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May 4, 2018

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

Re: Improper Episodic Payments to Home Health Providers
Report 2018-F-2

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, *Improper Episodic Payments to Home Health Providers* (Report 2016-S-4).

Background, Scope, and Objective

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. Effective May 1, 2012, the 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 a range of services in the home, including: 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. 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).

We issued our initial audit report on December 8, 2016. The audit objective was to determine whether the Medicaid program made improper payments to CHHAs under the EPS. The audit covered the period from May 1, 2012 through December 13, 2015. Our audit identified $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;
- $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.

We determined the Department had not established controls to identify, prevent, and recoup the types of overpayments we identified. We recommended that the Department review and recover the improper overpayments, and develop and implement mechanisms to identify and recover overpayments when CHHAs do not bill according to Department guidelines.

The objective of our follow-up was to assess the extent of implementation, as of March 15, 2018, of the two 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. However, further actions are still needed as only $590,455 of the $16.6 million in improper Medicaid payments we identified had been recovered. Moreover, the Department has not developed mechanisms to identify and recover overpayments when CHHAs do not bill according to Department guidelines.

Of the initial report's two audit recommendations, one was partially implemented and one had not yet been implemented.

Follow-Up Observations

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.

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 March 15, 2018, OMIG recovered $590,455 of the $16.6 million in improper Medicaid payments our initial audit identified. OMIG conducted an expanded review of EPS payments to CHHAs, including claims outside the original scope of our audit, and recovered an additional $661,920 in improper payments. According to OMIG officials, they will continue auditing the improper

payments we identified, including to those providers that received the largest dollar amount of overpayments, and will make additional recoveries as appropriate.

Recommendation 2

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

Status – Not Implemented

Agency Action – Department officials stated they were exploring the possibility of developing and implementing claim processing controls to identify and recover overpayments when CHHAs did not bill according to Department guidelines. However, officials could not provide evidence to support their stated efforts.

Major contributors to this report were Theresa Podagrosi and Emily Proulx.

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