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

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2015 Through September 30, 2015

Medicaid Program
Department of Health

Report 2015-S-16 August 2016

Executive Summary

Purpose

To determine whether the Department of Health's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The audit covered the period April 1, 2015 through September 30, 2015.

Background

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients, and it generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2015, eMedNY processed about 192 million claims, resulting in payments to providers of about $28.4 billion. The claims are processed and paid in weekly cycles, which averaged about 7 million claims and over $1 billion in payments to providers.

Key Findings

Auditors identified about $12.1 million in inappropriate Medicaid payments. The audit found:

- $7,134,184 in overpayments for Managed Long Term Care (MLTC) capitation payments made for recipients who were retroactively disenrolled from an MLTC plan;
- $2,282,626 in overpayments for deceased Medicaid recipients enrolled through New York State of Health, the Department's online marketplace for health insurance;
- $1,052,058 in overpayments for claims billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $813,412 in overpayments for newborn claims that were submitted with incorrect birth weights;
- $708,016 in overpayments for inpatient claims that were billed at a higher level of care than what was actually provided; and
- $77,861 in improper payments for duplicate billings and claims for clinic, transportation, durable medical equipment, and eye care services.

By the end of the audit fieldwork, about $2.1 million of the overpayments had been recovered.

Auditors also identified providers in the Medicaid program who were charged with or found guilty of crimes that violate health care programs' laws or regulations. The Department terminated 26 of the providers we identified, but the status of five other providers was still under review at the time our fieldwork was completed.

Key Recommendations

- We made 11 recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claims processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity October 1, 2014 Through March 31, 2015 (2014-S-53)

Department of Health: Medicaid Claims Processing Activity April 1, 2014 Through September 30, 2014 (2014-S-15)

State of New York
Office of the State Comptroller

Division of State Government Accountability

August 9, 2016

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

Dear Dr. Zucker:

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 Medicaid program entitled *Medicaid Claims Processing Activity April 1, 2015 Through September 30, 2015*. 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.

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

State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.state.ny.us
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

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 that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. In State Fiscal Year 2014-15, the federal government funded about 52.4 percent of New York's Medicaid claim costs; the State funded about 30.2 percent; and the localities (the City of New York and counties) funded the remaining 17.4 percent.

The Department of Health's (Department) Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2015, eMedNY processed about 192 million claims, resulting in payments to providers of about $28.4 billion. The claims are processed and paid in weekly cycles, which averaged about 7 million claims and over $1 billion in payments to providers.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, our auditors work with Department staff to resolve the exceptions in a timely manner so payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 2015, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. In addition, we identified the need for improvements in the processing of certain types of claims. We found about $12.1 million in improper payments pertaining to: claims for recipients who were no longer enrolled in a Managed Long Term Care (MLTC) plan; claims for deceased recipients enrolled through New York State of Health (NYSOH); claims with incorrect information pertaining to other insurance recipients had; claims with incorrect newborn birth weights; hospital claims that were billed at a higher level of care than what was actually provided; claims for duplicate services; and improper clinic and other claims.

At the time the audit fieldwork concluded, about $2.1 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments (totaling about $10 million) and recover funds as warranted.

Capitation Payments for Recipients No Longer Enrolled in Managed Care

MLTC plans provide services, such as home care, social day care, and nursing home care, to recipients who have a long-lasting health problem or disability. Medicaid pays MLTC plans a monthly capitation payment for every Medicaid recipient enrolled in an MLTC plan. The plans arrange for the provision of services their members require. Plans typically have networks of participating providers that they reimburse directly for services provided to their enrollees. Plans also submit encounter claims to the Department's eMedNY claims processing system to inform the Department of each medical service provided to enrolled recipients.

