New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Overpayments to Cabrini Medical Center

Medicaid Program

Department of Health

Report 2011-S-8 April 2012

Executive Summary

Purpose

To identify Medicaid overpayments made to the Cabrini Medical Center because of incorrect adjustments made to previously paid claims and to identify the eMedNY claims processing control weaknesses that allowed the overpayments to occur.

Background

Medicaid providers submit claims to the Department of Health's eMedNY claims processing system for payment of their services. For various reasons, Medicaid providers sometimes need to adjust a previously paid claim and resubmit it to eMedNY for additional processing.

Cabrini Medical Center (Cabrini), a hospital in New York City, was a Medicaid provider of inpatient care until it closed in June 2008. In July 2009, Cabrini filed for Chapter 11 bankruptcy. In August 2009, Cabrini hired The Gaeta Company, Inc. (Gaeta) to review Cabrini's previously paid Medicaid claims and determine if additional revenues could be obtained through claim adjustments. In this regard, Gaeta was a service bureau (billing agent) for Cabrini. Since August 2009, Gaeta adjusted and resubmitted over 360 claims for Cabrini. Medicaid originally paid Cabrini $2.2 million on those claims. However, after adjustment, the claims totaled $5.4 million - an increase of $3.2 million over their original amounts.

Key Findings

- Gaeta caused $1.9 million in Medicaid overpayments to Cabrini by incorrectly altering information on prior claims and resubmitting them to Medicaid. In these instances, the original claim was correct and should not have been adjusted and resubmitted. Auditors also referred $618,000 in potential overpayments to the Department of Health for further review.
- In some cases, the adjustment claim was significantly more than the original claim. On one particular claim, for example, Medicaid originally paid Cabrini $6,656. Gaeta, however, improperly adjusted the claim by omitting the amount Medicare already paid on it. As a result, Medicaid overpaid the adjusted claim by $355,859.
- The eMedNY system did not have the controls necessary to identify unreasonable or suspicious adjustment claims.

Key Recommendations

- Recover the Medicaid overpayments made to the Cabrini Medical Center.
- Investigate The Gaeta Company, Inc.
- Implement controls within eMedNY to identify questionable adjustment claims.

Other Related Audits/Reports of Interest

Medicaid Claims Processing Activity 2010-S-15

State of New York
Office of the State Comptroller

Division of State Government Accountability

April 3, 2012

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

Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Department of Health: New York State Medicaid Program entitled *Overpayments to Cabrini Medical Center*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

Table of Contents

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This report is also available on our website at: www.osc.state.ny.us

Background

The New York State Medicaid program is a federal, state and locally funded program which provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Office of Health Insurance Programs within the Department of Health (Department) administers the Medicaid program.

Many of New York State's Medicaid recipients are also covered by Medicare. Such recipients are often referred to as "dual eligible." Generally, Medicare is the primary payer on claims for medical services provided to dual eligible recipients. After Medicare pays its portion of a claim, Medicaid pays the balance not covered by Medicare (i.e., deductibles, coinsurance and copayments which are normally the financial responsibility of the recipient).

The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered and generates payments to the providers. The eMedNY system subjects claims to various automated edits to determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate. To enable eMedNY to properly process claims for dual eligible persons, the Department relied on medical providers to self-report accurate Medicare payment information, including the Medicare allowed amount, the Medicare paid amount and the coinsurance.

Medicaid allows service bureaus (independent private healthcare billing companies) to submit claims on behalf of medical care providers. Service bureaus are required to enroll in Medicaid and comply with all applicable regulations and policies. Thus, a service bureau must have a system to notify client providers of claims which are ready for submission to eMedNY. The Department also requires providers to review their claims before service bureaus submit them for payment.

