wrong Medicaid cards. This resulted in counties bearing unnecessary costs.

In the review of 62 sample family care placements, it was found that 14 clients did not receive NYSDSS Medicaid cards. Four of these cases were selected and investigated in order to determine the cause of ineligibility. Upon investigation it was found that in three of these cases not only were the individuals eligible for Medicaid, but they were actually receiving Medicaid cards from local social services districts.

For up to 15 months, Dennis Devine, Mary Bently and Felicia Downey had been receiving Medicaid services on the basis of Medicaid cards issued by local social services districts instead of NYSDSS, which is responsible for furnishing Medical Assistance to individuals conditionally released to family care. As a result, these local social services districts incurred nearly \$1,000 of unnecessary Medicaid expenses.²⁴

The fact that these mistakes had not been noticed by OMH or OMRDD placement staff, reported to Resource Agents and corrected by NYSDSS officials, until the errors were discovered and duly reported by the Commission, indicates the less than vigilant administration and coordinated oversight of the Medicaid card issuance process.

In a number of cases placement staff did not know if their family care clients had received a Medicaid card. In Ms. Downey's case, the facility's Director of Social Work, and the social worker assigned to Ms. Downey's case, had to be convinced that she did in fact receive a Medicaid card even though NYSDSS did not issue it. Subsequently, the social worker visited Ms. Downey's family care home and verified our finding that Ms. Downey had received a Medicaid card issued by the county in which she resided instead of receiving the NYSDSS issued card.

The less than vigilant control and monitoring of the Medicaid card issuance process not only results in clients receiving the wrong Medicaid card but in eligible clients sometimes not receiving any Medicaid cards.

John Collins was not in the Commission's sample of family care placements. However, while discussing the problems associated with the delayed issuance of Medicaid cards with staff of an OMRDD facility, a staff person responsible for Mr. Collins' family care placement asked if it could be determined why Mr. Collins had not received a Medicaid card. Upon a review of NYSDSS records, it was found that NYSDSS had never been notified of Mr. Collins' family care placement, therefore no card had been issued. Upon the Commission's findings, the Resource Agent for Mr. Collins was immediately notified. He indicated that, although he knew Mr. Collins had been placed in family care and had filed the appropriate forms, which should have generated a NYSDSS Medicaid card, this was the first time in the seven months since Mr. Collins' placement that he heard that Mr. Collins did not receive a Medicaid card.

Although both OMH and OMRDD in their policies and procedures establish a mechanism for monitoring and reporting any problems relating to the receipt of Medicaid cards by clients placed in family care, it is obvious, based on the cases cited above, that poor communication and lack of understanding of the Medicaid card issuance process impedes its effective working.²⁵

3. Who Will Accept This Card?

A serious problem within the system of providing Medicaid coverage for deinstitutionalized individuals is the

reluctance of health care providers to accept the State-issued Medicaid card. During the course of this study, representatives of OMH and OMRDD facilities frequently cited the difficulty in finding health providers who will accept the Medicaid card issued by NYSDSS to family care clients. OMRDD staff estimate, for example, that in Queens County, which is the second most populated county in the State, there are only three pharmacies which will honor the State-issued Medicaid card.

Representatives of NYSDSS, OMH and OMRDD indicate that providers are reluctant to accept the State-issued card because the reimbursement process is a manual system which has a long turn-around-time and which requires the use of additional billing forms and procedures. The problem was exacerbated in New York City, in their opinion, with the phasing in of the Medicaid Management Information System (MMIS).

With the advent of this automated management information and claims processing system, the turn-around-time for payments to health care providers, such as pharmacies, is reduced to ten days and a standardized billing procedure is established. However, the family care payment system has not as yet been integrated into the MMIS. As a result, health care providers who accept the State Medicaid card are still faced with additional paper work relating to the filing of claims and a turn-around-time of 45-60 days.

As mentioned in the previous chapter, the reluctance on the part of health care providers to accept the State card has serious consequences. Clients are inconvenienced by having to travel out of their neighborhoods to locate providers willing to accept the card. Often times, clients

return to the facility to secure health care services, a practice which has an impact on State finances and on integration into the community. Sometimes, as in the case of Jane Levin, clients who want the freedom of choice in selecting a health care provider resort to paying for medical services out of their own limited resources.

The incorporation of the statewide family care payment system into the MMIS, which is being phased in on a county-by-county basis, presents a logistical problem. According to a senior official of NYSDSS, no decision has as yet been reached as to how or when family care will be incorporated. NYSDSS in the meantime, however, sensitive to the problem faced by clients in family care, issued a statement describing the family care program, the State Medicaid card, and the State Medicaid billing procedures in its May 1979 issue of Medicaid Update. It is hoped that by publishing this article* in a newsletter sent to all Medicaid providers, the awareness of providers will be heightened and acceptance of the State Medicaid card will be increased.

*A copy of the article is attached as Appendix I.

Chapter VI

CONCLUSIONS AND RECOMMENDATIONS

The delays associated with the process of issuing Medicaid cards to individuals released from State psychiatric and developmental centers results each year in New York State's failure to secure hundreds of thousands of dollars of Federal reimbursement. Additionally, these delays cause considerable hardship for clients and the people responsible for their care who, faced with the challenge of securing community-based services, find in the absence of a Medicaid card a limited choice of health care providers. Finally, health care providers willing to treat individuals who do not have Medicaid cards are also inconvenienced and experience delays in reimbursement for their services.

The delayed issuance of Medicaid cards for individuals released from State facilities has not gone unnoticed, however, and diligent efforts are being made on many fronts to resolve the problems affecting the issuance of such cards.

For example, NYSDSS is reviewing the recommendations of the Public Executive Project's management study of the disability determination process. The problems associated with the transmittal of SSI eligibility data from Federal to State and local levels for the purpose of determining Medicaid eligibility are being addressed by the federally-chaired SSI Information Task Force. Additionally, the recent amendment of Social Services Law by Chapter 277 of the Laws of 1979, which designates NYSDSS as being responsible for providing Medical Assistance to 621 eligible individuals, mandates NYSDSS and the State Department of

Mental Hygiene to jointly prepare a report by March 1, 1980 which identifies the steps being taken to assure the timely issuance of Medicaid cards to deinstitutionalized individuals.

The delayed issuance of Medicaid cards, however, is symptomatic of a more pervasive problem -- that is, the absence of coordinated administrative controls among the multitude of agencies involved in the process of providing Medicaid coverage. In the absence of such controls to ensure that the labyrinth of Federal, State and local procedures are coordinated and actually work, the efforts of any one agency to improve its functional role within the process will offer only a partial solution to the problem of untimely issued Medicaid cards.