According to the Department's MLTC contract, the Department has the right to recover capitation payments made to plans for recipients who it is later determined were inappropriately enrolled (e.g., because of death, incarceration, or relocation out of the plan's service area). The Department and Local Departments of Social Services (LDSS) can retroactively disenroll a recipient back to the date when the recipient lost eligibility. Accordingly, the Department can recover capitation payments retroactive to the effective disenrollment date. However, the Department can only recover capitation payments if the Department determines the plan was not "at risk" for the provision of medical services during any portion of the payment period. A plan is considered to have been "at risk" if the Plan paid for medical services provided to recipients during the month covered by the capitation payment.

For the period February 1, 2015 to September 30, 2015, Medicaid made 1,745 capitation payments totaling more than $7.1 million for 1,324 recipients who were retroactively disenrolled from a plan, and the plan was not "at risk" during the disenrollment period (i.e., the plan did not incur medical expenses for members). As illustrated in the following table, in most instances,

the plans received one month of inappropriate capitation payments for recipients who were retroactively disenrolled. These payments totaled about $4.3 million. However, we also found instances where plans received multiple months of improper capitation payments for periods prior to a recipient's disenrollment. In one instance, a plan received seven months of capitation payments for a recipient totaling $31,855 from February 2015 through August 2015. According to the Department's eMedNY enrollment information, the recipient was retroactively disenrolled and was no longer enrolled in the plan during these months.

Number of Months of Improper Capitation Payments	Number of Recipients	Improper Capitation Payments	Percent of Total Improper Capitation Payments
1	1,062	$4,257,236	59.67%
2	173	1,438,979	20.17%
3	48	618,647	8.67%
4	22	368,520	5.17%
5	12	252,080	3.53%
6	4	107,608	1.51%
7	3	91,114	1.28%
Total	**1,324**	**$7,134,184**	**100%**

According to Department officials, the LDSS are responsible for notifying a plan when a recipient is disenrolled retroactively. The plan is then responsible for voiding any capitation payments subsequent to the disenrollment date as long as the plan was not "at risk" for providing services. However, the Department does not have a process in place to identify and monitor outstanding capitation payments that still need to be voided. According to Department officials, they are developing an internal report that will identify recipients who have been disenrolled retroactively and will use this report to identify improper capitation payments. However, Department officials could not tell us when such a report would be available for this purpose.

Recommendation

1. Review the $7,134,184 in improper capitation payments we identified and recover overpayments as appropriate.

Medicaid Payments for Deceased Recipients

With the enactment of the federal Patient Protection and Affordable Care Act (PPACA) in 2010, the State developed NYSOH as a new online marketplace for individuals to obtain health insurance coverage, including Medicaid. The PPACA requires NYSOH to verify an applicant's identifying information when determining Medicaid eligibility and enrollment. The PPACA requires NYSOH to submit an individual's name, date of birth, and Social Security Number (SSN) to the federal government's Data Services Hub for verification against various federal databases, including the Social Security Administration (SSA) for verification of whether an individual is alive or deceased. Additionally, once individuals are enrolled in Medicaid, NYSOH is required to periodically verify

the life status of recipients to ensure active coverage is appropriate.

We identified all Medicaid recipients who were enrolled through NYSOH during the audit period and, using an independent third-party service that maintains information from the SSA's Death Master File, we determined: NYSOH enrolled 119 deceased individuals into the Medicaid program, and NYSOH did not automatically terminate 1,177 enrollees who apparently died after enrollment. We determined Medicaid overpaid 4,892 claims totaling $2,282,626 on behalf of 966 of the 1,296 (119 + 1,177) NYSOH-enrolled recipients. With few exceptions, the overpayments were for managed care capitation payments. At the end of our fieldwork, 766 of the 1,296 deceased enrollees still had active Medicaid coverage through NYSOH.

The third-party service we used includes a level of certainty indicator for each SSN match. For example, a match with an indicator of "proven" means the death was confirmed by a death certificate, whereas a match with an indicator of "verified" means the death was reported by multiple other sources (not supported by a death certificate). Of the 1,296 recipients, we determined 618 had a status of proven and 678 had a status of verified.