Cabrini Medical Center (Cabrini), a hospital in New York City, closed in June 2008 and filed for Chapter 11 bankruptcy in July 2009. In August 2009, Cabrini began using The Gaeta Company, Inc. (or Gaeta - a service bureau in New York City) to review Cabrini's previously paid Medicaid claims and determine if the claims were billed correctly or if additional amounts could be claimed. Since August 2009, Gaeta processed about 360 inpatient adjustment claims for Cabrini. The adjustments increased the amounts of the claims by $3.2 million over their original amounts (of $2.2 million).

Audit Findings and Recommendations

Inappropriate Adjustment Claims

We determined Gaeta incorrectly altered Medicare payment information on many of Cabrini's previously paid claims and submitted erroneous claim adjustments to Medicaid. These actions resulted in overpayments of about $1.9 million to Cabrini. We also concluded the Department should review additional high risk claim adjustments for Cabrini totaling about $618,000.

We compared Medicare payment information on Cabrini's original claims and the corresponding claim adjustments submitted by Gaeta against Federal Medicare payment data. The Federal Medicare payment data matched the amounts reported on Cabrini's original claims, but did not match the Medicare amounts on the adjusted claims. We identified 89 claims that were incorrectly adjusted and caused overpayments of more than $1.9 million. In most cases, Gaeta changed the claims' Medicare payment amounts to zero, when in fact, Medicare (as the primary payer) already paid Cabrini the standard amounts for the services in question. Moreover, this resulted in significant Medicaid overpayments to Cabrini.

For example, on December 24, 2008, Cabrini submitted an original claim which stated Medicare allowed $188,965 and paid $182,309 for services to a dual eligible person. Medicaid paid the difference, a coinsurance amount of $6,656 ($188,965 - $182,309). However, Gaeta adjusted this claim on October 1, 2010, reducing the Medicare allowed and paid amounts to zero. As a result of these adjustments, eMedNY paid the full Medicaid rate of $362,515. Nevertheless, our review of Federal Medicare data confirmed Medicare did in fact pay $182,309 on the claim, and thus, eMedNY correctly processed the claim in its original form. Therefore, Medicaid overpaid Cabrini $355,859 ($362,515 - $6,656) on the adjusted claim.

We requested documentation from Cabrini and Gaeta to support adjustments to the claims' Medicare information; however, they were unable to provide any. In fact, with regard to certain claim adjustments, Cabrini's Chief Financial Officer stated, "At this time, Cabrini Medical Center does not have the documentation that you have requested, and therefore it does not contest the Office of the State Comptroller's findings." Gaeta officials stated they made the adjustments because it appeared Medicare did not cover the entire length of patients' hospital stays, according to Medicare information Gaeta had. However, in its response to our request to review the adjustments, the Medicare contractor stated the original payments by Medicare and Medicaid were correct, and consequently, it was inappropriate for Gaeta to adjust them.

We note that Gaeta has been a Medicaid billing service bureau since 2003, and therefore, should know the correct way to bill Medicaid. Further, according to Section 504.9 of Title 18 of the New York Codes, Rules and Regulations, service bureaus are required to maintain a system, approved by the Department, to notify providers of the claims to be submitted on their behalf. The Department also requires claims be reviewed by the provider of the services before submission to eMedNY. However, we determined Gaeta had no such system in place, and therefore, the adjustment claims were not reviewed by Cabrini before submission. We recommend the Department take

steps to ensure all service bureaus have an adequate system for providers to review their claims prior to submission to Medicaid.

We also identified 39 other questionable adjustment claims. As originally submitted, the claims resulted in Medicaid payments of $94,000. After Gaeta adjusted them, Medicaid paid $712,000 (an increase of $618,000) on the claims. Some of these adjustment claims were questionable because they changed the nature of services provided (from a lower level of care to a higher level of care), while others increased the number of days claimed for payment. For some claims, we questioned whether Medicare was billed as the required primary payer. According to eMedNY, the recipients were eligible for Medicare; however, Medicare made no payments on the claims. Further, Gaeta adjusted certain claims up to 5 years after they were originally paid.