The efforts of NYSDSS and the SSA to reduce time delays associated with disability determinations, for example, will not ensure the timely issuance of Medicaid cards to deinstitutionalized individuals if applications for their Public Assistance benefits are filed late. Similarly, the framework established by the Legislature in Chapter 277 of the Laws of 1979 for the timely issuance of Medicaid cards to 621 eligible individuals does not resolve the problem of the untimely issuance of Medicaid cards to the significant minority of individuals in State psychiatric and developmental centers who are not 621 eligible. Nor does it ensure that individuals will receive cards from appropriate jurisdictions; a problem which, as evidenced in our review of family care placements, resulted in counties bearing unnecessary expense.

In short, just as the determination of the Medicaid eligibility of individuals released from State psychiatric and developmental centers, and the issuance of Medicaid cards to such individuals, are necessarily dependent upon a labyrinth of Federal, State and local agencies' procedures, the timely and appropriate issuance of Medicaid cards will result only through the coordination of these agencies' efforts.

Therefore, the Commission recommends that:

1. Medicaid cards be issued to eligible individuals on the day of their release from State psychiatric and developmental centers. To this end, it is recommended that OMH, OMRDD, SSA, NYSDSS and local social services districts establish written agreements and procedures ensuring that:
 - a) Applications for assistance be submitted and processed prior to any individual's release from a psychiatric or developmental center;
 - b) Application packages for Public Assistance be initiated by OMH and OMRDD facilities at the time that individuals are first identified as possible candidates for community placement;
 - c) Completed application packages be submitted by Resource Agents at least 30 days prior to release;
 - d) Resource Agents be designated as the first and last steps of the Medicaid card issuance process--initiating the process by submitting applications prior to release and ending the process by handing individuals, on the day of their release, Medicaid cards issued by the appropriate jurisdiction upon its determination of the client's eligibility;

- e) In light of the delays inherent in the SSI eligibility determination process, clients be issued Medicaid cards on the basis of their eligibility for Home Relief or Medicaid Only, pending the determination and transmission of SSI eligibility and the generation of a Medicaid card on that basis.

In their responses, the Division of the Budget, OMH and OMRDD indicate that considerable progress has been made in this area. As a result of the implementation of the provisions of Chapter 277 of the Laws of 1979 and the emergence of the MMIS, individuals released from OMRDD facilities in New York City are being issued temporary Medicaid authorization cards on the day of release. The responses also indicate that as the MMIS becomes operational statewide the process of issuing temporary authorizations will be replicated in other regions. The success of the system in operation in the New York City area is also in part due to a shift in the role of Resource Agents who, according to the responses, are now becoming involved in discharge planning at an earlier date.

Recognizing, however, that the provisions of Chapter 277 will benefit only those individuals who are 621 eligible and that MMIS and WMIS will not be operational statewide for at least two years, an interagency task force, consisting of representatives from OMH, OMRDD, NYSDSS, the Division of the Budget and the Commission on Quality of Care has been created at the Governor's request to explore avenues for implementing the Commission's recommendations in a timely and comprehensive fashion.

2. To ensure that Medicaid eligible family care clients have received Medicaid cards and that these cards have been issued by the New York State Department of Social Services, it is recommended that:
 - a) Family care placement staff determine if clients have received Medicaid cards;
 - b) Family care placement staff, in coordination with Resource Agents, determine if the Medicaid card received by each client was in fact issued by the appropriate jurisdiction and duly report any errors;
 - c) Family care placement staff report to Resource Agents instances in which seemingly eligible individuals did not receive Medicaid cards.

Both OMH and OMRDD indicated that they are presently reviewing the eligibility status of all individuals in family care.

3. An organized campaign be initiated to recruit health care providers willing to accept State-issued Medicaid cards. OMH and OMRDD should have as their objectives:
 - a) The pooling of information regarding health care providers within geographic areas known to accept State-issued Medicaid cards;
 - b) The identification of geographic areas where there are concentrations of family care clients, but an inadequate number of providers willing to accept State-issued Medicaid cards;
 - c) The identification of categories of health care providers (i.e. dentists, internists, gynecologists, etc.) needed within underserved areas; and

- d) The delegation of responsibility for recruitment activities to develop the pool of available health care resources within geographic areas.

Although the responses of OMH and OMRDD indicate that MMIS will ameliorate this problem, it is recognized that statewide implementation of the MMIS is at least two years in the offing. As such, this issue will be addressed by the interagency task force.

4. Training sessions be initiated for appropriate institutional staff routinely involved in the process of documenting individuals' disabilities for public assistance purposes, so that errors in this initial stage of generating Medicaid coverage might be reduced.

The responses of both OMH and OMRDD indicated agreement with this recommendation.

5. The jurisdictional responsibility for furnishing Medical Assistance to individuals released to State-operated community residences be clarified by NYSDSS.

In response to this recommendation NYSDSS issued a directive to local social services districts clarifying their responsibility for issuing Medicaid cards to eligible individuals in State-operated community residences.

FOOTNOTES

1. Approximately 97 percent of the OMRDD inpatient population and 46 percent of the OMH inpatient population are Medicaid eligible. See Appendix A.
2. Family Care is a program using "certified family care homes to provide care for residents who do not require residential care and treatment in a psychiatric or developmental center, but who are unable to function adequately in their own homes or in completely independent living in the community." (State of New York Department of Mental Hygiene Family Care Manual for Staff, Section 10.1; Subject: Definitions.) "Community residences for the mentally disabled are facilities for mentally disabled persons who are unable to live independently at a particular time. Community residences are specifically designed and operated to assist mentally disabled persons to live as independently as possible through the provision of training and assistance in the skills of daily living, and by serving as an integrating focus for the mentally disabled person's overall rehabilitation." (Part 86 NYCRR Title 14.)
3. Letter from Angela Zeppetello, Federal Program Coordinator of the Bureau of Patient Resources of the Office of Mental Health, to Walter Saurack of the New York State Commission on Quality of Care for the Mentally Disabled (February 22, 1979). Letter attached as Appendix D.
4. Section 363-b Social Services Law and Part 360.30 NYCRR Title 18.
5. Section 365.2 Social Services Law.
6. Section 138-a.1 Social Services Law.
7. Data forwarded to the Commission in a letter of May 25, 1979 from Mr. Seth S. Grossman, Director, Social Services Program Operations. See Appendix E.
8. In addition to financial need, SSI eligibility which is determined on a Federal level and transmitted to the states, is determined on the basis of age (over 65) or disability. Of the 76 individuals in our sample who received Medicaid cards by virtue of their SSI eligibility, 91 percent were eligible for SSI on the basis of disability.