According to Department officials, NYSOH began using a federal Periodic Verification Composite (PVC) service in January 2016 to periodically check the life status of enrollees after enrollment (prior to this, NYSOH did not have a process to periodically verify the life status of all enrollees). The PVC includes a living/deceased indicator, and includes rules for automatically closing deceased individuals' Medicaid eligibility. Department officials believe this process will limit future inappropriate payments.

Recommendations

2. Review the $2,282,626 in improper Medicaid payments we identified and recover overpayments as appropriate.

3. Investigate the life status of the remaining 766 deceased NYSOH enrollees we identified and update their Medicaid enrollment and coverage, as appropriate.

(Auditor's Note: In response to the draft report, Department officials indicated that the Department had completed its review of the 766 enrollees and concluded that 4 individuals were alive. Officials also indicated that the Department took the necessary steps to close the accounts of the remaining 762 enrollees.)

Other Insurance on Medicaid Claims

Many Medicaid recipients also have health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, providers must verify whether such recipients have other insurance coverage on the dates of service in question. If the individual has other insurance coverage, that insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the patient's normal financial

obligation, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer and should be billed first.

Errors in the amounts claimed for coinsurance, copayments, or deductibles and/or in the designation of the primary payer will likely result in improper Medicaid payments. We identified such errors on 69 claims that resulted in overpayments totaling $1,052,058.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $575,634 on 63 claims (for which Medicaid originally paid $588,353) that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and, as a result of our inquiry, they adjusted 59 of the 63 claims, saving Medicaid $381,991. In addition, one claim was partially adjusted by the provider, saving Medicaid $16,378. However, we still question the remaining $1,183 paid on the adjusted claim. Also, three providers still needed to adjust three claims that were overpaid by an estimated $176,082.

Designation of Primary Payer

We identified five claims (for payments totaling $492,526) in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. Generally, primary payers pay more than secondary payers. We contacted the providers and advised them that the recipients had other insurance coverage when the services were provided and, therefore, Medicaid was incorrectly designated as the primary payer. At the time our audit fieldwork concluded, the providers adjusted three of the claims, saving Medicaid $254,387. Two providers, however, still needed to adjust two claims that were overpaid by an estimated $175,114.

Medicare Part A Days

The eMedNY system has various edits to help ensure claims are paid appropriately. Each edit has a disposition associated with it that indicates what the system should do with each claim an edit identifies, such as: pay the claim as is, pend the claim for further review, or deny the claim. The purpose of eMedNY edit 00847 is to deny (unless the claim is submitted via paper) inpatient claims that contain conflicting Medicare information. Specifically, the edit should deny claims that indicate: Medicare approved a portion of the claimed amount, yet Medicare Part A covered zero days of the inpatient stay.

Medicaid paid a hospital $150,686 for an inpatient psychiatric care claim. The patient was admitted on February 7, 2014 and was discharged on May 23, 2014, a stay of 105 days. The hospital reported that Medicare Part A paid $29,229 on the claim, but reported zero covered days. We contacted the hospital and determined the recipient's Medicare coverage began during the stay and covered 22 days. The individual responsible for billing the claim explained that they could not find any guidance on how to bill under these circumstances. Subsequent to our contact with the

hospital, the Department advised the hospital how to correct the claim to properly reflect the 22 Medicare covered days. The eMedNY system subsequently subtracted the 22 Medicare covered days from the total stay and Medicaid correctly paid $103,763 for the remaining 83 days, saving the Medicaid program $46,923.

According to the Department, Medicaid paid for the entire stay, as originally billed, because inpatient psychiatric care claims bypassed edit 00847. As a result of our inquiry, as of January 2016, inpatient psychiatric care claims no longer bypass this edit.

Recommendation

4. Review and recover the unresolved overpayments totaling $352,379 ($176,082 + $1,183 + $175,114).

Incorrect Birth Weights

Medicaid reimburses providers for newborn services using the fee-for-service and managed care payment methods. Under fee-for-service, Medicaid pays providers (such as hospitals) directly for Medicaid eligible services. Under managed care, Medicaid pays managed care plans (Plan) a fixed monthly capitation payment for each newborn enrolled in a Plan. The Plan, in turn, is responsible for the provision of covered health care services. Plans have networks of participating providers that they reimburse directly for services provided.

