NEW YORK STATE OF OPPORTUNITY. Department of Health

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Commissioner

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Executive Deputy Commissioner

November 20, 2017

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2017-F-3 entitled, "Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits." (2013-S-17)

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2017-F-3 entitled,
Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2017-F-3 entitled, "Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits"

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 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1

Review the actual and potential overpayments we identified, particularly for the five providers identified in this report and for the services that otherwise would be denied if provided outside a clinic or outpatient facility, 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. As of February 19, 2017, the OMIG recovered $196,296 of the $32.1 million in potential and actual overpayments identified in the initial audit. Of the $32.1 million, the five providers represented $4.1 million. The OMIG referred the claims billed by one of the five providers (totaling $1.5 million) for additional review by the federal Unified Program Integrity Contractor, Safeguard Services. OMIG officials stated they conducted a limited review of the remaining four providers and determined they would not pursue recoveries due to the uniqueness and complexity of these types of claims. However, we encourage OMIG officials to reconsider and review the claims for these four providers as our review found significant weaknesses in the supporting documentation they provided (of the 1,639 services we reviewed for these five providers, 1,134 – or 69 percent – lacked sufficient supporting documentation).

The OMIG is not reviewing the remaining $27.8 million ($32.1 million - $4.1 million - $196,296) in actual and potential overpayments we identified. According to OMIG officials, they cannot pursue recoveries from one provider that self-disclosed billing errors and entered into a settlement agreement with the New York State Attorney General. This provider's claims represented $214,735 of the $27.8 million ($26,108 is outside of the provider's settlement and may be available for recovery). We remind OMIG officials that the eMedNY system does not have comprehensive

edits or controls to prevent payments for excessive services beyond Medicaid service limits. Rather, the Department relies on providers to submit accurate APG claims that fully comply with the Department's APG billing rules and regulations. Additionally, during the initial audit, Department officials agreed that the services we identified, which eMedNY would have automatically denied had the claims been non-APG claims, were likely inappropriate. As such, we maintain that the OMIG should allocate appropriate resources to review these high-risk Medicaid payments

Response #1

Based on the addition of clinical staff as part of the Unified Program Integrity Contractor (UPIC), OMIG will share the results of its review of the identified overpayments of the remaining four providers, and assist the UPIC in pursuing recovery of any payments determined to be inappropriate.

Recommendation #2

Strengthen controls over APG claims processing to prevent improper payments for excessive services.

Status – Not Implemented

Agency Action – Department officials stated that they will assess eMedNY to see if it is possible to apply frequency limits to APG claims. However, at the time of our follow-up this had not been done, and the Department was unable to provide evidence that they had taken any action since our initial audit to strengthen controls over APG claims processing to prevent improper payment of excessive services.

Response #2

The Department repeatedly advised OSC that discussions had occurred between program staff, systems staff, and contractor staff on the feasibility of implementing payment edits for institutional claims to limit payments for services that may exceed frequency parameters. OSC was advised that the eMedNY payment system does not currently have the capability to employ procedure frequency edits similar to payment edits available for practitioner claims. The Department will ask systems and contractor staff to determine if there are any other approaches available to limit potentially inappropriate billings, perhaps at a more global rather than procedure code specific level. The Department will also do further analysis to determine if the issues are systematic or limited to specific providers. If the latter is found, identified providers will be referred to OMIG for further action. The Department will diligently work toward a solution; however potential service overutilization will be mitigated as member enrollment in managed care increases.

Recommendation #3

Review the duplicate Medicaid payments we identified and recover, as appropriate.

Status – Partially Implemented

Agency Action – As of February 19, 2017, the OMIG recovered $419,070 of the $7.5 million in duplicate Medicaid payments identified in the initial audit. According to OMIG officials, they will

not pursue any of the remaining $7.1 million in overpayments because the billing guidelines in place at the time of our audit may have caused provider confusion.

The following Department guidelines were in place during our audit:

- *APG Manual Policy,* "…the services of other licensed practitioners (dentists, nurse practitioners, midwives and podiatrists), except for orthodontists, are always included in the APG payment to the facility and may not be billed separately to Medicaid in the clinic or hospital OPD setting."
- *Nurse Practitioner Manual Policy*, "Payment for services provided by a nurse practitioner who is paid a salary/compensated by a medical facility reimbursed under the Medicaid Program for its services on a rate basis will be made on a fee for service basis only if the cost of the nurse practitioner's services is not included in the facility's rate."

Information in the Nurse Practitioner Manual was not updated to reflect new payment policies when the APG Manual was introduced. However, although this may have caused confusion among providers, the Department clarified the new policy and restated information contained in the APG Manual in a March 2010 Medicaid Update (the Department's official publication for Medicaid providers). The Department updated the Nurse Practitioner Manual in March 2016 to accurately reflect the APG policy.

Medicaid made two payments for the same service because the practitioners in our overpayment population were not allowed to bill separately for the services they provided. As a result, we question the decision not to pursue the overpayments we identified on the basis of provider confusion. As of May 31, 2017, $4.7 million of the outstanding $7.1 million in duplicate payments may no longer be recoverable under regulatory look-back rules that prohibit the Department from recovering a payment more than six years after the date the corresponding claim was filed. To avoid further loss of recoverable overpayments, we encourage OMIG officials to place sufficient priority on the pursuit of the remaining $2.4 million ($7.1 million - $4.7 million) that is still recoverable.

Response #3

Based on the addition of clinical staff as part of the UPIC, OMIG will share the results of its review of the identified overpayments, and assist the UPIC in pursuing recovery of any payments determined to be inappropriate.

Recommendation #4

When granting exemptions from official State Medicaid policies, ensure such exemptions are based on appropriate rationales, which are properly documented.

Status – Not Applicable

Agency Action – According to Department officials, no additional exemptions to the APG billing rules have been granted to providers since our initial audit. As such, we cannot evaluate whether exemptions granted by the Department were properly documented and based on appropriate rationales.

Response #4

As this recommendation was deemed not applicable by the OSC, no further action is required by the Department.

Recommendation #5

To encourage compliance with prescribed payment policies, establish formal repayment plans for recipients of exemptions, when warranted.

Status – Not Applicable

Agency Action – As noted in Recommendation 4, the Department has not granted additional exemptions from APG billing rules since our initial audit. As such, no repayment plans were necessary and we were unable to assess the implementation of this recommendation.

Response #5

As this recommendation was deemed not applicable by the OSC, no further action is required by the Department.

Recommendation #6

Ensure the recently implemented eMedNY system controls prevent overpayments for the types of professional claims identified in this audit.

Status – Partially Implemented

Agency Action – In June 2014, after the conclusion of our initial audit's fieldwork, the Department developed an eMedNY system edit to prevent payment to a practitioner for services already included in a separate APG payment to a clinic or outpatient facility. However, subsequent monitoring of this edit by the Department determined it was not working as intended and, if used, would also result in eMedNY denying appropriate claims. As a result, the Department is reviewing the edit to determine if it can be modified to work appropriately, or if a new edit will be required. In the meantime, Medicaid continues to be at risk of making duplicate payments like the ones we identified in our initial audit. We identified additional Medicaid overpayments of about $3.1 million since the end of our prior audit for these types of duplicative payments.

Response #6

The Department is in the process of updating the clinic APG provider manual, which provides billing instructions to providers. The manual includes guidelines on when a practitioner may submit a professional claim for services provided in an institutional setting. Providing this information to providers will help to enforce practitioner billing requirements. It is important to note that potential inappropriate billings will decrease dramatically over time as the Medicaid Program moves to full member enrollment in managed care.