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OFFICE OF THE STATE COMPTROLLER

October 9, 2008

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

Re: Report 2008-F-10

Dear Dr. Daines:

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 Department of Health officials to implement the recommendations contained in our audit report, *Medicaid Payments to Clinic Providers When Recipients were Hospitalized* (Report 2006-S-51).

Background, Scope and Objective

The New York State Department of Health (Department) administers the State's Medicaid program. 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.

Our initial audit report, which was issued on April 4, 2007, examined selected Medicaid claims to determine if inappropriate Medicaid payments were made to clinic providers for patients that were hospitalized. We found that clinics inappropriately billed Medicaid over $25.7 million for recipients who were hospitalized during the five year audit scope ending April 30, 2006. We further concluded that the Department had designed claims processing edits in eMedNY (the claims payment and information reporting system for Medicaid) that could have detected and prevented these overpayments, but the Department was not using them.

The objective of our follow-up was to assess the extent of implementation, as of September 24, 2008, of the four recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

We found that Department officials have made progress in correcting problems we identified. However, additional action is necessary. Of the four prior audit recommendations, two recommendations have been implemented and two recommendations have been partially implemented.

Follow-up Observations

Recommendation 1

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

Status - Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) conducted audits of two clinics we visited that had questionable payments totaling more than $4.9 million (or nearly 20 percent of the overpayments identified in our audit). OMIG determined inappropriate payments were in fact made to these providers and is in the process of recouping such payments. Additionally, OMIG is considering excluding these two providers from the Medicaid program.

For the remainder of the overpayments we identified, nearly $21 million, OMIG is in the process of determining if any of these overpayments were previously resolved by the computer matches OMIG periodically runs that are designed to identify inappropriate claims on a post payment basis.

Recommendation 2

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

Status - Implemented

Agency Action - The March 2007 edition of *Medicaid Update*, the Department's official publication for Medicaid providers, reminded providers of the proper billing policies regarding payments to hospital-based clinic providers when enrollees are hospitalized.

Recommendation 3

Implement the eMedNY edits to prevent these overpayments.

Status - Partially Implemented

Agency Action - According to Department and OMIG officials, eMedNY claims processing Edit 760 was modified to prevent the payment of clinic claims for recipients who were hospitalized on the clinic date of service. Modifications to the edit were made and the edit was activated in November of 2007. However, in December of 2007 additional modifications to the edit were initiated and subsequently completed in September of 2008. The Department has not established a date that the edit will begin denying clinic claims, but officials state that once providers are notified of the billing changes, the edit will be set to deny clinic claims. Since our initial audit, we determined that clinic providers have been improperly paid over $1.7 million.

Recommendation 4

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

Status - Implemented

Agency Action - OMIG has added additional clinic claims to the computer matches they periodically run to identify inappropriate claims. More specifically, OMIG has added 55 OASAS (Office of Alcohol and Substance Abuse Services) certified Inpatient Rehabilitation Programs and 817 Residential Rehabilitation Services for Youth providers to their current match of the 2006 and 2007 calendar years. Pending results of this match, OMIG will decide whether to continue including OASAS providers in future system matches.

Major contributors to this report were Andrea Inman and Christopher Morris.

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 process.

Very truly yours,

Sheila A. Emminger
Audit Manager

cc: Stephen Abbott, Department of Health
Steven Sossei, OSC Division of State Government Accountability