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December 28, 2015

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Program: Overpayments of
Ambulatory Patient Group Claims
Report 2015-F-20

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report*, Overpayments of Ambulatory Patient Group Claims* (Report 2011-S-43).

Background, Scope, and Objectives

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. In 2008, changes to the State's Public Health Law required a new Medicaid outpatient payment methodology (known as Ambulatory Patient Groups [or APG]) for clinic and ambulatory surgery services as well as hospital-based emergency room services. The APG system was adopted in an effort to more accurately pay providers for the services they rendered. Under the APG payment methodology, claims are reimbursed based on a patient's condition and the complexity of the service. Prior to the APG implementation, outpatient services were paid under an all-inclusive reimbursement model, and the patient's condition and complexity of the service were not factored into the claim payment. Under the new APG system, the Department assigned providers new APG rate codes and deactivated the rate codes used under the previous payment methodology. The Department phased in APGs beginning with hospital outpatient departments and ambulatory surgery centers on December 1, 2008. APGs were then implemented in freestanding diagnostic and treatment centers and freestanding ambulatory surgery centers on September 1, 2009.

We issued our initial audit report on August 20, 2013. The audit objective was to determine

if Medicaid overpaid APG claims because of deficiencies in the claims processing and payment system. The audit covered the period December 1, 2008 through March 31, 2012. Our initial audit identified flaws in the Department's eMedNY claims processing system that allowed improper payments on 6,615 claims (totaling Medicaid payments of $1,204,186). We determined that the claims contained certain improper combinations of APG rate codes which led to overpayments. Auditors also identified $933,399 in duplicate payments made to providers for the same services under both the old and the new (APG) payment methodologies. Furthermore, we identified 56,241 claims totaling $4,286,603 that were at risk of duplicate payment and needed to be reprocessed using the new APG methodology.

The objective of our follow-up was to assess the extent of implementation, as of November 30, 2015, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made significant progress in implementing the recommendations we made in our initial audit, which included recovering nearly $898,000 in overpayments and implementing new claims processing controls to prevent future improper payments. Of the initial report's five audit recommendations, four were implemented and one was partially implemented.

Follow-Up Observations

Recommendation 1

Review the 6,615 instances of improper payments (totaling $1,204,186) and make recoveries, as appropriate.

Status - Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. After our initial audit, the OMIG identified additional instances of improper payments, for a total of 7,197 such instances. As of November 30, 2015, the OMIG recovered $17,881 on 366 of the improper payments. Also, by January 2016, the OMIG will initiate recoupments from 20 Medicaid providers who account for 74 percent of the problematic claims. The OMIG will instruct the providers to take certain corrective steps, including voiding and adjusting the problematic claims. Once the corrective steps are taken, the OMIG will determine the net overpayment on the instances of improper payments identified. OMIG officials informed us they will continue to review the improper payments identified in the initial audit report and make additional recoveries.

Recommendation 2

Design and implement eMedNY system edits which prevent the improper payments we identified.

Status - Implemented

Agency Action - In January 2014, the Department implemented eMedNY edits designed to prevent the improper payments that were identified during the initial audit. The initial audit found that providers billed prohibited combinations of APG reimbursement codes, which led to improper Medicaid payments. In certain instances, the eMedNY system erroneously paid the improper claims because of the order in which providers billed the improper rate code combinations. The new edits for the APG reimbursement system are programmed to deny payment for claims containing the prohibited rate code combinations, regardless of the order in which the rate codes are billed.

Recommendation 3

Review the 8,819 duplicate payments (totaling $933,399) and make recoveries, as appropriate.

Status - Implemented

Agency Action - The Department reviewed the 8,819 duplicate payments and recovered $879,825. In the initial audit, it was determined that providers received duplicate payments because providers were able to bill both the pre-existing non-APG rate codes as well as the new APG rate codes for the same service to the same recipient on the same date. In response to our audit, the Department reviewed the duplicate payments we identified and, by December 2013, set the non-APG rate codes billed on the claims to pay zero dollars on a retroactive basis. By doing so, the Department recovered $879,825. Also, we determined that most of the remaining payments (totaling $53,574) related to third party co-insurance and co-payments and, for various reasons, might not be recoverable.

Recommendation 4

Complete the deactivation of pre-APG rate codes providers use to submit claims.

Status - Implemented

Agency Action - During December 2013, the Department completed the deactivation of the pre-APG rate codes that providers used to submit claims. The deactivation of pre-APG rate codes prevents Medicaid from making inappropriate duplicate payments to providers who submit claims under both the pre-APG and APG reimbursement methodologies.

Recommendation 5

Using the APG methodology, promptly reprocess the 56,241 claims that were processed using pre-APG rate codes.

Status - Implemented

Agency Action - To mitigate the risk of duplicate Medicaid payments, the Department completed the deactivation of pre-APG rate codes (as noted in the agency's action to Recommendation No. 4). Further, as part of this process, the Department reprocessed the 56,241 claims in question.

Major contributors to this report were Brian Krawiecki, Theresa Podagrosi, and Anthony Calabrese.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Warren Fitzgerald
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General