We initially identified the improper adjustments (totaling more than $1.9 million) in September 2010. At that time, eMedNY had already paid Cabrini about $1 million for the adjustments. Also at that time, we stopped scheduled payments of $904,000 (the balance of the improper adjustments) to Cabrini before they were made. As a result of our audit, Gaeta stopped submitting adjustment claims and is no longer submitting claims for Cabrini. Further, in response to our audit, Cabrini hired a consultant to review the 128 (89 + 39) improper and questionable adjustment claims to determine the total amount Cabrini owes the State.

Moreover, we believe there is considerable risk that the improper and questionable adjustment claims resulted from deliberate efforts to obtain excessive Medicaid payments. Based on our review, we concluded the Department should recover the $1 million in outstanding overpayments (from the initial 89 claims) and should review the $618,000 in potential overpayments (from the other 39 claims) and recover any overpayments, as appropriate. Consequently, during our audit fieldwork, we provided the details of these claims and their related payments to the Office of the Medicaid Inspector General for investigation and recovery.

In December 2009, the Department implemented an automated Medicare/Medicaid cross-over system to reduce problems with Medicare-related Medicaid claims. As a result of the crossover system, providers no longer need to submit separate claims to Medicare and Medicaid for services to dual eligible persons. Rather, a provider sends a claim to Medicare, and Medicare pays its portion of the claim to the provider. The provider's claims data is then electronically crossed over to Medicaid for processing and payment of coinsurance, deductible or copayment amounts.

However, the improper adjustment claims we identified were not subjected to the crossover system because the adjustments' original claims predated the crossover's implementation - in December 2009. The resulting overpayments occurred because eMedNY relied on inaccurate Medicare payment information (reported by Gaeta) to pay the adjustment claims. Moreover, we concluded that eMedNY lacks the controls to properly assess the risk and validity of adjustment claims. Specifically, eMedNY had no automated and/or manual controls to flag adjustment claims that: result in major increases in payment amounts; come from (or are submitted on behalf of) providers who are out of business; and are several years old.

In addition, we also concluded that eMedNY cannot identify the party (i.e., a provider or a service bureau) which actually submits a claim. This likely limits the Department's ability to identify a range of problematic claims, particularly if they are submitted by the same service bureau for multiple providers. Gaeta officials identified two other providers (besides Cabrini) they provide billing services to. We forwarded this information to the Department and the Office of the Medicaid Inspector General for review of those providers' claims. However, because eMedNY lacks the capability to identify who is actually submitting the claim, we were not able to confirm that there were only two other providers that Gaeta served. We recommend that the Department investigate the billing practices of Gaeta and ensure all service bureaus are identified on all claim submissions.

Recommendations

1. From the $1.9 million in excessive claims we identified, recover the $1 million in overpayments made to Cabrini.

2. Review the $618,000 in potential overpayments and recover additional money as appropriate.

3. Ensure all service bureaus have the required systems in place for Medicaid providers to review their claims prior to the service bureaus' submission of the claims to eMedNY.

4. Develop and implement controls within eMedNY to identify and review questionable adjustment claims with high risk attributes. Such attributes should include (but not be limited to) claims that: result in major increases in payment amounts; come from (or are submitted on behalf of) providers who are out of business; and are several years old.

5. Investigate Gaeta's billing practices and determine the extent of its inappropriate claim submissions for Cabrini and its other client Medicaid providers as well.

6. Develop and implement controls within eMedNY to identify the service bureaus billing Medicaid on behalf of healthcare providers.

Audit Scope and Methodology

Our primary objective was to determine if claim adjustments submitted by Gaeta, on behalf of Cabrini, were processed and paid correctly by Medicaid. We also sought to determine why any possible overpayments were made. Our audit period was the 2-year period from August 1, 2009 through July 31, 2011.

