

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

January 16, 2014

Mr. Brian Mason
Acting Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2011-S-43 entitled, "Overpayments of Ambulatory Patient Group Claims."

Please feel free to contact James Clancy, Assistant Commissioner, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,



Nirav R. Shah, M.D., M.P.H.
Commissioner of Health

Enclosure

**Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2011-S-43 Entitled
Overpayments of Ambulatory Patient Group Claims**

The following are the New York State Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2011-S-43 entitled, "Overpayments of Ambulatory Patient Group Claims."

Comments:

As the OSC audit points out, the Ambulatory Patient Group (APG) outpatient reimbursement methodology, which is similar to Medicare's outpatient rate setting methodology (known as APCs), replaced an existing "one-size-fits all" methodology that paid a Medicaid provider the same rate regardless of the service provided. The APG methodology, as is the case with Medicare's APCs, reimburses based on the intensity of the service, which is directly related to the biller's cost of providing the service.

Providers have used the APG methodology for nearly five years and have been very pleased that they now get paid more for higher cost services. This allows them to provide better, and more clinically appropriate, health care – rather than trying to cut corners and withhold the more costly procedures. At the same time the Department no longer overpays for low cost procedures (like dental exams) as it did under the pre-APGs methodology.

To date, under the APG methodology, the Department has paid out over \$4 billion to 190 hospitals and 365 free-standing clinics. The implementation of the APG rate setting methodology has been extremely successful and, on an ongoing basis, the methodology generates almost zero complaints from providers, while accurately reimbursing them for over 99.9% of the services they provide. So, while the audit's recommendations are helpful, they apply to only a miniscule portion of the APG payments to date.

The following is the Department response to the recommendations for the above subject report.

Recommendation #1:

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

Response:

Recommendation #1 of the OSC audit focuses on what are known as "combination edits," under which a provider would, for example, not be allowed to bill for a clinic visit and an ambulatory surgery visit for the same patient for the same day. At the time of the audit, the Department was unaware that these edits were not working correctly; however, as OSC points out in their audit

report, the Department has already implemented a project to correct these errors. The total over payment of \$1,204,186 on 6,615 claims over the 40 month period of the audit represents only five-hundredths of one percent of the total of more than \$2.2 billion that was paid out under the affected hospital APG rates codes during the same period. Additionally, 99.94% of claims were paid correctly with respect to this issue.

The Office of the Medicaid Inspector General (OMIG) will review these payments and initiate recoveries as appropriate.

Recommendation #2:

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

Response:

The Department's analysis revealed that several systems edits designed to prevent all the billing combinations cited were created and implemented. Beginning January 1, 2013 (after the audit period in question), a system edit was implemented to prevent 1401/1402 billing combinations for the same recipient, on the same date of service. In November 2011 a Medical-Cantra Edit Request Form was submitted to implement billing system edits (effective December 1, 2008) for all the other improper billing combinations cited in this Audit. However, based on the findings of this Final Audit Report it appears that the combination edits that were intended to prevent the majority of the improper billing combinations cited in the Audit (beginning December 1, 2008) are not working properly. The Department has now established system edits for the Ambulatory Patient Group reimbursement system that will deny payment for the second claim irrespective of claim order for prohibited rate code combinations, including: ambulatory surgery (AS) and emergency department (ED), ED and clinic, AS and clinic, beginning January 2014.

Recommendation #3:

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

Recommendation #4:

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

Response to Recommendations #3 and #4:

With respect to the \$933,399 in duplicate claims where a provider was paid under both an APG and a non-APG rate code, the Department completed the necessary payment system input. This system input set all the non-APG rates to zero on a retroactive basis. Monies were recovered during December 2013. The Department was aware of this issue from the outset, but was making special short-term accommodations to providers that had requested that be done.

Recommendation #5:

Using the APG methodology, promptly reprocess the 56,241 claims (totaling \$4,286,603) that were processed using pre-APG rate codes.

Response:

Recommendation #5 identifies \$4,286,603 in claims where a provider was paid under a non-APG rate code after the implementation of APGs. The Department has completed the necessary payment system input to recover whatever portion of those monies that are, in fact, attributable to an APG biller. These monies were recovered during December 2013. In order for claims to reprocess (where appropriate) using the APG rate codes, providers will need to amend their claim to the appropriate rate code. Due to the timeliness of the re-submission of these claims, the providers affected will need to contact the Department for approval prior to the claim re-submission. The Department was aware of this issue from the outset, but was making special short-term accommodations to providers that had requested that be done.