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

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2016 Through September 30, 2016

Medicaid Program
Department of Health

Report 2016-S-12 July 2017

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, 2016 through September 30, 2016.

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, 2016, eMedNY processed about 202 million claims, resulting in payments to providers of about $29 billion. The claims are processed and paid in weekly cycles, which averaged over 7.8 million claims and $1.1 billion in payments to providers.

Key Findings

The audit identified approximately $16.6 million in potential and actual Medicaid cost savings, as follows:

- $13.6 million in potential savings for Medicaid recipients diagnosed with end stage renal disease who were entitled to Medicare coverage at the time of the claims;
- $1.1 million in improper episodic payments to home health care providers;
- $845,824 in overpayments for newborn claims that were submitted with incorrect birth weights;
- $471,321 in overpayments for claims billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $357,498 in improper payments for inpatient, durable medical equipment, clinic, child care, and transportation services;
- $160,759 in overpayments for an inpatient claim that was billed at a higher level of care than what was actually provided; and
- $25,354 in improper payments for duplicate billings.

By the end of the audit fieldwork, about $1.8 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 15 providers that we identified. Prior to program termination, Medicaid paid 9 of the 15 providers a total of $99,038 from the date they were charged with a crime to their termination date. The Department should assess whether these payments should be recovered.

Key Recommendations

- We made eight 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, 2015 Through March 31, 2016 (2015-S-74)

Department of Health: Medicaid Claims Processing Activity April 1, 2015 Through September 30, 2015 (2015-S-16)

State of New York
Office of the State Comptroller

Division of State Government Accountability

July 25, 2017

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 entitled *Medicaid Claims Processing Activity April 1, 2016 Through September 30, 2016*. 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

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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 2015-16, the federal government funded about 53.2 percent of New York's Medicaid claim costs; the State funded about 30.6 percent; and the localities (the City of New York and counties) funded the remaining 16.2 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, 2016, eMedNY processed about 202 million claims, resulting in payments to providers of about $29 billion. The claims are processed and paid in weekly cycles, which averaged over 7.8 million claims and $1.1 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 (OSC) 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 OSC's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet OSC'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, 2016, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers.

In addition, we identified the need for improvements in the processing of certain types of claims. We found about $13.6 million in potential cost savings and $3 million in improper payments pertaining to: claims for recipients diagnosed with end stage renal disease who were entitled to Medicare coverage; improper episodic home health care payments; claims with incorrect newborn birth weights; claims with incorrect information pertaining to other insurance recipients had; improper clinic and other claims; a hospital claim that was billed at a higher level of care than what was actually provided; and claims for duplicate services.

At the time the audit fieldwork concluded, about $1.8 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments (totaling about $1.2 million) and the $13.6 million in potential cost savings, and recover funds as warranted.

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 15 of the providers we identified from the Medicaid program. Prior to program termination, Medicaid paid 9 of the 15 providers a total of $99,038 from the date they were charged with a crime to their termination date. Department officials should determine the appropriateness of these payments.

Medicaid Payments for Recipients With End Stage Renal Disease

End stage renal disease (ESRD) is a medical condition in which a person has permanent kidney failure and requires dialysis or a kidney transplant to stay alive. Medicaid recipients with ESRD are eligible for Medicare coverage if they receive regular dialysis treatments or a kidney transplant, and meet one of the following requirements: (1) have worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee; (2) are already receiving or are eligible for Social Security or Railroad Retirement Board benefits; or (3) are the spouse or dependent child of a person who meets either of the aforementioned requirements.

When Medicaid recipients with ESRD are also enrolled in Medicare, Medicare becomes the primary insurer (payer) and Medicaid the secondary. As a secondary payer, rather than pay for the medical service itself, Medicaid can pay a recipient's Medicare premiums, deductibles, and coinsurance amounts, which allows for a significant cost avoidance for the Medicaid program.

