New York State Office of the State Comptroller

Thomas P. DiNapoli

Division of State Government Accountability

Improper Episodic Payments to Home Health Providers

Medicaid Program
Department of Health

Report 2016-S-4

December 2016

Executive Summary

Purpose

To determine whether the Medicaid program made improper payments to Certified Home Health Agencies under the Episodic Payment System. The audit covered the period May 1, 2012 through December 31, 2015.

Background

Effective May 1, 2012, the Department of Health (Department) implemented the new Episodic Payment System (EPS) to reimburse Certified Home Health Agencies (CHHA) for health care services provided to Medicaid recipients in the home. CHHAs provide various services including, but not limited to: part-time services to individuals who need skilled health care; long-term nursing services; home health aide services; physical therapy; and social worker and nutrition services. CHHAs allow Medicaid recipients to receive services in their homes instead of unnecessary placement in medical facilities, such as hospitals or rehabilitative centers.

The EPS is based on 60-day episodes of care. CHHAs can be paid for a full episode (when the episode of care is 60 days) or for a partial episode (when the episode of care is less than 60 days). Payments for a partial episode may be pro-rated based on the number of days of care on the claim or may be a full payment for certain circumstances – such as when the patient is transferred to hospice, a hospital, or home self-care or in the event of the patient's death. For the period May 1, 2012 through December 31, 2015, Medicaid made $1.2 billion in EPS payments.

Key Findings

Auditors identified about $16.6 million in improper Medicaid payments to 95 CHHAs. About 93 percent ($15.4 million) of the overpayments went to 20 CHHAs. Specifically, the audit found:

- $8.2 million in overpayments to CHHAs for recipients who were transferred into Managed Long Term Care (MLTC) during a 60-day episode of care. The CHHAs should not have received full 60-day payments. Rather, the CHHAs should have received pro-rated payments for the partial episodes of care. For example, a CHHA received a full payment of $11,607 for a recipient who received home health services for only four days. On the fifth day, the recipient was enrolled in an MLTC plan. The CHHA billed Medicaid using an incorrect discharge status code of "Discharged to Home or Self-Care" on the claim. If the provider used the correct discharge code, the provider would have received $774 (not $11,607) for the episode. As a result, Medicaid overpaid $10,833 for this episode of care;
- $7.1 million in overpayments to CHHAs that improperly billed multiple episodes for the same recipient within 60 days of the recipient's original episode start date; and
- $1.3 million in overpayments to CHHAs that improperly received full 60-day payments for recipients who subsequently obtained services from a different CHHA within 60 days of an episode of care.

Auditors also determined that the Department had not established controls to identify, prevent, and recoup the types of overpayments we identified.

Key Recommendations

- Review the $16.6 million in improper payments made to CHHAs and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers that received the largest dollar amounts of overpayments.
- Develop and implement mechanisms to identify and recover overpayments when CHHAs do not bill according to Department guidelines.

Other Related Audits/Reports of Interest

Department of Health: Appropriateness of Medicaid Eligibility Determined by the New York State of Health System (2014-S-4)
Department of Health: Optimizing Medicaid Drug Rebates (2015-S-1)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 8, 2016

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
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Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Episodic Payments to Home Health Providers*. The audit was performed 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.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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This report is also available on our website at: www.osc.state.ny.us

Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2016, the New York State Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $56 billion. The federal government funded about 53.2 percent of New York's Medicaid claim costs, the State funded about 30.6 percent, and the localities (the City of New York and counties) funded the remaining 16.2 percent.

In January 2011, the New York State Governor's Office established the Medicaid Redesign Team to reduce Medicaid costs and improve the delivery of health care services. As part of this initiative, effective May 1, 2012, the Department of Health (Department) implemented the new Episodic Payment System (EPS) to reimburse Certified Home Health Agencies (CHHA) for home care services provided to Medicaid recipients. The EPS was designed to address the rapid growth in CHHA costs per patient by better aligning payments with needed services.

CHHAs provide a range of services in the home, including but not limited to: part-time, intermittent health care and support services to individuals who need intermediate and skilled health care; long-term nursing and home health aide services; physical, occupational, and speech therapy; medical supplies and equipment; and social worker and nutrition services. CHHAs can also help patients determine the level of services they need. By receiving services in the home, patients can avoid unnecessary placement in medical facilities, such as hospitals or rehabilitative centers.

The EPS is based on a price for 60-day episodes of care, and is adjusted for patient acuity and also considers regional wage differences. CHHAs can be paid for a full episode (when the episode of care is 60 days) or for a partial episode (when the episode of care is less than 60 days). Payments for a partial episode may be pro-rated based on the number of days of care on the claim or may be a full payment for certain circumstances – such as when the patient is transferred to hospice, a hospital, or home self-care or in the event of the patient's death. From May 1, 2012 through December 31, 2015, Medicaid made $1.2 billion in EPS payments to 142 CHHAs for services provided to 81,560 recipients.