In addition to the monthly capitation payments, Medicaid pays Plans a one-time Supplemental Newborn Capitation Payment for the inpatient birthing costs of each newborn enrolled. If, however, a newborn has a low birth weight, Medicaid pays Plans a one-time Supplemental Low Birth Weight Newborn Capitation Payment (or “kick” payment) for each enrolled newborn weighing less than 1,200 grams (or approximately 2.64 pounds) at birth. The low birth weight kick payments are intended to cover the higher cost of care these newborns require. Medicaid also makes separate fee-for-service Graduate Medical Education (GME) payments to hospitals for care provided to recipients enrolled in Plans to cover the costs of training residents.

Medicaid reimbursement of inpatient services for newborns is highly dependent on the birth weight. Low birth weights often increase payment amounts. We determined Medicaid overpaid $813,412 for nine incorrect claims that contained low birth weights. The overpayments generally occurred because hospitals reported inaccurate birth weight information to the Plans and Medicaid on their claims. We contacted the providers and, as a result of our inquiries, they corrected seven of the nine claims, saving Medicaid $602,945. However, by the end of our audit fieldwork, two providers had not corrected the two remaining claims totaling overpayments of $210,467.

Low Birth Weight Kick Payments

Medicaid paid three Plans $324,904 for three low birth weight kick claims that contained inaccurate birth weights. We found that hospitals did not accurately report birth weights to the

Plans on these claims. In turn, the Plans reported the incorrect information to Medicaid, causing overpayments of $313,034 on the claims.

For example, one hospital's billing system truncated a birth weight of 3,970 grams to 397 grams. The incorrect birth weight was submitted to the Plan. Consequently, the Plan then billed Medicaid for a low birth weight kick claim since it appeared the newborn weighed less than 1,200 grams. Medicaid paid the Plan $106,658 for this claim. However, based on the correct birth weight, Medicaid should have only paid the Plan $3,811, resulting in an overpayment of $102,847 ($106,658 - $3,811). The Plan corrected the birth weight on this claim, changing the low birth weight kick payment to the lesser paying supplemental newborn capitation payment. However, the change in birth weight also caused a $280 increase in the hospital's subsequent GME payment, resulting in a total net Medicaid savings of $102,567 ($102,847 - $280). By the end of our audit fieldwork, the two other Plans still needed to adjust the two remaining low birth weight kick claims that were overpaid by an estimated $210,467.

Hospital Fee-for-Service Payments

We found that Medicaid overpaid $402,196 for five duplicate fee-for-service newborn claims. In each case, Medicaid made a fee-for-service payment to a hospital and a capitation payment to a Plan. The overpayments occurred because the newborns were retroactively enrolled into a managed care plan, making the fee-for-service payments inappropriate. The hospitals corrected the five claims, saving Medicaid $402,196.

We also identified a claim for a newborn with a reported birth weight of 150 grams (less than one pound) who was discharged in one day. We contacted the provider and, as a result of our inquiry, the provider corrected the birth weight on the claim, saving Medicaid $98,182.

Recommendation

5. Review the two unresolved overpayments totaling $210,467 and recover as appropriate.

Incorrect Billing of Alternate Level of Care

According to the Department's Medicaid inpatient policies, hospitals must indicate a patient's "level of care" on claims to ensure accurate processing and payment. Certain levels of care are more intensive and, therefore, more expensive than others. When a patient is placed in a lower Alternate Level of Care (ALC) setting, hospitals should not bill Medicaid for more intensive acute levels of care. Rather, hospitals should bill less expensive ALC per diem rates.