In a previous OSC report (2015-S-14), auditors found the Department did not identify Medicaid recipients with ESRD, notify ESRD recipients of their entitlement to Medicare, or take actions to help (or encourage) recipients to apply and enroll in Medicare. The audit covered the period

January 1, 2010 through December 31, 2015. In response to the audit findings, on July 13, 2016, the Department initiated a project that will identify recipients with an ESRD diagnosis. The Department will provide information to these recipients on how and where to apply for Medicare coverage. The Department is also taking steps to acquire contractor assistance to conduct outreach to all Medicaid recipients with an ESRD diagnosis who are not enrolled in Medicare (such outreach would include providing information about Medicare benefits, the potential for Medicaid to pay the cost of Medicare premiums, and how and where to apply for Medicare, as well as Medicare application assistance).

At the time our audit fieldwork concluded, the Department had not completed the project to identify and notify ESRD recipients of their entitlement to Medicare, and the contractor had not been selected. For the period of January 1, 2016 through September 30, 2016, we identified an additional $13.6 million in total net payments (after deducting Medicare out-of-pocket-expenses) that Medicaid could have avoided for 781 recipients (identified in our previous audit report) who were entitled to Medicare coverage at the time of the claims. Social Security Administration policies allow for retroactive ESRD Medicare enrollment for up to 12 months to cover medical services already provided. Therefore, the Department can obtain claim recoveries by tracking when Medicaid recipients diagnosed with ESRD are retroactively enrolled in Medicare. The Department should track and pursue Medicaid claim recoveries for recipients who become retroactively enrolled in ESRD Medicare.

Recommendation

1. Recover claims paid for any retroactive Medicare enrollments of recipients diagnosed with ESRD.

Improper Episodic Payments for Home Care

Effective May 1, 2012, the Department implemented the Episodic Payment System (EPS) to reimburse Certified Home Health Agencies (CHHA) for in-home health care services provided to Medicaid recipients. The EPS is based on 60-day episodes of care. CHHAs can be paid for a full episode (when the episode of care is 60 days) or for a partial episode (when the episode of care is less than 60 days). Payment for a partial episode may be pro-rated based on the number of days of care on the claim. For the period January 1, 2016 through September 30, 2016, we determined Medicaid overpaid 58 CHHAs a total of $1,131,122 under the EPS.

Transfer to Managed Long Term Care

According to the EPS billing guidelines, a CHHA should receive a partial pro-rated episodic payment when a recipient is discharged to a managed long term care (MLTC) plan within 60 days of the recipient's episode start date. All MLTC plans provide Medicaid home care and other long-term care services. Therefore, a Medicaid capitation payment to an MLTC plan and a full episodic payment to a CHHA for the same recipient during overlapping service dates is duplicative. From January 1, 2016 through September 30, 2016, Medicaid overpaid 40 CHHAs $699,944 for 305

claims for recipients discharged from a CHHA to an MLTC plan. In each case, the CHHAs submitted a claim indicating an incorrect discharge code, allowing them to be paid for a full episode when they should have been paid for a partial pro-rated episode.

Multiple Episodic Payments Within 60 Days

From January 1, 2016 through September 30, 2016, we also identified $431,178 in overpayments to 38 CHHAs that improperly received duplicate full payments for patients who were readmitted within 60 days of their original episode start date. These overpayments occurred because the CHHAs did not follow the Department's billing guidelines for the EPS. Specifically, we identified 198 claims totaling $342,100 paid to 26 CHHAs that billed multiple episodes of services for the same recipient within 60 days of the recipient's original episode start date. Each CHHA should have submitted an adjustment claim to include all services within 60 days of the first episode start date, and then a second (pro-rated) claim for the remaining service dates after the 60-day episode. We also identified overpayments for recipients discharged from one CHHA and admitted to a different CHHA within 60 days of the first episode start date. Department guidelines require the first CHHA to adjust the original claim and submit for a partial pro-rated payment; however, we found this was not always done. As a result, Medicaid overpaid 40 claims to 19 CHHAs totaling $89,078 for services provided to recipients who subsequently received additional services from a different CHHA within 60 days of the first episode.

As a result of OSC's audit work, on March 1, 2017, the Department issued a letter to CHHAs. The letter explained the overpayment scenarios identified in our audits, directed CHHAs to review the existing billing guidelines, and encouraged CHHAs to review their billings systems to ensure compliance.

Recommendation

2. Review the $1.1 million in improper payments made to the CHHAs that we identified and recover overpayments as appropriate.

