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October 6, 2017

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

Re: Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits
Report 2017-F-3

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, *Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits* (Report 2013-S-17).

Background, Scope, and Objective

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. The Medicaid program reimburses outpatient services based on the Ambulatory Patient Groups (APG) payment methodology. The APG system pays providers based on patient condition and complexity of service and is designed to pay more for services requiring a higher level of professional care than those requiring a lower level of care. The Department phased in the APG methodology beginning with hospital outpatient departments and ambulatory surgery centers on December 1, 2008. The APG methodology was then implemented in freestanding diagnostic and treatment centers and freestanding ambulatory surgery centers on September 1, 2009.

Medicaid claims from health care providers are processed and paid by an automated system called eMedNY. When eMedNY processes claims, they are subject to various automated controls, or edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate. For example,

some edits compare claims to detect and prevent duplicate billings for the same service. Other edits track the number of services provided to a recipient in a certain period to ensure they don't exceed Medicaid service limits. In some cases, eMedNY edits flag claims for further scrutiny by the Department, after which a determination is made to approve or deny payment.

We issued our initial audit report on June 29, 2015. The audit objective was to determine whether the Department had established adequate controls to prevent duplicate and excessive Medicaid payments to clinics and outpatient facilities reimbursed by the APG payment methodology. The audit covered the period December 1, 2008 through May 29, 2013. Our initial audit determined the Department did not implement adequate controls to enforce APG policy and payment rules. As a result, Medicaid made $32.1 million in actual and potential overpayments for services that exceeded Medicaid's established service limits (such as one clinic that billed 41 dental exams for one recipient over three years when the service limit is two exams per year).

The audit also determined that the Department did not have controls in place to prevent duplicate claims (such as when a clinic and individual practitioner both bill Medicaid for the same service), resulting in $7.5 million in overpayments. We recommended that the Department: review and recover the inappropriate APG payments; strengthen controls over APG claims processing to prevent improper payments for excessive services; ensure eMedNY system controls prevent overpayments for the duplicate (professional) claims identified during the audit; and ensure exemptions from official State Medicaid policies are based on appropriate rationales, are properly documented, and include formal repayment plans for recipients of exemptions.

The objective of our follow-up was to assess the extent of implementation, as of June 29, 2017, of the six recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in addressing the problems we identified in the initial audit report. About $800,000 of the identified overpayments were recovered and the Department updated policy manuals to give clearer billing guidance to providers. However, the Department has not recovered a significant amount of the overpayments for services exceeding service limits, or the overpayments for duplicate services. Furthermore, the Department has not implemented system controls to prevent the overpayments we identified in the initial audit.

Of the initial report's six audit recommendations, three were partially implemented, one was not implemented, and two were not applicable during the time of our follow-up.

Follow-Up Observations

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.

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.

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.

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.

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.

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.

Major contributors to this report were Christopher Morris and Daniel Rossi.

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,

Christopher Morris
Audit Manager

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