9. Section 1382c(a)(3)(A) United States Code Title 42 and Part 360.35(b) NYCRR Title 18.
10. Sections 12103.1 and 12103.2 of the Social Security Administration Claims Manual are appended in Appendix E.
11. Part 313.1(d)(1) NYCRR Title 18.
12. State of New York Department of Mental Hygiene, Family Care Manual for Staff, Section 10.9.1; Subject: Fiscal Affairs.
13. Ibid. Section 10.9.1; Subject: Fiscal Affairs.
14. Ibid. Section 10.8.1; Subject: Placement.
15. Policies and Procedures for Mental Retardation, Section 7.5.3, Subject: Preparation for Community Placement.
16. Department of Mental Hygiene, Department Policy Manual, Section 1237, "Referral of Patients from Institutions for Public Assistance."
17. Section 1382(c) United States Code Title 42.
18. As illustrated in Appendix G, approximately 89 percent of the clients in family care are receiving SSI. In our sample of 47 individuals placed in family care, who received SSI as a result of an initial application or a redetermination (i.e., they were already on SSI), we found that in 21 percent of the cases initial applications were filed late resulting in a loss of \$3,083. Assuming that 89 percent of the 3,272 individuals placed in family care in 1978 were SSI eligible, we projected the rate of delayed applications and related costs found in our sample and estimated that \$188,348 of Federal funds were lost.
19. Audit Report AL-ST-43-78 and NY-ST-13-78, "Administration of the Family Care Programs at Newark and Suffolk Developmental Centers and Pilgrim and Middletown Psychiatric Centers," Division of Audits and Accounts.
20. In an April 12, 1979 memorandum from William A. Carnahan, OMRDD Deputy Commissioner and Counsel to Richard A. Brown, Counsel to the Governor, supporting an OMRDD legislative proposal which proposed that the State be given full responsibility for furnishing Public Assistance to individuals in community residences, the OMRDD projected the amount of lost Federal reimbursement caused by the non-issuance of Medicaid cards to clients in State operated community residences.

21. In the case of family care, OMH and OMRDD facilities are responsible for integrating clients into the network of community services. Section 10.7.1 of the State of New York Department of Mental Hygiene Family Care Manual for Staff states that the OMH or OMRDD facility shall be responsible for "developing arrangements with local communities to provide residents in family care with programs and services." Similarly, governing bodies of community residences are responsible for assuring that clients receive services in the community. Part 86.6 NYCRR Title 14 states that these bodies "shall assure that primary habilitative and rehabilitative services are provided by non-residential service agencies or programs in the community in which the residence is located.
22. As illustrated in Appendix B, last year over 4,500 mentally disabled individuals were discharged to living situations where they lived alone in either their own home, SRO's, boarding homes, motels, hotels, or other living arrangements. Additionally, Appendix 3 illustrates that in over 3,500 cases data on the clients' living arrangements are unknown or unavailable.
23. Section 1382(e)(1)(c) United States Code Title 42.
24. This figure is based on the OMRDD estimate that the average medical costs for clients placed in the community are approximately \$100 per month per client.
25. State of New York Department of Mental Hygiene Family Care Manual for Staff, Section 10.9.3; Subject: Fiscal Affairs.
26. As illustrated in Appendix H, approximately 23 percent of the inpatients in State psychiatric and developmental centers are not 621 eligible.

APPENDICES

Analysis of Inpatient Population
 Relative to Medicaid Eligibility
 NYS, April 30, 1979

Type of facility	Total inpatients	<u>Medicaid eligible</u>		<u>Nonmedicaid eligible</u>	
		Inpatients	Percent	Inpatients	Percent
TOTAL	42,210	27,640	65.0	14,570	35.0
Adult psychiatric centers	25,999	12,043	46.0	13,956	54.0
Children's psychiatric centers	590	432	73.0	158	27.0
Developmental centers	15,621	15,165	97.0	456	3.0

SOURCE: DMH Statistical Operations

APPENDIX B

Analysis of Releases by Living Arrangement
NYS, Year Ending December 31, 1978

Living arrangement	Adult psychiatric centers		Developmental centers		Total	
	Number	Percent	Number	Percent	Number	Percent
Total	22,754	100.0	3,815	100.00	26,569	100.0
Own home	2,759	12.1	14	.40	2,773	10.4
SRO hotel/motel	593	2.6	1	.03	594	2.2
Boarding house	693	3.1	2	.05	695	2.6
Other alone	688	3.0	4	.10	692	2.6
With parents	4,024	17.7	492	12.90	4,516	17.0
With spouse	2,306	10.1	0	0.00	2,306	8.7
With relations	2,029	9.0	25	.70	2,054	7.7
With non-relatives	878	3.9	21	.50	899	3.4
Community residences	784	3.4	573	15.00	1,357	5.1
Proprietary home	1,095	4.8	10	.30	1,105	4.2
Foster care	140	.6	15	.40	155	.6
Family care	1,599	7.0	1,673	43.80	3,272	12.3
Other domiciliary care	280	1.2	10	.30	290	1.1
Mental hospital	289	1.3	10	.30	299	1.1
General hospital- psych.	223	1.0	0	0.00	223	.8
General hospital	68	.3	0	0.00	68	.3
V.A. hospital	291	1.3	0	0.00	291	1.1
Skilled nursing facility	177	.8	13	.30	190	.7
Intermediate care facility	126	.6	18	.50	144	.6
Facility for retarded	34	.1	36	.90	70	.3
Narcotic residence	31	.1	0	0.00	31	.1
Prison or correction facility	165	.7	3	.07	168	.6
Other facility	358	1.6	180	4.70	538	2.0
Data unavailable	3,124	13.7	715	18.70	3,839	14.5

NOTE: Detail may not add to total due to rounding.

SOURCE: DMH Statistical Operations.

