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STATE COMPTROLLER

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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 4, 2007

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Payments to Clinic Providers When Recipients were Hospitalized
Report 2006-S-51

Dear Dr. Daines:

According 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 audited Medicaid claims submitted by clinic providers during the five year period ended April 30, 2006.

A. Background

The Department of Health (Department) administers the State's medical assistance program (Medicaid), which was established under Title XIX of the federal Social Security Act to provide needy people with medical assistance. In New York State, this program is funded jointly by the federal, State, and local governments. Its management information and claims processing functions are handled through the State's eMedNY system, which the Department implemented on March 24, 2005.

Under Part 86 of Title 10 of the New York State Health Code, Rules and Regulations, Section 86-1.18, the Department establishes all-inclusive hospital inpatient rates that generally cover the costs of medical services provided to Medicaid recipients during a hospital stay. As such, no other payment should be made for services provided to these patients while they are hospitalized. According to other Medicaid policies, if a Medicaid patient receives medical services in a hospital emergency room or outpatient clinic and is subsequently admitted directly to that hospital providing the services, Medicaid reimbursement is limited to the hospital's inpatient rate. No separate payments should be made to these hospitals for emergency room or clinic services provided to patients on the day they are admitted to these hospitals.

Based on our prior audit entitled *Medicaid Clinic and Emergency Room Claims Paid During a Recipient's Hospital Stay* (Report 98-S-10, issued August 29, 2000), Department officials recognized improvements were needed in the Medicaid claims processing system to prevent separate payments for services provided to patients that are hospitalized. The eMedNY claims processing system was designed with controls (edits) to address these concerns. However, since implementing eMedNY in March 2005, the Department has not used these edits to process claims. Since these edits were not being used, the Department relied on computer routines maintained by the Office of the Medicaid Inspector General (OMIG) which are designed to identify inappropriate claims on a post payment basis. OMIG's process relies on providers to make the appropriate claim adjustments of any inappropriate payments OMIG has identified.

B. Audit Scope, Objective and Methodology

We audited selected Medicaid claims paid to clinic providers during the five year period ended April 30, 2006. The objective of our audit was to determine if Medicaid made inappropriate payments to clinic providers for patients that were hospitalized.

We did our audit according to generally accepted government auditing standards. During the audit period, we audited Medicaid claims submitted by clinic providers and processed by the Department. To accomplish our audit objective, we extracted questionable claims from the Medicaid payment file and verified the accuracy of the payments. We interviewed Department officials, visited selected clinic providers to review medical records, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant payment policies and procedures.

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, several of which are performed by the Division of State Services. 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, some of whom have minority voting rights to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

We determined clinics inappropriately billed Medicaid totaling over $25.7 million during our five year audit period for clinic services provided to Medicaid recipients who were hospitalized as follows:

- $17.7 million for services provided to patients during a hospital stay - after the hospital admission date and before the hospital discharge date; and

- $8 million for clinic and emergency room services provided to patients on the date the patients were admitted to the hospitals providing these services.

These inappropriate payments occurred because the clinics were not aware of, misinterpreted, or ignored the Department's Medicaid billing guidelines. For example, two of the clinics we visited had questionable payments totaling more than $4.9 million. These two clinics were located in drug and alcohol rehabilitation facilities certified by the Office of Alcohol and Substance Abuse Services (OASAS) to provide inpatient services to individuals recovering from various addictions. The clinics were to provide services outside the specialties of the inpatient rehabilitation hospitals, such as services for physical, speech, and occupational therapies and podiatry services. According to the medical records we reviewed, the clinics billed for routine medical services (e.g., taking of blood pressure, patient physical exams, etc.) that would be included in the inpatient rates the affiliated hospitals were paid. For one of these clinics, almost 77 percent of its total Medicaid payments for our audit period ($2.2 million of $2.8 million) were for these inappropriately billed claims. We also determined the owners of the two clinics involved were related to the owners of the affiliated hospitals, further raising concern about the appropriateness of the clinic billings. When we met with Department and OASAS officials to discuss the audit findings and these two clinics, officials agreed the services provided by the clinics were included in the hospital reimbursement rates and should not have been paid separately. Because of the significance of the billing problems we identified at these two facilities, Department officials informed us that they will no longer be reimbursing these facilities and will seek full recovery of the overpayments we identified. In addition, Department and OASAS officials are considering decertifying these two clinics, which would discontinue their participation in the Medicaid program.