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 payment is intended to cover the higher cost of care these newborns require. Medicaid also makes separate fee-for-service Graduate Medical Education payments to hospitals for care provided to recipients (including newborns) 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 $845,824 for nine incorrect claims that contained low birth weights. The overpayments generally occurred because hospitals reported inaccurate birth weight information to the Plans and to Medicaid on their claims. We contacted the providers and, as a result of our inquiries, they corrected all nine claims, saving Medicaid $845,824.

Low Birth Weight Kick Payments

Medicaid overpaid five Plans $597,427 for six low birth weight kick claims that contained inaccurate birth weights. We found that the hospitals did not accurately report birth weights to the Plans on these claims. In turn, the Plans reported the incorrect information to Medicaid, causing the overpayments.

For example, one hospital's billing department truncated a birth weight of 3,480 grams to 348 grams. The hospital submitted the incorrect birth weight to the Plan. Subsequently, the Plan billed Medicaid for a low birth weight kick claim since it appeared the newborn weighed less than 1,200 grams. Medicaid paid the Plan $106,659 for its claim. However, based on the correct birth weight (3,480 grams), Medicaid should not have paid the Plan for a low birth weight kick claim. At our request, the hospital reviewed the birth weight and notified the Plan of the incorrect information. Subsequently, the Plan voided the low birth weight kick claim, saving Medicaid $106,659.

Hospital Fee-for-Service Payments

We found that Medicaid overpaid $248,397 for three 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 three claims, saving Medicaid $248,397.

Recommendation

3. Formally advise the hospitals in question to report accurate birth weight information on claims.

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 12 claims that resulted in overpayments totaling $471,321.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $370,604 on eight claims (for which Medicaid originally paid $378,746) 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 inquiries, they adjusted all eight of the claims, saving Medicaid $370,604.

Designation of Primary Payer

We identified four claims (for which Medicaid originally paid $132,078) 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, one provider adjusted its claim, saving Medicaid $85,320. Two providers, however, still needed to adjust three claims that were overpaid by an estimated $15,397.

Recommendation

4. Review and recover the three unresolved overpayments totaling $15,397.

Improper Payments for Inpatient, Durable Medical Equipment, Clinic, Child Care, and Transportation Claims

We identified $357,498 in overpayments that resulted from excessive charges on inpatient, durable medical equipment (DME), clinic, child care, and transportation claims. At the time our audit fieldwork concluded, $338,810 of the overpayments had been recovered. However, actions were still required to address the balance of the overpayments totaling $18,688.

The overpayments occurred under the following scenarios:

- Medicaid made a fee-for-service payment to a hospital for $130,467. However, the recipient was retroactively enrolled into a managed care plan, making the fee-for-service payment inappropriate. At our request, the hospital reviewed and subsequently corrected the claim, saving Medicaid $100,892.
- One provider billed an inpatient claim for a tracheostomy it did not perform. At our request, the provider reviewed and subsequently corrected the claim, saving Medicaid $98,691.
- One provider billed an inpatient claim that indicated the patient was discharged to home, even though the patient had actually been transferred to another facility. At our request, the provider reviewed and corrected this information on the claim, saving Medicaid $91,876.
- One provider billed $73,274 for 11 speech generating devices at higher rates than allowed by Medicaid policy. By the end of our fieldwork, the provider had not yet corrected these claims, which would save Medicaid $14,384.
- One provider was overpaid for three clinic claims that were submitted with a vaccination modifier code for a non-vaccination service. At our request, the provider reviewed and corrected the claims, saving Medicaid $13,392.
- One provider incorrectly billed nine child care claims (that totaled $17,682 in payments). The provider billed an incorrect reimbursement code which caused the overpayments. At our request, the provider reviewed and corrected the nine claims, saving Medicaid $12,838.
- One provider billed five clinic claims for the treatment of ESRD that indicated the use of a non-ESRD physician-administered drug. At our request, the provider reviewed and corrected all five claims, saving Medicaid $7,413.
- One provider incorrectly billed a clinic claim indicating they administered a stroke treatment drug for a forehead laceration. At our request, the provider reviewed and corrected the claim, saving Medicaid $7,246.
- One provider incorrectly billed a clinic claim for the insertion of a cardiac pacemaker as part of a methadone maintenance treatment. At our request, the provider reviewed and voided the claim, saving Medicaid $6,462.
- Medicaid inappropriately paid two providers $3,226 for two DME claims where the equipment was either not medically necessary or already included in the reimbursement of a separate item. By the end of audit fieldwork, the two claims had not been corrected.
- One provider reported incorrect mileage on a claim that paid $1,388 for a 622-mile round-trip non-emergency taxi ride, even though the actual round-trip was only 132 miles. By the end of our audit fieldwork, the provider had not corrected the claim, which would save Medicaid $1,078.