APPENDIX C

Distribution of Sample Cases by Releasing Institution
NYS, 1976-1979

Institution	Family care sample cases	Community residence sample cases
Total	62	51
Bronx Psychiatric Center	7	9
Capital District Psychiatric Center	2	6
Hudson River Psychiatric Center	2	0
Hutchings Psychiatric Center	9	4
Manhattan Psychiatric Center	2	0
Bernard Fineson Developmental Center	10	7
Brooklyn Developmental Center	10	13
Manhattan Developmental Center	4	4
O. D. Heck Developmental Center	3	6
Syracuse Developmental Center	5	2
Wassaic Developmental Center	8	0



JAMES A. PREVOST, M.D., Commissioner

Division of Program Support
NELSON WEINSTOCK, Deputy Commissioner

February 22, 1979

Walter Saurack
Commission on the Quality of
Care for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Saurack:

Attached are the statistics you requested on Family Care clients of the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities.

The statistics are by facility with totals for each of the Offices. The first column on the attached is the number of Family Care clients in SSI pay status. This information was taken from the 1/12/79 SDX. The second column is the total number of clients in Family Care status. This information was taken from the OMH/OMR Statistical Report as of 12/31/78.

If further information is needed, please contact me.

Very truly yours,

ANGELA ZEPPELLO
Federal Program Coordinator
Bureau of Patient Resources

Attach.

AZ:dmp

cc: Mr. Wick
Mr. Maul
Mr. Courington
Mr. Schomaker
Mr. Glover

RECEIPTS:

MONTH:

DEVELOPMENTAL CENTERS	Pay Status SSI 1/12/79	Family Care Status 12/31/78
224 BASIC RESEARCH	-	-
225 SUNMOUNT	157	156
226 BRONX	114	128
227 SUFFOLK	124	166
228 GOUVERNEUR	-	-
229 WEST SENECA	228	241
230 B FINESON	106	141
232 MONROE	71	78
233 BROOME	543	563
234 WESTCHESTER	30	34
235 BROOKLYN	84	104
236 O D HECK	358	374
237 MANHATTAN	22	34
238 KINGS PARK	-	-
270 WILTON	78	88
271 LETCHWORTH	195	221
272 NEWARK	363	376
273 ROME	128	132
274 SYRACUSE	165	185
275 WASSAIC	378	389
276 WILLOWBROOK	172	199
277 CRAIG	53	55
279 J N ADAM	154	166
TOTAL	3524	3830

RECEIPTS:

MONTH: PSYCHIATRIC CENTERS	Pay Status - SSI 1/12/79	Family Care Status 12/31/78
001 BINGHAMTON	186	234
002 KINGSBORO	-	-
003 BUFFALO	414	463
004 CENTRAL ISLIP	10	8
005 CREEDMOOR	1	0
006 GOWANDA	191	220
007 HARLEM VALLEY	149	145
008 HUDSON RIVER	184	194
009 KINGS PARK	9	4
010 MANHATTAN	-	-
011 MARCY	52	70
012 MIDDLETOWN	228	255
013 PILGRIM	174	185
014 N Y PSYCH	-	-
015 ROCHESTER	63	87
016 ROCKLAND	56	61
017 ST LAWRENCE	357	431
018 HUTCHINGS	43	66
019 UTICA	107	128
020 WILLARD	225	271
021 BRONX	70	86
024 CAPITAL DIST	77	96
025 SAGAMORE CHILD	1	9
026 ROCKLAND CHILD	22	25
027 QUEENS CHILD	-	-
028 BRONX CHILD	-	-
029 N E NASSAU	4	3
030 HOCH	2	2
031 MEYER	17	43
032 KIRBY	3	9
033 DUNLAP	5	10
035 ELMIRA	105	137
036 SO BEACH	1	6
037 WESTERN NY CH	2	3
038 MID HUDSON	-	-
039 MANHATTAN CHILD	-	-
TOTAL	2758	3251

12103.1 Prerelease Agreements Between SSA and Public Institutions

(a) General

A claimant who is an inmate of a public institution throughout the month of filing is ineligible for the SSI program unless that institution is receiving or expects to receive substantial payments for the claimant under a State's Medical plan (see §§ 12220 ff) or it is a publicly operated community residence which serves no more than 16 residents (see § A12210).

Some claimants who are ineligible for SSI (and SSA administered State supplements) because they are inmates could be released from institutions if sufficient funds were available to permit them to live outside of institutions. If they are 65 or older, blind, or disabled, receipt of SSI (and, if applicable, State supplementation) payments could result in their release.

A public institution can arrange with its servicing DO for a prerelease program which seeks to assure SSI benefits on release for any qualifying inmate. Under such a program, the institution identifies any inmate who is potentially eligible for the SSI program and who will be released if the DO reports he or she will actually be eligible in the expected placement (future living arrangement) when the release occurs. The special effect of a prerelease program is that the DO will process claims fully and report the results to the institution so that it can plan the future release, despite the claimant's lack of eligibility in the month of filing and the following month because of status as an ineligible inmate of a public institution.

Despite the fact that a public institution does not have a prerelease program, an inmate can file an SSI program application, because there is no limitation on anyone's right to file an SSI program application (see § 2003(a)). In some situations, inmates of public institutions who are near release must undertake their own planning (e.g., an aged prisoner who is near the end of his sentence in a correctional institution which does not have a prerelease program). Assist such an individual and process the claim as explained in § 12103. Eligibility is possible when the information obtained shows release is imminent and the claimant will no longer be an ineligible inmate of a public institution in the month of or the month after filing, or within 30 days of the date of DO adjudication. The date of effective filing is the first day of the month that the claimant meets all of the eligibility requirements (see § 12103(c)).

(c) Prerelease Program Obligations of the Public Institution

The DO should notify the public institutions in its service area of the prerelease procedures. DO's parallel to State agencies which operate a number of institutions can execute agreements with the agen-

cies, as specified by the RO. A public institution with a prerelease program must agree to:

- (1) Identify those inmates scheduled or being considered for release;
- (2) Assess their probable SSI eligibility according to the information the servicing DO provides;
- (3) Refer only those inmates who will probably be eligible for payments;
- (4) Use a screening guide provided by the DO to obtain necessary information; and
- (5) Provide evidence from its records (including any medical evidence which is available) either with the referral form or at the time of filing the application; and advise whether the inmate is capable of filing, pursuing the application, and handling funds, and, if not, provide any information available on persons who might be willing to file or be the representative payee.

With this help from the institution, the DO can process the claims of inmates who are referred more easily and quickly and concentrate on inmates who are most likely to be eligible for SSI payments (and State supplements, if applicable).