The Department's eMedNY computer system processes Medicaid claims submitted by health care providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, others verify the eligibility of the medical service, and some verify the appropriateness of the amount billed for the service.

Audit Findings and Recommendations

For the period May 1, 2012 through December 31, 2015, we determined Medicaid overpaid 95 CHHAs $16.6 million under the EPS. The overpayments were for: full episodic payments for recipients enrolled in Managed Long Term Care (MLTC) plans within 60 days of the recipient's episode start date; multiple episodic payments to the same CHHA for recipients readmitted within 60 days of the recipient's episode start date; and full episodic payments for recipients discharged to another CHHA within 60 days of the recipient's episode start date. According to the Department's billing guidelines, CHHAs should not receive a full payment for services under these scenarios; rather, CHHAs should submit a pro-rated claim for the actual number of days that services were provided.

The following table provides a breakdown of the overpayments made to the 95 CHHAs. About 93 percent (or $15.4 million) of the overpayments went to 20 CHHAs.

Overpayment Range	No. CHHAs	Overpayments	Percent of Total Overpayments
> $1,000,000	6	$10,631,700	64%
$500,000–$1,000,000	3	2,397,976	15%
$250,000–$500,000	2	833,328	5%
$100,000–$250,000	9	1,560,691	9%
< $100,000	75	1,226,265	7%
Totals	**95**	**$16,649,960**	**100%**

We determined the Department has not established eMedNY system controls to prevent the improper episodic home health claims that we identified. According to Department officials, the issues identified in this audit were raised during the construction of the EPS. However, insufficient resources and the EPS billing configuration prevented the development of effective eMedNY system controls to prevent the overpayments. We made recommendations to the Department to recover the improper Medicaid payments we identified and to develop and implement mechanisms to identify and recover future improper billings.

Episodic Payment System Overpayments

Transfer to Managed Long Term Care

According to the EPS billing guidelines, a CHHA should receive a partial pro-rated episodic payment when a recipient is transferred into an MLTC within 60 days of the recipient's episode start date. All MLTC programs provide Medicaid home care and other long-term care services. Therefore, a Medicaid capitation payment to an MLTC plan and a full episodic payment to a CHHA for the same recipient during overlapping service dates are duplicative. The Department's episodic payment billing guidelines state that CHHAs cannot use the following discharge status codes when a recipient is transferred to an MLTC program because it will improperly result in a full payment:

- 01 - Discharged to Home or Self-Care,
- 02 - Discharged/Transferred to Hospital,
- 20 - Patient Expired,
- 50 - Discharged to Hospice (Home), or
- 51 - Discharged to Hospice (Medical Facility).

From May 1, 2012 through December 31, 2015, Medicaid overpaid 65 CHHAs $8.2 million on 2,285 claims for recipients discharged from a CHHA to an MLTC plan. In each case, the CHHAs submitted a claim indicating an incorrect discharge code, allowing them to be paid for a full episode when they should have been paid for a partial pro-rated episode. For example, one CHHA received a full payment of $11,607 for a recipient who received home health services for four days. The provider billed Medicaid using the discharge status code of "Discharged to Home or Self-Care" on the claim. However, we determined the recipient was actually enrolled in an MLTC plan. If the provider used the correct discharge code, the provider would have received only $774 for the episode. As a result, Medicaid overpaid $10,833 ($11,607 - $774) for this episode of care.

Multiple Episodic Payments Within 60 Days

For the period May 1, 2012 through December 31, 2015, we identified $8.4 million in overpayments to 82 CHHAs that improperly received a full payment for services to patients who were readmitted within 60 days of their original episode start date. These overpayments occurred because CHHAs did not follow the Department's billing guidelines for the EPS.

In particular, we identified 2,689 claims totaling overpayments of about $7.1 million to CHHAs that billed multiple episodes for the same recipient within 60 days of the recipient's original episode start date. In some cases the multiple episodes were for the same services, and in other cases the services changed. In each of the scenarios we identified, the CHHAs should have submitted an adjustment claim to include all services they provided within 60 days of the first episode start date, and then the CHHA could submit a second (pro-rated) claim for the remaining service dates.

We also identified overpayments for recipients who were discharged from one CHHA, and then received services from a different CHHA within 60 days of the first episode start date. Department guidelines require the first CHHA to adjust the original claim and submit a partial pro-rated payment; however, we found this is not always done. As a result, Medicaid overpaid 469 claims totaling about $1.3 million for services provided to recipients who subsequently received additional services from a different CHHA within 60 days of the first episode.

For example, a CHHA was paid $10,979 (a full 60-day payment) for ten days of services. Five days later, the recipient then received services from a different CHHA. Medicaid paid the second CHHA $4,202 for 56 days of services. According to the Department's guidelines, the first CHHA should have received a pro-rated payment amount of $1,830 for the 10 days. As a result, the provider was overpaid $9,149 because it did not submit an adjusted claim to Medicaid.