Recommendation

5. Review and recover the 14 unresolved overpayments totaling $18,688 ($14,384 + $3,226 + $1,078).

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 an overpayment totaling $160,759 to one provider that billed for higher (and more costly) levels of care than what was actually provided to a patient. Medicaid paid the hospital $160,759 for 175 days of acute care that should have been billed at a lower ALC rate. At the time our audit fieldwork concluded, the hospital voided the claim. However, the review of ALC days is still ongoing by the hospital.

Recommendation

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

Duplicate Billings

Medicaid overpaid six providers a total of $25,354 on eight claims (which originally paid $40,490) because the providers billed for certain services more than once. At the time our audit fieldwork concluded, $14,831 of the overpayments had been recovered. However, actions are still required to address the balance of the overpayments totaling $10,523. The duplicate payments occurred under different scenarios, as follows:

- Four providers billed six claims for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same patient encounter, even though the evaluation is allowed only once per encounter. We contacted the four providers regarding the duplicate claims. At the time our fieldwork concluded, two providers corrected two claims, saving Medicaid $9,399. Two providers had not yet corrected the remaining four claims, which would save Medicaid $10,523.
- One provider billed for an outpatient clinic service; however, the recipient was subsequently admitted to an inpatient setting on the same day. At our request, the provider reviewed and corrected the claim, saving Medicaid $5,035.
- One provider billed for an outpatient clinic radiation service that was covered by a separate overlapping clinic claim. At our request, the provider reviewed and adjusted the claim, saving Medicaid $397.

Recommendation

7. Review and recover the four unresolved CPEP overpayments totaling $10,523.

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 15 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 three providers who were involved in civil settlements that involved health care-related matters. Of the 18 providers, 17 had an active status in the Medicaid program. The remaining provider had an inactive status (i.e., two or more years of no claims activity and, therefore, would be required to seek reinstatement from Medicaid to submit new claims). We advised Department officials of the 18 providers and the Department terminated 15 of them from the Medicaid program. Prior to program termination, Medicaid paid 9 of the 15 providers a total of $99,038 from the date they were charged with a crime to their termination date. Also, the Department determined that 3 of the 18 providers should not be terminated.

Recommendation

8. Determine the appropriateness of the $99,038 received by the nine terminated providers and recover improper payments as warranted.

Audit Scope, Objectives, 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, 2016 through September 30, 2016. 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 to certain boards, commissions, and public authorities, some of whom have minority voting rights. 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 concurred with the audit's recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to certain Department comments is included in the report's State Comptroller's Comment.

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

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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

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

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

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

May 17, 2017

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

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2016-S-12 entitled, "Medicaid Claims Processing Activity April 1, 2016 Through September 30, 2016."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2016-S-12 entitled,
Medicaid Claims Processing Activity April 1, 2016 Through
September 30, 2016

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-12 entitled, "Medicaid Claims Processing Activity April 1, 2016 Through September 30, 2016."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1

Recover claims paid for any retroactive Medicare enrollments of recipients diagnosed with ESRD.

Response #1

This recommendation is unnecessary. An established, ongoing process already exists to track and pursue recoveries when individuals are retroactively enrolled in Medicare. OMIG takes steps to pursue allowable recoveries regardless of diagnosis, End Stage Renal Disease (ESRD) or otherwise, when any retroactive Medicare enrollment occurs.