(c) Filing Procedures for Prerelease Programs

Upon receipt of a referral (lead) form from an institution participating in a prerelease program, obtain a complete SSI application and other needed forms from the applicant (SSA-401, etc.). If the individual is capable, he normally should be the applicant. Otherwise, the institution or other proper applicant (see § 2025(c)) may file on his behalf. If the institution files, develop capability and representative payee (see §§ 3000 ff.), keeping in mind the expected living arrangements upon release.

At the time of filing, obtain a statement from the institution that the inmate is scheduled or being considered for release if eligible for payments and the approximate date of planned release.

If the institution files on behalf of the inmate, obtain a statement explaining the expected living arrangements upon release, and enter the current living arrangements on the application. If the inmate files, have him explain the current and the expected living arrangements upon release on the application (items on living quarters, members of the household, and/or "Remarks" as necessary) (see §§ 12122-12123).

(d) Claimant's Disability or Blindness Previously Established

If the DDS previously established disability or blindness for the claimant, see § 6259(c) for instructions.

(e) Input Procedures for Prerelease Claim

Refer to section 13505 of the Systems Handbook for the special input procedure for prerelease claims.

12103.2 Notification and Procedures for Prerelease Programs

Because DO's make prospective determinations in some instances and report them to public institutions when there is an agreed upon prerelease program, additional notification procedures apply during the period inmates are pending release and claims are in process.

(a) Informal Notice to Institution and 30-Day Control Period

DO's notify institutions of the results of claims processing when there is a prerelease program, even when the institution is not filing on behalf of an inmate. When the institution files on behalf of an inmate, an institution receives both an informal notice of the result of claims processing in a manner agreed upon and the appropriate formal notice (generated by the computer or prepared by the DO). When an inmate files, the institution receives only an informal notice (telephone call or in-person notification). The purpose of the informal notice is to let the institution know *as quickly as possible* whether payments can be expected, so that release planning and action can go forward, be stopped, or modified.

The DO should notify the institution informally, when it knows the inmate is potentially eligible for payments on release. If an inmate is age 65 or older or the DO finds that disability or blindness has already been established (see § 6259), the DO may be able to provide the informal notice immediately after obtaining the application and determining the inmate's future status on the remaining eligibility issues. If a claim is based on disability or blindness and a DDS determination is required after the DO evaluates all other issues, the DO will be able to notify the institution when it receives the notice of the formal determination from the DDS.

In no instance does the informal notice to the institution remove the requirement for a formal notice to the applicant who signed the application.

(1) DO ACTION 30 DAYS AFTER NOTICE

Whenever potential eligibility for payments exists for an inmate pending release, remind the institution at the time of giving informal notice that final DO action on the claim is delayed for 30 days pending release. Set up DO controls on the case for 30 days pending notice of release from the institution or inmate. If no notice of release is received at the ex-

piration of the 30 days, contact the institution and verify the situation with respect to release. If release is expected soon after this contact, do not disallow the claim, but extend the period. However, if release is not imminent, advise the institution that the DO will take final action to disallow the claim.

(2) DO DETERMINES INMATE INELIGIBLE

Whenever an inmate is not eligible because of a factor other than status as an inmate of the public institution which made the referral, provide the institution with an informal notice of this fact *as soon as the determination is made or becomes known to the DO*. This may occur, for example, when income precludes payment, resource limitations are exceeded and an agreement to dispose of property does not apply, the planned living arrangements are a change to another public institution where the claimant will continue to be ineligible, the DDS telephones and reports that disability or blindness does not exist, etc.

(b) Denial Notice

In a denial case, the notice must explain the disallowance *based on the main reason for denial*. Note that when a DDS decides the case is a denial, the computer prepared formal notice shows that the individual is not disabled or blind. In this way, the most significant reason for denial appears in the notice.

(c) Complete Notice in Allowance

Note that when an individual leaves a public institution and is eligible for one or more months, it is common to have situations of a month (or months) of ineligibility followed by a month when the highest standard payment amount applies, which is followed by a month of one-third reduction, deeming of income, or other situation causing payments to decrease. The formal notice of allowance must explain all of these determinations.

12104. Scope of SSI Program Applications

The scope of an SSI program application is explained in § A2013. In addition to being an application for all SSA administered programs, an application for SSI can also be an application for State administered Medicaid programs, when that is the policy of the State (see § 13066). This addition to the scope of SSI program applications is completely up to the State, and when it applies avoids additional filing for Medicaid.

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
50 NORTH PEARL STREET, ALBANY, NEW YORK 12243
BARBARA B. BLUM
Commissioner

APPENDIX F
(P. 1 of 2)



May 25, 1979

Mr. Thomas R. Harmon
Program Cost Analyst
State of New York
Commission on Quality of Care
For The Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Project #67

Dear Mr. Harmon:

As per your letter of May 16, 1979, we are including the information we recently developed covering the time between SSI application date and the date HEM forwarded the information to New York State. HEM ran the data on December 4 through 8 and we had forwarded all of the data by December 19.

Initial Eligibles - 847

<u>Application Date</u>	<u>Aged</u>	<u>Disabled/Blind</u>
Prior 1978	3	15
1/78 through 6/78	6	44
7/78	-	23
8/78	7	81
9/78	23	122
10/78	71	133
11/78	223	78
12/78	17	1
	<u>350</u>	<u>497</u>

You will note from the preceeding that 240 (69%) of the Initial Aged Applications were processed by HEM within 38 days. An additional 71 (20%) were processed by HEM within 69 days.

Although the Disabled/Blind cases are not determined as readily, there were 79 cases determined within 38 days and an additional 133 cases within 69 days.

Additional time would have to be added for the local agency processing after our forwarding.

-2-

We cannot determine the time lag on changes made by HEM. There are no dates that can be used for this purpose in the SDX file.

We hope that the above will be of value to you.

Sincerely yours,

Handwritten signature of Seth S. Grossman in cursive, followed by a small 'ES' monogram.

Seth S. Grossman, Director
Social Services Program Operations

SSG:RG:vm
cc: J. Oliver

APPENDIX G

Analysis of Family Care Population by SSI Pay Status
NYS, Calendar Year 1978

Facilities	Family care clients	Family care clients on SSI pay status	Percent
Total	7081	6282	88.7
OMH	3251	2758	84.8
OMRDD	3830	3524	92.0

SOURCE: DMH Statistical Operations

Analysis of Inpatient Populations by 621 Eligibility
NYS, April 30, 1979

Facilities	Inpatients	621 Eligible		621 Ineligible	
		Number	Percent	Number	Percent
TOTAL	41,620	31,917	76.7	9,703	23.3
Adult psychiatric centers	25,999	17,353	66.7	8,646	33.3
Developmental centers	15,621	14,564	93.2	1,057	6.8

SOURCE: DMH Statistical Operations

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

BARBARA B. BLUM
Commissioner

RECEIVED
MAR 21 1980
COMMISSION ON
QUALITY OF CARE

APPENDIX J

p. 1 of 13



PHILIP S. CARTENBERG
Executive Deputy Commissioner

March 20, 1980

Mr. Clarence J. Sundram, Chairman
Commission on Quality of Care for
the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Clarence:

The purpose of this letter is to respond to the draft report on the problem associated with the issuance of Medicaid cards to individuals released from State psychiatric and developmental centers.