We identified overpayments totaling $708,016 to two providers that billed for higher (and more costly) levels of care than what was actually provided to patients. For example, Medicaid paid a hospital $423,258 for 365 days of acute psychiatric care. We reviewed the hospital's medical records and determined that all 365 days were incorrectly billed as acute care. The hospital then also determined Medicaid paid $455,784 on two other claims for the same stay and these claims

were also incorrectly billed. As a result, the hospital was overpaid a total of $639,274 for the three improperly billed claims. Medicaid paid another hospital $96,264 for 105 days of acute psychiatric care. Upon review, the hospital determined 96 days were incorrectly billed as acute care and should have been billed at a lower ALC rate, resulting in a Medicaid overpayment of $68,742.

At the time our audit fieldwork concluded, the hospitals adjusted all four claims, saving Medicaid $708,016 ($639,274 + $68,742).

Recommendation

6. Formally advise the two hospitals to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment.

Duplicate Billings

Medicaid overpaid five providers a total of $20,348 on seven claims (which originally paid $30,828) because the providers billed for certain services more than once. The duplicate payments occurred under different scenarios, as follows:

- One provider billed for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same patient encounter, even though the evaluation is allowed only once per encounter. This resulted in overpayments totaling $10,645 on two claims.
- One provider billed Medicaid for an insulin pump for a recipient who was also receiving services from a child care provider. According to the Medicaid policy, durable medical equipment (DME) is included in the child care facility's Medicaid reimbursement rate and, therefore, should not be billed to Medicaid separately. This resulted in an overpayment of $5,129.
- One provider billed Medicaid for an outpatient clinic radiation service that was covered by a separate overlapping inpatient claim. This resulted in an overpayment of $2,121.
- One provider billed the same physician-administered drug twice on the same claim, resulting in an overpayment of $1,435.
- One provider billed Medicaid for multiple dentures on a claim, even though only one denture was approved, resulting in an overpayment of $880.
- One provider billed Medicaid twice for the same vision care service, resulting in an overpayment of $138.

We contacted the providers and, as a result of our inquiries, they corrected five of the seven claims, saving Medicaid $14,339. However, by the end of our audit fieldwork, certain providers had not corrected the two remaining claims totaling $6,009 ($5,129 + $880).

Recommendation

7. Review and recover the two unresolved overpayments totaling $6,009.

Other Improper Claim Payments

We identified $57,513 in overpayments resulting from excessive charges related to clinic, transportation, DME, and eye care claims. At the time our audit fieldwork concluded, $56,506 of the overpayments had been recovered. However, actions are still required to address the balance of the overpayments totaling $1,007.

The overpayments occurred under the following scenarios:

- Two providers billed incorrect procedure codes on six clinic claims that paid $56,730. At our request, the providers reviewed and subsequently adjusted all six claims, saving Medicaid $54,512.
- One provider reported incorrect mileage on a claim that paid $2,149 for a 762-mile round-trip non-emergency taxi ride, even though the actual round-trip was only 50 miles. At our request, the provider reviewed and subsequently adjusted the claim, saving Medicaid $1,994. The Department advised us that this provider frequently overcharged mileage for transportation claims and had already been referred to the Office of the Medicaid Inspector General for review.
- One provider inappropriately billed $7,295 for a speech-generating device that was listed on the Medicaid fee schedule with a price of $6,661. By the end of our audit fieldwork, the provider had not corrected this DME claim, which would save Medicaid $634.
- One provider billed an eye care claim that contained both a new patient exam and an established patient exam on the same date of service. The provider was unable to provide supporting documentation for the claim by the time our audit fieldwork completed. As a result, we question the entire $256 that Medicaid paid for these services.
- One provider inappropriately billed an eye care claim for a second set of frames and lenses within a 24-month period, even though the prescription did not change significantly enough to meet the Medicaid requirement for a second set of frames and lenses. By the end of our fieldwork, the provider had not yet corrected this claim, which would save Medicaid $117.

Recommendations

8. Review and recover the three unresolved overpayments totaling $1,007 ($634 + $256 + $117).

9. Formally instruct the providers in question how to correctly bill Medicaid to help ensure appropriate payment.

Status of Providers Who Abuse the Program

If a Medicaid provider has violated statutory or regulatory requirements related to the Medicaid or Medicare programs (or has engaged in other unacceptable insurance practices), the Department can impose sanctions against the provider. These sanctions can range from excluding the provider from the Medicaid program to imposing participation requirements, such as requiring all claims

to be reviewed manually before payment. If the Department does not identify a provider who should be excluded from the Medicaid program or fails to impose proper sanctions, the provider remains active to treat Medicaid patients, perhaps placing recipients at risk of poor-quality care while the provider continues to receive Medicaid payments.