Mechanisms to Control Improper Payments

Our audit determined the Department has not established eMedNY system controls to prevent the improper episodic payment claims that we identified. According to Department officials, during the construction of the EPS, CHHAs raised concerns about the challenge of billing for recipients served by more than one CHHA. The Department was also aware of the potential issues concerning overlapping payments to the same CHHA for the same recipient, and the potential for inappropriate payments when a CHHA uses the wrong discharge code upon MLTC enrollment. Although the Department was aware of these issues, they were unable to design appropriate eMedNY system edits to prevent overpayments. However, despite the control limitations in eMedNY, we determined the Department had not established compensating controls (automated and/or manual) to identify and recover overpayments.

Recommendations

1. Review the $16.6 million in improper payments made to CHHAs and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers that received the largest dollar amounts of overpayments.

2. Develop and implement mechanisms to identify and recover overpayments when CHHAs do not bill according to Department guidelines.

Audit Scope and Methodology

The objective of our audit was to determine whether the Medicaid program made improper payments to CHHAs under the EPS. The scope of our audit was from May 1, 2012 through December 31, 2015.

To accomplish our audit objective and assess internal controls, we reviewed applicable sections of State laws and regulations, examined the Department's Medicaid payment policies and procedures, and analyzed Medicaid claim data in eMedNY. We used the Medicaid Data Warehouse and executed computer programs to quantify the amount of overpayments made to providers. We also interviewed officials from the Department of Health and the Office of the Medicaid Inspector General.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State

contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed 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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials concurred with the audit recommendations and indicated the actions that will be taken to address them. In particular, the Department will ensure that a "back end fix" will be put in place to help prevent future overpayments and that overpayments already made will be recovered.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

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Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

November 18, 2016

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
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Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2016-S-4 entitled, "Improper Episodic Payments to Home Health Providers."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2016-S-4 entitled,
Improper Episodic Payments to Home Health Providers

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-4 entitled, "Improper Episodic Payments to Home Health Providers."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

General Comments

The issues cited in the audit were potential issues that were identified and vetted during the construction of the Episodic Payment System (EPS) with the Department of Health's (Department) Division of Payment Systems and the Department's billing contractor staff (eMedNY).

The concern over the potential for overlapping billing for the same patient served by two or more different Certified Home Health Agencies (CHHAs) was raised internally, and also raised by CHHA providers who, under the Medicare Prospective Payment System (PPS), are able to utilize an interactive system supplied by the Centers for Medicare and Medicaid Services (CMS) to track patients in an effort to avoid these issues. NYS EPS does not have a similar interactive system on the State level. Absent such a mechanism, the use of billing edits to deny the overlapping claim would in almost all cases have the undesirable result of penalizing the second CHHA, who was likely submitting a valid claim. This was documented as an area to evaluate for potential review on post-adjudication audit.

The concern over the potential for overlapping payments to the same CHHA for the same patient was also considered. Edits were put in place at the outset to ensure that duplicate payments could not be paid for multiple episodes with the same "from" and "through" dates, for the same patient, at the same CHHA. However, that edit could not be fashioned in a way that insured that a partial claim paid as a full episode would not result in an overlapping payment when a CHHA billed incorrectly with the inaccurate discharge status code. This is because the partial claim only identifies the "from" and "through" dates of service for the partial period. This also was documented as an area to evaluate for potential review on audit.

Finally, the potential for overlapping payments when a partial episode is paid as a full because the CHHA incorrectly billed the wrong discharge code upon (Managed Long Term Care) MLTC

enrollment, was also a concern. That is why CHHA providers were strongly advised in the NYS Department billing guidelines to insure that the discharge status was accurately completed on a claim, particularly for MLTC enrollment situations. This too was documented as an area to evaluate for potential review on audit.

Given the complexity of the issue, the Department will ensure that a "back end fix" will be put in place and that all potential over payments will be fully recovered.

Recommendation #1

Review the $16.6 million in improper payments made to CHHAs and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers that received the largest dollar amounts of overpayments.

Response #1

The Department will assist the OMIG to identify potential overpayments made to CHHA providers through the EPS. OMIG will review potential overpayments, paying prompt attention to identified providers, and pursue recovery of any determined to be inappropriate.

Recommendation #2

Develop and implement mechanisms to identify and recover overpayments when CHHAs do not bill according to Department guidelines.

Response #2

The Department plans to issue guidance to all CHHA providers, reiterating the existing billing rules, particularly as they relate to overlapping billing for the same patient by the same CHHA and patient enrollment in MLTC. This guidance will be released by December 2016.

The Department is currently working with a new Medicaid billing contractor Xerox to establish a new statewide Medicaid billing system, New York Medicaid Management Information System (NYMMIS), to replace the current eMedNY system. During discussions for implementation of the CHHA EPS to that system, the Department will take into consideration the findings by the Office of the State Comptroller and evaluate with Xerox contractor staff the potential for stronger edits that balance the need to insure fair and accurate payments to providers with the need to control for potential overpayments.

The Department will contact Xerox (the NYMMIS contractor) to ensure that all appropriate edits are placed into the new system to mitigate possible overpayments.