Our delay in response was related to the need to complete a number of documents which are important parts of our answer.

The draft report grouped together those who were discharged to Keyes amendment facilities and to non-Keyes amendment facilities. I think it is important that distinctions be drawn between these groups since the applicable provisions of the law are somewhat different.

Residents in Keyes amendment facilities receive no Medicaid cards. The problems that the Department faced in establishing eligibility were caused by delays in amending Title XIX regulations to comply with the provisions of Title XVI. These changes have taken place. The Department is about to issue an administrative letter (copy attached) advising local districts of their responsibility for these cases. Once this letter is released, there should be no further difficulty in processing these persons for medical assistance.

The non-621 individuals who reside in non-Keyes facilities face several problems. A stumbling block has been presented by the process of determining the actual county of fiscal responsibility. The Department will be submitting program legislation (copy attached) which will clarify and simplify this issue. In addition, your report correctly identifies delays that result from the time necessary to establish SSI eligibility. Our response to this is twofold; first, authority currently exists for pre-release applications by the Offices of Mental Health and Mental Retardation. We are prepared to work with both agencies to assure that there is clarity in the pre-release planning, including applications for SSI and Medical Assistance. Second, many people released from these facilities would qualify for HR-Interim Assistance. I have asked our Income Maintenance staff to work cooperatively with staff of OMH and OMR to assure that appropriate procedures are put in place to establish assistance where necessary. As you know, provision of home relief would qualify an individual for medical assistance.

Mr. Clarence J. Sundram
Page 2
March 20, 1980

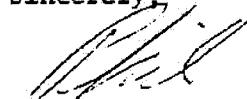
Individuals discharged who are 621-eligible and in non-Keyes facilities are subject to the provisions of Chapter 277 of the Laws of 1979. I have attached a copy of the soon-to-be released report governing the plans developed by DSS, OMH, and OMR to implement this law. As it indicates, we have chosen to implement provisions of Chapter 277 in New York City where Medicaid Management Information System is in full operation. The process began for OMRDD clients as of January 15, 1980, and will begin for OMH clients in New York City this month. We anticipate expanding coverage of the provisions of Section 277 as the implementation of MIS progresses across the State.

A separate category are those individuals who are conditionally released to family care. As the procedure currently stands, Medicaid cards are issued to these individuals by New York State. We will not usually learn of the discharge until after it has taken place; however, we will be working with OMH to improve the timeliness of this notice.

Finally, your report relates to the reluctance of providers to honor State-issued MA/ID cards. Again, as MMIS expands the State picks up the possibility for issuance of all cards the distinction and therefore the reluctance to use State-issued cards will decrease directly.

The Department of Social Services stands ready to work with you and Offices of Mental Health and Mental Retardation and Developmental Disabilities in improving the linkages and cooperation between the departments involved and to assure that clients receive their maximum benefit from medical assistance as well as the State receive maximum optimum reimbursement.

Sincerely,



Philip Gartenberg
Executive Deputy Commissioner

Attachments

cc: Commissioner Blum
Robert Skerrett
Sydelle Shapiro



NEW YORK STATE
OFFICE OF MENTAL HEALTH

JAMES A. PREVOST, M.D. Commissioner

January 23, 1980

Mr. Clarence J. Sundram
Chairman
Commission on Quality Care
99 Washington Avenue
Albany, New York

Dear Chairman Sundram:

We have reviewed the Commission Report on the Medicaid issuance process, Delays, Dollars and Disorganization. As the agency responsible for ensuring that the mentally disabled population receive the services they require, we share the concern and frustration which the report expressed over the delays in securing Medical Assistance. We have already taken several alternative courses of action in seeking a remedy to this problem. Other alternatives are being planned or are in the process of being implemented.

Some time ago facility staff were given detailed instructions on the correct completion of disability statements. The discharge planning model which we are developing will augment the quality of those reports by requiring additional elements be documented in the case record and by providing for closer linkage between the clinical staff, case management staff, and Patient Resource staff. Patient Resources, recently reorganized and redirected, will coordinate the information and provide the formal linkages allowing for an efficient discharge process.

The Bureau of Patient Resources is currently taking a survey of all Family Care clients to determine their SSI/Medicaid status as part of the implementation process for the Food Stamp Program.

Patient Resources is also in the process of negotiating an Interim Assistance Agreement with the Social

-2-

Security Administration. That agreement would ensure the repayment of voucher funds sent to Family Caretakers by permitting the Social Security Administration to send the first (retroactive) SSI check directly to OMH.

Patient Resources also implemented a Family Care Control Log late last year. This log established standards for the filing for SSI on Family Care placements and a reporting and control mechanism for monitoring its compliance.

Of special interest to us is the pre-release filing option which the Commission recommends. This option adds flexibility to the application process by allowing an SSI application to be filed and approved 30 days prior to actual placement. While this will make it somewhat easier for us to develop benefits for clients as they enter the community, we are nevertheless still constrained by the SSA's insistence that a new disability determination be made each time a new SSI is filed. This means that if a client, determined permanently disabled or disabled for a full year, is not released from the institution within 30 days of his SSI approval, because a suitable placement could not be found, his application must be denied. If a suitable placement is found and he is placed the following month, a new SSI application, along with a new disability determination, is required. There should be some mechanism for retaining the disability determination for the full time certified.

While these program changes will ameliorate the problems associated with the Family Care population, the changes do not go far enough to meet the needs of our largely short-term population. Characterized by a median length of stay of only 35 days, over 80% of our releases have spent less than three months in the facility. Thus, no accelerated disability determining process, alone or coupled with even the most aggressive discharge planning model, can process applications fast enough to hand each client a Medicaid card as he leaves. Only an eligibility determination process completely under OMH control could meet that type of time constraint.