To meet our audit objectives, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We also met with representatives from Cabrini and Gaeta. We reviewed applicable Federal and State laws and regulations. We examined applicable Department Medicaid payment policies and procedures. With assistance from the Office of the Medicaid Inspector General, we obtained Federal Medicare payment data from SafeGuard Services, LLC (a Medicare contractor), and we confirmed data accuracy with this contractor, as necessary. Using the Medicare data, we assessed 163 of Cabrini's inpatient adjustment claims (totaling about $3.1 million) that were both Medicare-related and greater than $1,000.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. 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 functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed 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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally agreed

with our recommendations and indicated that certain actions are planned or have been taken to address them. In particular, officials noted that the Office of the Medicaid Inspector General has reviewed this matter and advises that Cabrini will make restitution for the overpayments we identified. Also, our rejoinder to a Department comment is included as a State Comptroller's Comment.

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Vision

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Agency Comments

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 27, 2012

Brian E. Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2011-S-8 on "Overpayments to Cabrini Medical Center."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: James C. Cox
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Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2011-S-8 on Overpayments to Cabrini Medical Center

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2011-S-8 on "Overpayments to Cabrini Medical Center."

Recommendation #1:

From the $1.9 million in excessive claims we identified, recover the $1 million in overpayments made to Cabrini.

Response #1:

The Office of Medicaid Inspector General (OMIG) has been in contact with the provider's attorney who indicates the provider is unable to locate files to disprove OSC's audit findings and that the provider is willing to make restitution to the OMIG for these overpayments.

Recommendation #2:

Review the $618,000 in potential overpayments and recover additional money as appropriate.

Response #2:

The OMIG is currently reviewing the 39 claims associated with this $618,000, and will make recoveries as warranted.

Recommendation #3:

Ensure all service bureaus have the required systems in place for Medicaid providers to review their claims prior to the service bureaus' submission of the claims to eMedNY.

Response #3:

The Department will consider modifying the Regulation cited in the draft audit report requiring it to approve service bureaus' systems as it believes the resources required for performing this activity would be better utilized in the continued review of questionable claims with high risk attributes (see Response #4 below). The Department will additionally collaborate with the OMIG on evaluating the possibility of implementing additional OMIG review processes.

* Comment

Recommendation #4:

Develop and implement controls within eMedNY to identify and review questionable adjustment claims with high risk attributes. Such attributes should include (but not be limited to) claims that:

* See State Comptroller's Comment, page 14.

result in major increases in payment amounts; come from (or are submitted on behalf of) providers who are out of business; and are several years old.

Response #4:

The planned April 2012 implementation of eMedNY Evolution Project 1464 on Timeliness Edits will require providers to include a delay reason code on claim adjustments, which is not a current requirement. This system enhancement will reduce the risk of the Department reimbursing inappropriate adjustments of older claims such as those highlighted in the audit. Plans are additionally underway to upgrade the business intelligence tools available in the Data Warehouse, as a means of further improving control over claim adjustments. In addition to implementing these technology enhancements, Department staff will also continue to collaborate with CSC on routine review and follow-up on the potentially high risk claims highlighted in the "surge" reports.

Recommendation #5:

Investigate Gaeta's billing practices and determine the extent of its inappropriate claim submissions for Cabrini and its other client Medicaid providers as well.

Response #5:

The OMIG is performing the recommended investigation.

Recommendation #6:

Develop and implement controls within eMedNY to identify the service bureaus billing Medicaid on behalf of healthcare providers.

Response #6:

The Department is in the process of developing eMedNY Evolution Project 1522 which will allow for analyzing the relationship between the service bureau that submits an electronic transaction on behalf of a provider and the provider itself.

State Comptroller's Comment

We question the propriety of modifying the pertinent Regulation - thus obviating the Department from its responsibility to ensure service bureaus provide clients with the opportunity to review their claims prior to submission to Medicaid. As our report details, Gaeta (Cabrini's service bureau) had no process for pre-submission claim reviews, and the absence of such reviews might have contributed to the excessive claims and payments we identified. Consequently, we maintain that it is critical that systems for pre-submission claim reviews exist and function properly. Moreover, without verifying that such systems exist, there is increased risk that service bureaus will submit excessive claims and significant Medicaid overpayments (similar to those detailed in our report) will occur.