ADMINISTRATIVE PRACTICES

ADVICE FOR

MENTAL HEALTH PROGRAMS

NYS Office of Mental Health
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INTRODUCTION

The purpose of this document is to provide advice for programs licensed by the NYS Office of Mental Health regarding administrative practices, processes and structures that contribute to the financial well-being of an agency, and facilitate better ways of doing business. Much of this advice was gleaned from a review of corrective action recommendations resulting from on-site reviews of a variety of mental health providers. These recommendations are now presented in a consolidated format.

This document is organized into the following six components:

- Governance Structure;
- Billing and Accounting System;
- Compliance with Medicaid Requirements;
- Fee Schedules;
- Quality and Productivity; and
- Expenditure Control.

Providers are encouraged to share these materials with their Board of Directors, as well as members of the executive, clinical and finance staff.

GOVERNANCE STRUCTURE

- ❑ Providers should establish and maintain an active and involved Board of Directors, which must have overall responsibility for the operation of the program. While the Board may delegate responsibility for the day-to-day management of the program (e.g., to an Executive Director), the Board cannot delegate its ultimate oversight role.

- ❑ The Board must either include recipient representatives or establish a mechanism for receipt of recipient input.

- ❑ In not-for-profit corporations (other than general hospitals), no person can simultaneously serve as a member of the Board and as a paid member of the program staff without the prior approval of OMH.

- ❑ Board members should avoid related-party transactions. Any such transactions should be reviewed and approved in advance by the Board, with such approval documented in the Board's minutes.

- ❑ The Board should establish and periodically review the effectiveness of a system of internal controls to ensure that there are adequate checks and balances and division of duties in place to safeguard agency assets (e.g., ensure that bank reconciliations are regularly prepared and independently reviewed by supervisory personnel).

- ❑ The Board should review details of annual budgets and year-to-date performance against budgets to keep fully informed of any changes in the financial well-being of the agency.

- ❑ Any financial difficulties should be promptly presented to the Board of Directors and aggressively addressed in accordance with a realistic business plan that is designed to ensure the agency's financial recovery.

- ❑ Board members should meet regularly, take and record votes on all important issues, and fully document all meetings.

- ❑ Board members should have diverse management skills, including fiscal, legal and fund-raising expertise.

- ❑ Board members are encouraged to attend available Board of Directors Training sessions.

- ❑ Providers are legally required to participate, with the local governmental unit, in the local planning process. Board members and program management are encouraged to increase their involvement with local government officials to continually discuss their role within the local mental health system.

- ❑ Board members and management are encouraged to establish or strengthen relationships with other service providers in order to develop additional referral sources and to network on issues of mutual concern.

BILLING AND ACCOUNTING SYSTEM

- ❑ A system should be established and maintained that ensures that every service provided results in the timely and accurate submission of a claim to a valid payor (i.e., Medicaid, third party insurance or self-pay).

- ❑ Procedures should be established for determining, upon intake, each recipient's funding source, and for collecting appropriate information.

- ❑ Providers should ensure that bills comply with insurance requirements by providing billing staff with current copies of insurance agreements and reviewing insurance denials to correct systemic billing errors.

- ❑ Denials of claims should be monitored and addressed. For example, providers should:

    - ❑ identify related problems;
    - ❑ promptly resubmit claims; and
    - ❑ correct any systemic problems.

- ❑ Providers should determine and resolve problems which result in improper denials by payors.

- ❑ Unpaid bills should be monitored regularly.

- ❑ Any unusual fluctuations in monthly revenue receipts should be investigated.

- ❑ An annual audit should be obtained from a competent CPA firm that has an established knowledge base regarding the performance of audits of mental health provider agencies in accordance with State and Federal guidelines. The CPA should provide a management letter and annually present audit results to the full Board of Directors and agency management.

- ❑ CFR guidelines should be fully understood to ensure the accurate and timely submission of annual CFR documents.

- ❑ All fiscal records must be available for review for a period of six years following the date of service delivery.

COMPLIANCE WITH MEDICAID REQUIREMENTS

- ❑ Providers should ensure compliance with documentation and billing requirements to avoid vulnerability to audit adjustments. (see, for example, "Medicaid Requirements for OMH-Licensed Outpatient Programs").

- ❑ As part of the agency's quality improvement program, clinical supervisors and program administrators should conduct assessments of adherence to documentation and billing rules. For example, providers are advised to:

  - ❑ continuously monitor and improve documentation procedures and practices; and

  - ❑ identify record keeping procedures and practices which, if uncorrected, could lead to disallowances.

> **NOTE:** The purpose of this review process is to inform and modify future practices. Existing records must *never* be modified.

MOST COMMON REASONS FOR MEDICAID DISALLOWANCES		
ELIGIBILITY*	**BILLING***	**DOCUMENTATION***
✓ pre-admission visits exceed the limit	✓ improper rate codes used	✓ missing progress notes
✓ minimum duration of visit is not met	✓ duplicate bills in the same day	✓ missing physician signature on treatment plan
		✓ missing treatment plans
		✓ no indication of services provided
		✓ untimely completion or review of treatment plans
		✓ duration of visit not documented
		✓ missing case records

* requirements associated with OMH-licensed outpatient programs

FEE SCHEDULES

- ❑ Providers should understand their cost per unit of service, and its relationship to productivity.

- ❑ Providers should negotiate rates with third party payors that cover the agency's cost per unit of service, and are sufficient to ensure the provider's financial well-being.

- ❑ Providers should establish a reasonable schedule of payment levels for self-pay clients, update the payment schedule periodically, and ensure that self-pay clients' financial status and availability of payor sources are regularly assessed or verified.

QUALITY AND PRODUCTIVITY

- ❑ Clinician productivity standards should be developed to keep the program operating with sufficient revenues to meet or exceed expenses.

    - ❑ Actual performance should be monitored against these standards.
    - ❑ The provider should develop and implement policies to address situations where staff do not achieve the established productivity levels.

- ❑ The use of clinician's time for service delivery should be maximized.

    - ❑ When possible, support staff should be used to collect recipient information, schedule appointments, make follow-up telephone calls, file client records, etc.

    - ❑ No-show rates should be reduced through the use of reminder calls, more efficient scheduling, and clinical review of the therapeutic relationship.

- ❑ Recipient satisfaction with services should be monitored, and clinicians should receive feedback.

- ❑ Providers should consider adjusting their hours of operation to accommodate the needs of working recipients and significant others.

- ❑ Quality improvement activities should include reviews of no-show rates and recipient satisfaction.

EXPENDITURE CONTROL

- ❑ Administrative overhead costs should be contained (e.g., by keeping them under 15 percent of operating costs). If these costs exceed reasonable levels, organizational changes to reduce the overhead rate should be considered.

- ❑ Providers should implement purchasing guidelines to ensure that large expenditures are competitively bid, and that all agency purchases of goods and services are made at the best price available, consistent with acceptable quality. Available State contracts for large purchases (e.g., multi-passenger vehicles) should be utilized to the extent practical in existing circumstances.