The $25.7 million of inappropriate payments also occurred because the eMedNY claims processing Edits 759 and 760 designed to detect and prevent these inappropriate payments were not being used to process claims. According to Department officials, the Department decided not to use these edits over concern the edits might cause undue financial burden on the providers. In particular, Edit 759 would initiate recovery of inappropriate clinic payments before the clinics had a chance to challenge the Department's recovery action. While we understand the Department's hesitation to operate Edit 759 without assessing the issue of fair notice to providers, we do not understand why the Department has hesitated to implement Edit 760. Instead, the Department has relied on computer routines maintained by the Office of the Medicaid Inspector General (OMIG) which were designed to identify inappropriate claims on a post payment basis. However, we question whether OMIG's process for identifying questionable claims is as thorough as it could be. For example, OMIG excluded OASAS-certified drug and rehabilitation facilities from its process. Consequently, OMIG's process did not identify the two clinics we identified with questionable payments totaling more than $4.9 million that the Department and OASAS are now considering decertifying from the Medicaid program.

Recommendations

1. *Review the $25.7 million inappropriate clinic payments we identified and recover overpayments where appropriate.*

2. *Instruct the clinic providers on the appropriate way to bill clinic and emergency room services provided to patients that are hospitalized.*

3. *Implement the eMedNY edits to prevent these overpayments.*

4. OMIG should re-evaluate its process for identifying and recovering clinic payments made for patients that are hospitalized.

We provided a draft copy of the matters contained in this report to Department officials for their review and comment. Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them. The Department provided two responses to this report. Complete copies of the Department's responses are included as Appendices A and B. Appendix C contains State Comptroller's comments which address matters contained in the Department's responses.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 therefor.

Major contributors to this report include Warren Fitzgerald, Dennis Buckley, Nancy Cecot, Brianna Redmond, Brenda Maynard and Peter Amorosa.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours

Sheila Emminger
Audit Manager

cc: Lisa Ng, Division of the Budget
Tom Howe, Department of Health

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

December 5, 2006

Sheila A. Emminger, Audit Manager
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Emminger:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2006-S-51) on "Medicaid Payments to Clinic Providers When Recipients Were Hospitalized".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Charbonneau
Mr. Griffin
Mr. Howe
Ms. Napoli
Ms. O'Connor
Mr. Reed
Mr. Seward
Mr. Wing

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2006-S-51 on
"Medicaid Payments to Clinic Providers
When Recipients Were Hospitalized"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2006-S-51 on "Medicaid Payments to Clinic Providers When Recipients Were Hospitalized."

Recommendation #1:

Recover the $25.7 million inappropriate clinic payments we identified and recover overpayments where appropriate.

Recommendation #2:

Instruct the clinic providers on the appropriate way to bill clinic and emergency room services provided to patients that are hospitalized.

Recommendation #3:

Implement the eMedNY Edits 759 and 760 designed to prevent these overpayments.

Recommendation #4:

OMIG should re-evaluate its process for identifying and recovering clinic payments made for patients that are hospitalized.

Response to Recommendations #1 through #4:

For dual eligibles, the Medicaid program is legally required to pay the Medicare coinsurance amount. This is the amount that the patient would ordinarily be responsible for, but because the patient is also eligible for Medicaid, we are required to pay by federal law. This Medicare cost-sharing payment is really a Medicare-related amount that Congress has decided to pay for out of Medicaid funds. We are not permitted to make judgmental calls on whether we think it is appropriate to make these payments. Even though the patient may have been an inpatient at the time that the clinic provided a service and billed Medicare, the fact that Medicare paid the clinic triggers our obligation to make the coinsurance payment from Medicaid funds. The appropriate response is not to attempt to recover the coinsurance amount from the clinic but, rather, to alert Medicare that their Part B clinic payment may have been duplicative of their own

* Comment 1

* See State Comptroller's Comments, Page 13

2

Part A inpatient hospital payment. If Medicare agrees and reverses the Medicare clinic payment, then the provider is obligated to return the coinsurance amount as well. In the case of New York City Health and Hospitals Corporation v. Perales, the Department of Social Services argued that since the coinsurance payments came from Medicaid funds, all Medicaid rules should apply. The Second Circuit Court of Appeals disagreed, holding that the patients were primarily Medicare patients, not Medicaid, and that Medicare coinsurance obligations controlled.

To the extent that OSC's $25.7 million number includes dual eligible crossover amounts, OSC should remove these amounts from this calculation. Otherwise, we will comply by attempting to recover only that portion of the $25.7 million that represents straight Medicaid payments on behalf of non-dual eligibles.

* Comment 1

* See State Comptroller's Comments, Page 13

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DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

December 11, 2006

Sheila A. Emminger, Audit Manager
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Emminger:

Enclosed are the Department of Health's supplemental comments on the Office of the State Comptroller's (OSC) draft audit report (2006-S-51) on "Medicaid Payments to Clinic Providers When Recipients Were Hospitalized".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix B

cc: Mr. Charbonneau
Mr. Griffin
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Ms. Napoli
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Mr. Reed
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Department of Health
Supplemental Comments on the Office of the State Comptroller's Draft Audit Report 2006-S-51 on "Medicaid Payments to Clinic Providers When Recipients Were Hospitalized"

The following are the Department of Health's (DOH) supplemental comments in response to the Office of the State Comptroller's (OSC) draft audit report 2006-S-51 on "Medicaid Payments to Clinic Providers When Recipients Were Hospitalized."

