NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

March 21, 2014

Ms. Andrea Inman, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street - 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments in response to the Office of the State Comptroller's Follow-Up Audit Report 2013-F-19 on Department actions relative to the recommendations contained in earlier OSC Report 2011-S-8 entitled, "Overpayments to Cabrini Medical Center."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Jason A. Helgerson
James C. Cox
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Ronald Farrell
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Department Of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2013-F-19 Entitled
Overpayments to Cabrini Medical Center

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's Follow-Up Audit 2013-F-19 entitled, "Overpayments to Cabrini Medical Center" (2011-S-8).

Recommendation #1:

From the $1.9 million in excessive claims we identified, recover the $1 million in overpayments made to Cabrini.

Status – Implemented

Agency Action – The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. As a result of an investigation, the OMIG and Cabrini's bankruptcy Plan Administrator agreed to a "Stipulation of Settlement." Based on the settlement, the OMIG accepted a payment of $1,460,503 from Cabrini on October 26, 2012 in full and final satisfaction of any and all alleged Medicaid overpayments resulting from our initial audit. Including the $904,000 in overpayments prevented at the time of the initial audit, the total cost savings resulting from the audit totaled about $2.4 million.

Response #1:

The Department confirms our agreement with this report.

Recommendation #2:

Review the $618,000 in potential overpayments and recover additional money as appropriate.

Status – Implemented

Agency Action – As stated previously, the OMIG recovered $1,460,503 from Cabrini as a result of our initial audit. This included recoveries pertaining to the $618,000 in potential overpayments we identified.

Response #2:

The Department confirms our agreement with this report.

Recommendation #3:

Ensure all service bureaus have the required systems in place for Medicaid providers to review their claims prior to the service bureaus' submission of the claims to eMedNY.

Status – Partially Implemented

Agency Action – A recent Department Medicaid Update article reminded service bureaus and health care providers that claims must be reviewed by the provider, prior to their submission to eMedNY, to allow the provider to correct or delete any inaccurate claim data. However, the Department has no formal mechanism to ensure service bureaus have the required systems in place for providers to review their claims prior to the bureaus' claim submissions to eMedNY.

Response #3:

The Department agrees with the recommendation as Section 504.9(b) of the Social Services Law currently states that service bureaus must maintain a system approved by the Department for notifying providers of claims to be submitted on their behalf, and Section 504.9(c) states service bureaus must submit systems documentation to the Department for the systems configuration which they will be using to process claims prior to acceptance of their enrollment application. The Department no longer has a formal mechanism to ensure these requirements. The Department will work with The Office of the Medicaid Inspector General (OMIG) to ascertain whether OMIG can audit the service bureaus to ensure compliance. If that is not possible, steps will be taken to amend the regulation.

Recommendation #4:

Develop and implement controls within eMedNY to identify and review questionable adjustment claims with high risk attributes. Such attributes should include (but not be limited to) claims that: result in major increases in payment amounts; come from (or are submitted on behalf of) providers who are out of business; and are several years old.

Status – Partially Implemented

Agency Action – The Department has not developed or implemented controls within eMedNY to identify and review adjustment claims that result in major increases in payment amounts or were submitted by or on behalf of providers who are out of business. However, in 2012, the Department implemented a project to strengthen eMedNY controls associated with adjustments to claims that are several years old. Specifically, eMedNY will deny a claim adjustment if the adjustment is submitted more than six years after the original claim's processing date. Further, Department officials stated they will continue to analyze billing patterns and, with available resources, perform manual reviews of high risk adjustment claims.

Response #4:

The Department agrees with the recommendation. By implementing Evolution Project (EP) #1464 – Timeliness Edits, adjustments made to paid claims more than 90 days from the service date now require a delay reason code or they will be denied. The General Billing Guidelines in the eMedNY Provider Manual instructs providers to use Delay Reason Code 11, Other, for

limited situations including adjustments to paid claims. In April 2013, edit 02166 – Delay Reason Code 11 (Other) Invalid, was set to deny claims with inappropriate use of reason 11. This edit will also allow the Department to select claim adjustments to manually review for specific provider types and deny adjustments submitted beyond regulatory time limits. Additionally, the Department will continue to analyze billing patterns and review high risk claims adjustments.

Recommendation #5:

Investigate Gaeta's billing practices and determine the extent of its inappropriate claim submissions for Cabrini and its other client Medicaid providers as well.

Status – Implemented

Agency Action – Gaeta's billing practices were reviewed by OMIG and referred to the Attorney General's Medicaid Fraud Control Unit (MFCU) for further investigation. At the time of our follow-up, the MFCU's investigation of Gaeta's incorrect claim submissions and billing practices was ongoing.

Response #5:

The Department confirms our agreement with this report.

Recommendation #6:

Develop and implement controls within eMedNY to identify the service bureaus billing Medicaid on behalf of healthcare providers.

Status – Partially Implemented

Agency Action – According to Department officials, they initiated an eMedNY project to identify service bureaus that submit electronic transactions on behalf of Medicaid providers. However, officials postponed the project to address other priorities. At the time of our follow-up, the project was scheduled to be completed in November 2014.

Response #6:

The Department agrees with the recommendation and has confirmed that EP #1522, designed to identify service bureaus that submit electronic transactions on behalf of Medicaid providers, is on schedule for completion in November 2014.