We identified 38 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. In addition, we identified six providers who were involved in a civil settlement. Of the 44 providers, 39 had an active status in the Medicaid program. The remaining five providers had an inactive status (i.e., two or more years of no claims activity and, therefore, they would be required to seek re-instatement from Medicaid to submit new claims). We advised Department officials of the 44 providers and the Department terminated 26 of them from the Medicaid program. Prior to program termination, Medicaid paid seven of the 26 providers a total of $2,888 from the date they were charged with a crime to their termination date. Also, the Department determined 13 of the 44 providers should not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the five remaining providers.

Recommendations

10. Determine the status of the five remaining providers with respect to their future participation in the Medicaid program.

11. Determine the appropriateness of the $2,888 received by the seven terminated providers and recover improper payments as warranted.

Audit Scope and Methodology

We audited selected Medicaid claims processed by the Department to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The scope of our audit was from April 1, 2015 through September 30, 2015. Additionally, claims and transactions outside of the audit scope period were examined in instances where we observed a pattern of problems and high risk of overpayment.

To accomplish our audit objectives and to determine whether internal controls were adequate and functioning as intended, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments, and tested the operation of certain system controls. We interviewed officials from the Department, Computer Sciences Corporation (the Department's Medicaid fiscal agent), and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Our audit steps reflect a risk-based approach, taking into consideration the time constraints of the weekly cycle and the materiality of payments.

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 the audit recommendations and indicated that certain actions have been and will be taken to address them.

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

Contributors to This Report

Andrea Inman, Audit Director
Dennis Buckley, Audit Manager
Christopher Morris, Audit Supervisor
Andrea LaBarge, Examiner-in-Charge
Rebecca Tuczynski, Examiner-in-Charge
Earl Vincent, Examiner-in-Charge
Judith McEleney, Supervising Medical Care Representative
Suzanne Loudis, Medical Care Representative
Roman Karpishka, Research Specialist
Eric Spence, Research Specialist
Benjamin Babendreier, Senior Examiner
Lauren Bizzarro, Senior Examiner
Teeranmattie Mahtoo-Dhanraj, Senior Examiner
Suzette Millard, Senior Examiner
Daniel Rossi, Senior Examiner
Francesca Kent, Staff Examiner
Natesha Salmon, Staff Examiner
Shannon Younkin, Staff Examiner

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.state.ny.us

Brian Mason, Assistant Comptroller
518-473-0334, bmason@osc.state.ny.us

Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 1, 2016

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2015-S-16 entitled, "Medicaid Claims Processing Activity April 1, 2015 through September 30, 2015."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
Dennis Rosen
James Dematteo
James Cataldo
Ronald Farrell
Brian Kiernan
JoAnn Veith
Elizabeth Misa
Geza Hrazdina
Jeffrey Hammond
Diane Christensen
Lori Conway
OHIP Audit SM

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-16 entitled,
Medicaid Claims Processing Activity April 1, 2015 through September 30, 2015

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2015-S-16 entitled, "Medicaid Claims Processing Activity April 1, 2015 through September 30, 2015."

Background

New York State is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

Recommendation #1:

Review the $7,134,184 in improper capitation payments we identified and recover overpayments as appropriate.

Response #1

OMIG completed an initial analysis of the data for this recommendation, and found that many claims identified by OSC are included in the current OMIG Retroactive Disenrollment audit, which is a continuous and ongoing project conducted by OMIG. OMIG will continue to pursue recovery of any inappropriate payments in the next OMIG Retroactive Disenrollment audit.

Recommendation #2:

Review the $2,282,626 in improper Medicaid payments we identified and recover overpayments as appropriate.