While it would be organizationally possible for OMH to take over the eligibility determination process for our clients, and to guarantee a high level of integrity in its operation, it would be a politically difficult situation to negotiate. Because most released clients enter the local

social services system, we would need the agreement of each county social service district that they would accept our determination of eligibility. Legislative authorization, as well as HEW approval, would also be required.

Short of taking over the entire eligibility process, OMH could significantly expedite the Medicaid issuance process by taking over the disability determination process for released clients from DSS. That is what OMH is already doing for our inpatient Medicaid applications. Similarly, when the Resource Agent is advised by the Discharge Planning Team that the client is being considered for discharge, s/he would contact the patient's physician and request that a disability determination be made and transmitted to him. The Resource Agent would then coordinate with the patient's case manager to determine which type of placement is being considered for the client. Based on the type of placement and financial resources available to the client, the Resource Agent would advise the case manager of which programs (SSI, Medicaid, etc.) the client needs to be enrolled in. The Resource Agent would then complete those forms s/he could and provide the case manager with those forms the client must sign, and those offices the client must visit in order to pre-release file for needed benefits.

Important as Medicaid is for inpatients entering the community, cash assistance is as important. Delays in obtaining cash assistance can postpone discharge from the institution. SSI is the preferred choice of cash assistance for disabled clients. OMH could expedite the SSI eligibility process by taking over the disability determination for SSA. Currently SSA contracts with DSS to determine whether clients meet the disability requirements of the law. If DSS is willing to allow OMH to perform Medicaid disability determinations, they should allow OMH to do SSI disability determinations. Since DSS would only be subcontracting the disability determination to OMH, the SSA should not object. An SSI application which is filed with a disability determination should take no longer than 10 working days for SSA adjudication. Coupled with a pre-release filing program, OMH disability determinations should virtually guarantee that our clients be able to obtain both an SSI check and a Medicaid card within a few days of release.

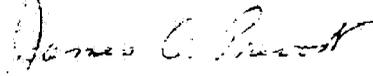
There are other areas we will also pursue designed to streamline the SSI/Medicaid approval process for clients entering the community. For Family Care and Community Residence

clients, in cooperation with NYS DSS, we will accelerate procedures which will ensure that they receive a card at the time they are placed. For all clients, through our new discharge planning process, we will more closely coordinate the facility staff, Patient Resource staff, case management staff, and local social service staff to ensure the timeliest receipt of benefits possible.

We appreciate the work which the Commission has done in producing this report. It has served not only to focus our attention on areas requiring improvement, but to propose specific, thoughtful solutions which will be of assistance to us. We would also like to be able to call on the Commission's support as we negotiate the solution to these and other related problems with the other agencies involved.

If clarification of any of the issues raised in this letter are needed, please contact me.

Very truly yours,



JAMES A. PREVOST, M.D.
Commissioner



STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 Holland Avenue - Albany - New York - 12229

JAMES E. INTRONE
Commissioner

January 22, 1980

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Sundram:

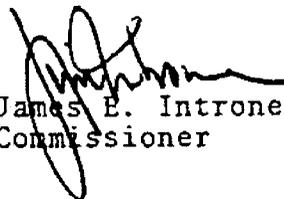
Attached is a copy of our comments on the confidential draft of the Commission's report on its study of problems associated with the issuance of Medicaid cards to individuals released from state psychiatric and developmental centers.

You will note from our comments on your recommendations that we have been aware of this problem for some time and have made this a priority issue since the April 1, 1978 reorganization.

Recent policy statements issued by us, and new mechanisms developed for processing Medicaid cards including the establishment of MMIS statewide, should alleviate many of the problems identified in your report. However, we will continue to be extremely sensitive to the need to provide training to individuals involved in the documentation of disability and to pursue more diligently with the Department of Social Services the resolution of a number of unresolved issues.

Thank you for allowing us the opportunity to comment on this report.

Sincerely,



James E. Introne
Commissioner

Attachment



Being retarded never stopped anyone from being a good neighbor.

DELAYS, DOLLARS AND DISORGANIZATION:

A Report on the Problems Associated with the Issuance
of Medicaid Cards to Individuals Released from
State Psychiatric and Developmental Centers

January 1980

Recommendations

1) Medicaid cards be issued to eligible individuals on the day of their release from State psychiatric and developmental centers. To this end, it is recommended that the OMH, OMRDD, SSA, NYSDSS, and local social services districts establish written agreements and procedures ensuring that:

- a) Applications for assistance be submitted and processed prior to any individual's release from a psychiatric center or developmental center;
- b) Application packages for Public Assistance be initiated by OMH and OMRDD facilities at the time that individuals are first identified as possible candidates for community placement;
- c) Completed application packages be submitted by Resource Agents at least 30 days prior to release.
- d) Resource Agents be designated as the first and last steps of the Medicaid card issuance process--initiating the process by submitting applications prior to release and ending the process by handing individuals, on the day of their release, Medicaid cards issued by the appropriate jurisdiction upon its determination of the client's eligibility.
- e) In light of the delays inherent in the SSI eligibility determination process, clients be issued Medicaid cards on the basis of their eligibility for Home Relief or Medicaid Only pending the determination and transmission of SSI eligibility and the generation of a Medicaid card on that basis.

The OMRDD has long supported the goal of ensuring that the client be issued a Medicaid card on the day of release from a Developmental Center. We have been moving in that direction since the April 1, 1978 reorganization, and recently reached our objective for the New York City population.

One of the earliest activities in this regard was the Resident Resource negotiation of a procedure to ensure that NYS DSS would issue a Medicaid card for all eligible clients beginning with the first full month of placement. This procedure is outlined in Resource Letter 78-19 issued June 6, 1978 (see attachment I). As recommended by the Commissioner, this procedure does provide for cards based on Medicaid only (Home Relief is not applicable to Family Care), and this eliminates the need to wait for SSI development.

While this procedure brought us closer to our goal, final achievement was not possible until the passage of Chapter 277. With the legislation in place, the Bureau of Resident Resources acted immediately to devise a master plan and coordinate the various activities of the OMRDD, NYS DSS, and local social services districts. As a result of this effort, Resource Agents will begin to issue Medicaid cards to Chapter 621 clients released in New York City after January 15, 1980. This process, outlined in Resource Letter 79-31 (see Attachment II), will be implemented statewide as soon as possible. Because the existence of MMIS is a process requirement, upstate implementation will be on a phase-in schedule concurrent with the MMIS statewide phase-in.