General Comments:

The OSC questions whether our process of generating computer runs is as thorough as it could be because the Office of Alcoholism and Substance Abuse Services certified drug and rehabilitation facilities are not included in our process. By definition, the two clinics in this report were to provide specialties outside those provided by the inpatient rehabilitation hospital.

The questionable services provided by the two clinics were not the result of a crossover run, but rather a field audit of individual medical records. OSC documented inappropriate billing behavior based on individual case review – not based on any discrete criteria that could be used to enhance desk crossover reviews. To include allowable clinic visits in routine runs would compromise the credibility of the current program logic.

* Comment 2

The validity of the audit data is also questionable as the audit period includes eMedNY claims for which line level detail is not yet available in the eMedNY data warehouse. Since the start of eMedNY claims processing in April 2005, the data warehouse has captured only the date of service and procedure code from the first line submitted on the document. The claims are bundled into one and can not currently give a clear indication of individual service date. We are currently waiting for the systems solution which is expected to be effectuated in January 2007 before requesting runs for 2005.

* Comment 3

Recommendation #1:

Recover the $25.7 million inappropriate clinic payments we identified and recover overpayments where appropriate.

Response #1:

The Office of Medicaid Inspector General (OMIG) is currently conducting audits of the two clinics that were providing services to inpatient clients of two alcohol rehabilitation

* See State Comptroller's Comments, Page 13

facilities. Both clinics were targeted by the OMIG and were being audited prior to any notification of OSC involvement. A partial withhold has been placed on the accounts of both clinics. It is anticipated that both audits will result in the identification of significant overpayments and may result in other OMIG actions.

* Comment 4

The OMIG will make a determination if the inappropriate clinic payments identified in the OSC audit have already been recovered via computer matches that have been conducted by the OMIG periodically on a post payment basis. Please provide a copy of the payments you have identified in Excel format.

* Comment 5

Recommendation #2:

Instruct the clinic providers on the appropriate way to bill clinic and emergency room services provided to patients that are hospitalized.

Response #2:

A Medicaid Update Article will be prepared to remind providers that ancillary services should not be billed separately during an inpatient stay and that it is inappropriate for providers to bill for clinic visits and emergency room services on the same day as an inpatient admission.

Recommendation #3:

Implement the eMedNY Edits 759 and 760 designed to prevent these overpayments.

Response #3:

A project which will enhance the logic for edits 759 and 760 is now undergoing analysis for prioritization and scheduling.

Recommendation #4:

OMIG should re-evaluate its process for identifying and recovering clinic payments made for patients that are hospitalized.

Response #4:

OMIG staff are continually evaluating the post payment process for identifying and recovering clinic payments made for patients that are hospitalized.

* See State Comptroller's Comments, Page 13

State Comptroller's Comments

1. At most, $1.1 million of the $25.7 million in inappropriate payments were claims for recipients who were dually eligible for Medicare and Medicaid. We have referred the clinic claims to the federal Centers for Medicare and Medicaid Services (CMS) for review. When the results are received, we will share them with the Department. If CMS determines Medicare should not have paid the clinic claim, the Department will need to recover the $1.1 million in Medicaid payments associated with these claims.

2. The Department is incorrect in stating that the questionable services provided by the two clinics were not the result of a crossover run - a matching of hospital and clinic claims. The Department did not understand OSC's methodology. We did match hospital and clinic claims. However, we included drug and rehabilitation clinics, a service category the Department excludes from its match process. Our match results caused us to question the outliers - two drug and rehabilitation clinics with a significant amount of inappropriate clinic billings. Further analysis of these clinics' billings determined between 50 to 80 percent of their total Medicaid billings were for hospitalized recipients. We then supplemented the match results with on-site reviews of the clinics' individual medical records. Through our multi-stage review process we identified questionable Medicaid payments totaling more than $4.9 million to these clinics. The results of our audit approach demonstrate the benefits OMIG could realize from expanding its current matching criteria. Such expansion, used in conjunction with analysis of outliers, would enhance, not compromise OMIG's current program logic, and enable OMIG to identify additional providers who are billing inappropriately such as OSC did. The results of OSC's approach support the need for the Department and OMIG to re-evaluate their processes for identifying inappropriate clinic payments for hospitalized recipients.

3. We audited Medicaid claims submitted by clinic providers during the five year period ended April 30, 2006. The situation described by the Department would not pertain to claims processed before the start of eMedNY processing in April 2005. Of the $25.7 million in inappropriate payments we identified, 80 percent were submitted for processing before the start of eMedNY. Moreover, the building of the clinic claims is not the issue - the clinic should not have billed Medicaid in the first place because the recipient was hospitalized.

4. We are pleased to acknowledge that the Department and OMIG have accepted our audit results and plan to take action against the two providers we identified.

5. Details of inappropriate payments were provided to both Department and OMIG officials on November 8, 2006.