Response #2

First level review of deceased recipients is completed at the district level. OMIG performs a second level review to identify those overpayments not captured in the first review. OMIG completes an annual audit of deceased recipients enrolled in managed care. As part of this audit, OMIG will review and recover any inappropriate payments.

Recommendation #3:

Investigate the life status of the remaining 766 deceased NYSOH enrollees we identified and update their Medicaid enrollment and coverage, as appropriate.

Response #3:

The Department has completed its review of the remaining 766 deceased NY State of Health enrollees and has determined that four individuals were alive. The Department took the necessary steps to close the remaining 762 accounts.

Life status continues to be verified through the federally required Social Security Administration Composite service at application or when a consumer updates their NY State of Health application. This occurs prior to the effectuation of eligibility and/or enrollment. In addition, since 2016, newly eligible individuals are included in the federal Periodic Verification Composite (PVC) batch service starting the first month of eligibility in order to identify deceased individuals. The newly eligible individuals, along with all existing enrollees/eligibles are included in the monthly PVC batch service for each subsequent month of eligibility. Medicaid eligible individuals who are identified as being deceased through the PVC service are given 15 days to refute the PVC service findings. If the response period ends and no response is received, the individual is made ineligible back to the date of death.

Before the federal PVC service became operational, NY State of Health received a weekly file from eMedNY of suspected deceased individuals that were manually researched and closed, as appropriate. As a result of that process, 40 percent of the individuals identified by OSC were researched and appropriate actions taken before OSC fieldwork concluded. The remaining cases were researched and appropriate actions taken in the subsequent months as part of the interim manual process.

OMIG completes an annual audit of deceased recipients enrolled in managed care. As part of this audit, OMIG will review and recover any inappropriate payments.

Recommendation #4:

Review and recover the unresolved overpayments totaling $352,379 ($176,082 + $1,183 + $175,114).

Response #4

OMIG's Third Party Liability Contractor (HMS) has recovered $166,476, and continues its recovery efforts.

Recommendation #5:

Review the two unresolved overpayments totaling $210,467 and recover as appropriate.

Response #5

OMIG reviews supplemental low birth weight payments, and recovers any payments determined to be inappropriate. OMIG is in the process of recovering one of the inappropriate payments, and the other will be pursued for recovery in the next OMIG audit.

Recommendation #6:

Formally advise the two hospitals to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment.

Response #6:

Computer Sciences Corporation (CSC), the Department's contractor that conducts provider billing outreach and education, formally advised the providers identified in this audit on how to accurately report Alternate Level of Care days on claims.

Recommendation #7:

Review and recover the two unresolved overpayments totaling $6,009.

Response #7

OMIG will review and recover the unresolved overpayments, where appropriate.

Recommendation #8:

Review and recover the three unresolved overpayments totaling $1,007 ($634 + $256 + $117).

Response #8:

The provider has reversed the claim so that the overpayment of $634 has been recouped. The Prior Approval has been adjusted to allow payment of the speech generating device at the established Medicaid Reimbursement Amount listed on the fee schedule.

OMIG will review and recover the remaining unresolved overpayments, where appropriate.

Recommendation #9:

Formally instruct the providers in question how to correctly bill Medicaid to help ensure appropriate payment.

Response #9:

A letter was sent to one provider formally instructing them on the Medicaid billing policies for submitting claims based on actual loaded mileage incurred.

Furthermore, CSC formally advised the two providers identified in this audit on the correct Medicaid billing policies for submitting eye care claims.

Recommendation #10:

Determine the status of the five remaining providers with respect to their future participation in the Medicaid program.

Response #10

Of the five providers, OMIG has determined the following:

- Four have been excluded.
- One is under investigation.

Recommendation #11:

Determine the appropriateness of the $2,888 received by the seven terminated providers and recover improper payments as warranted.

Response #11

OMIG reviewed the $2,888 claims paid to the seven providers after their eMedNY termination date. It was determined that the dates of service were prior to the providers being terminated; but, payment was not adjudicated until after the termination dates.