Relative to developing this procedure, the OMRDD has revised its policy on preplacement planning. As described in Bureau of Standards and Policy Planning Memorandum of December 13, 1979 (see attachment III), policy now calls for Resource Agent participation in the development of the Community Service Plan in all cases. With this provision we can ensure compliance with the Commissioner's recommendations for prerelease filing of Public Assistance and Medicaid-only applications.

The Bureau of Resident Resources will also initiate research into the possibilities of prerelease filing of new SSI applications. Federal regulations include this provision, but OMRDD has never pursued the possibility, mainly because of the problems related to the Resource Agent receiving timely and reliable release planning information. This problem should be eliminated with Agent participation in development of the Community Service Plan.

2) To ensure that Medicaid eligible family care clients have received Medicaid cards and that these cards have been issued by the New York State Department of Social Services, it is recommended that:

- a) Family care placement staff determine if clients have received Medicaid cards;
- b) Family care placement staff, in coordination with Resource Agents, determine if the Medicaid card received by each client was in fact issued by the appropriate jurisdiction and duly report any errors;
- c) Family care placement staff report to Resource Agents instances in which seemingly eligible individuals did not receive Medicaid cards.

In line with this recommendation, Resident Resource Letter 78-19, noted above, calls for the client coordinator to verify Medicaid card receipt and refer problems to the Resource Agent for appropriate follow-up and resolution. Even with the existence of this directive, we are aware of continued problems in this area and other aspects of Family Care funding.

As part of a comprehensive review of Family Care initiated in 1979, the Bureau of Resident Resources is completing a survey of Family Care vouchering and is preparing a review of all non-SSI cases. (Current statistics indicate a higher incidence of non-SSI cases in OMRDD than the 1979 level referenced in the report.)

Preliminary indications are that the fragmented assignment of responsibility for various aspects of the Family Care funding process should be replaced by placing full responsibility with the Resource Agent who is in the best position to be aware of and to coordinate all parts of the process. This redesign would include provision to place the Resource Agents in more direct communication with Family Care providers to insure that problems are addressed immediately. This would be accomplished through assignment of the Agent's Family Care caseload by provider rather than by alphabetical breakdown as is now the case. With this change the Agent would be required to initiate a monthly contact with the provider to identify problems related to Medicaid cards or other aspects of client funding.

We anticipate providing the Agent with two new mechanisms for effectively fulfilling this responsibility. One of these is an Automated Medicaid Eligibility System (AMES) now in final stages of development. The second is an on-site terminal for input and inquiry when the OMRDD population is brought into the Welfare Management System (WMS). A request for these terminals (copy attached) was submitted on December 19, 1979.

3) An organized campaign be initiated to recruit health care providers willing to accept State-issued Medicaid cards. OMH and OMRDD should have as their objectives:

a) The pooling of information regarding health care providers within geographic areas known to accept State-issued Medicaid cards;

b) The identification of geographic areas where there are concentrations of family care clients, but an inadequate number of providers willing to accept State-issued Medicaid cards;

c) The identification of categories of health care providers (i.e., dentists, internists, gynecologists, etc.) needed within underserved areas; and

d) The delegation of responsibility for recruitment activities to develop the pool of available health care resources within geographic areas.

We recognize the difficulties some of our clients have in locating providers and obtaining services. We feel, however, that the approach recommended by the Commissioner, while independently viable, will not be necessary because of the MMIS.

While the system will accommodate the concept of a "State charge" client, differences in cards and billing mechanisms will be eliminated. With full MMIS implementation the Family Care client will lose his/her uniqueness as far as the Medicaid provider is concerned.

4) Training sessions be initiated for appropriate institutional staff routinely involved in the process of documenting individuals' disabilities for public assistance purposes, so that errors in this initial stage of generating Medicaid coverage might be reduced.

Since 98 percent of the OMRDD resident population is Medicaid eligible while in the Developmental Center, the problems related to disability determination are not as extensive as they are for other populations. Nevertheless, we recognize the need for staff to be aware of the Social Security definition of disability

-5-

since about 50 percent of the population must have SSI eligibility established upon movement to the community.

In 1977 the OMRDD, in cooperation with DSS Medicaid Division, prepared materials on disability determination for distribution to facility staff and also provided training sessions by DSS personnel. No formal training arrangements have been made since that time and we do agree that periodic review and update of the material is necessary. We will arrange through our training staff for a definite training plan to incorporate both initial training for new employees, and periodic inservice review for all employees involved in documenting disability for Medicaid or SSI purposes.

5) The jurisdictional responsibility for furnishing Medical Assistance to individuals released to State-operated community residences be clarified by the NYS DSS.

The fact that clients in State-operated Community Residences are not receiving Medicaid cards is a matter of great concern to the OMRDD and one which we have worked to resolve since the beginning of the program. As early as December of 1976 we made this an agenda issue for interagency meetings on implementation of the Keys Amendment. When advised by NYS DSS that a statutory change was required to issue State Medicaid cards to these clients, we proceeded to sponsor necessary legislation. With the failure of this legislation during the 1979 session we requested NYS DSS to issue a directive to the local agencies advising them that these clients are their responsibility under the existing law. We have made frequent follow-up contacts with DSS to emphasize the urgent need for action; but to the best of our knowledge, the directive has not yet been issued.



HOWARD F. MILLER
DIRECTOR OF THE BUDGET

STATE OF NEW YORK
EXECUTIVE DEPARTMENT
DIVISION OF THE BUDGET
STATE CAPITOL
ALBANY 12224

APPENDIX J
p. 13 of 13

February 7, 1980

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Sundram:

I have reviewed the Commission's draft report concerning the problems associated with the issuance of Medicaid cards to individuals released from State Psychiatric Centers and Developmental Centers. The report is informative, comprehensive, and to the point.

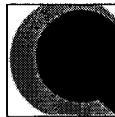
It may be of interest to you that OMRDD has just recently begun issuing temporary Medicaid authorizations (pending receipt of an MMIS card) to 621 eligible persons in New York City. This temporary card (CS-19) is issued to Developmental Center clients immediately upon release from the facility. It seems likely that the result of this new procedure will be to decrease the number of clients who experience delays in obtaining their Medicaid card. Although the newly instituted temporary authorization system addresses the problem of untimely issued Medicaid cards for part of the MR population, it certainly is not a solution to the labyrinth of problems so explicitly detailed in your report.

Thank you for soliciting my comments.

Very truly yours,

Harriet Jacob
Budget Examiner

The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities is an independent, New York State government agency charged with improving the quality of life for New Yorkers with disabilities, protecting their rights, and advocating for change.



New York State
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