* Comment 1

Furthermore, this ongoing cost reduction process is independent from the savings initiative that OSC discussed in the *Medicaid Payments for Recipients with ESRD* section of the report. In 2016, the Department voluntarily implemented an initiative to assist Medicaid recipients who may be potentially eligible for Medicare. The Department took these steps because they will benefit Medicaid recipients with an ESRD diagnosis who choose to apply, and are determined eligible for Medicare by the Social Security Administration (SSA). Additionally, judicious implementation of this initiative will benefit New York's Medicaid program because it is expected to yield savings even though OSC's potential estimates are overstated. The amounts reflected in the report assume that all the potentially eligible individuals identified by OSC would have completed the application process and been found eligible by SSA, which is unrealistic. The stated figures also fail to appropriately account for the costs associated with building and maintaining the program operations and resources needed to identify, notify and assist Medicaid recipients to apply to SSA for Medicare coverage on an ongoing basis.

OMIG will review claims paid for any retroactive Medicare enrollments of Medicaid recipients, and pursue recoveries of payments determined to be inappropriate.

* See State Comptroller's Comment, Page 21.

Recommendation #2

Review the $1.1 million in improper payments made to the CHHAs that we identified and recover overpayments as appropriate.

Response #2

As mentioned in the audit report, the Department issued a letter to Certified Home Health Agencies (CHHAs) on March 1, 2017, directing CHHAs to review the existing billing guidelines and encourage them to review their billing systems to ensure compliance. This letter will also be included in a future Medicaid Update to be released by June 2017.

Due to the complexity of the claims and services provided, OMIG has met with the Department to determine an appropriate course of action. OMIG will extract their own data and perform analysis, and pursue recovery of any payment determined to be inappropriate.

Recommendation #3

Formally advise the hospitals in question to report accurate birth weight information on claims.

Response #3

The Department was notified by its Medicaid fiscal intermediary on February 21,2017, via transmittal, that such communication had been executed and that the hospitals identified in this audit had taken various internal steps to improve the accurate reporting of birth weights.

Recommendation #4

Review and recover the three unresolved overpayments totaling $15,397.

Response #4

OMIG has sent the third-party liability contractor the identified claims for review and recovery where appropriate.

Recommendation #5

Review and recover the 14 unresolved overpayments totaling $18,688 ($14,384 + $3,226 + $1,078).

Response #5

OMIG will review the unresolved overpayments. OMIG has recovered $1,388, and will continue to pursue recovery of any payment determined to be inappropriate.

Recommendation #6

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

Response #6

The Department was notified by its Medicaid fiscal intermediary on February 21, 2017, via transmittal, that such communication had been executed as instructed. More specifically, the hospital had already taken steps to implement a new Alternate Level of Care (ALC) billing process, and that the applicable ALC claim has been voided.

Recommendation #7

Review and recover the four unresolved CPEP overpayments totaling $10,523.

Response #7

OMIG will review the unresolved overpayments, and pursue recovery of any payment determined to be inappropriate.

Recommendation #8

Determine the appropriateness of the $99,038 received by the nine terminated providers and recover improper payments as warranted.

Response #8

OMIG's analysis of the OSC data determined $97,236 of the $99,038 were appropriately paid by Medicaid. The dates of service were prior to the effective date of the exclusion from the Medicaid program, and the payments were not adjudicated until after the date of exclusion.

OMIG is reviewing the remaining $1,802, and will recover, if these payments are determined to be inappropriate.

State Comptroller's Comment

1. Although Department officials assert that the recommendation is unnecessary, officials stated the OMIG will review claims paid for retroactive Medicare enrollments of Medicaid recipients and pursue recoveries of Medicaid payments determined to be inappropriate. We are pleased the OMIG will review and recover such claim payments, including those identified by this audit. Further, officials indicated that the Department voluntarily implemented an initiative in 2016 to assist Medicaid recipients who may be potentially eligible for Medicare, consistent with a recommendation from a prior OSC audit, entitled *Reducing Medicaid Costs for Recipients With End Stage Renal Disease* (2015-S-14). We believe this action will help individuals identified in this report, who met the Social Security Administration's eligibility requirements, to enroll in Medicare. Further, such enrollments will likely yield significant Medicaid savings for New York State and localities now and for years to come.