NEW YORK STATE OF OPPORTUNITY. Department of Health

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Commissioner

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Executive Deputy Commissioner

March 12, 2018

Mr. Kenneth Shulman
Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Shulman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2016-S-66 entitled, "Medicaid Claims Processing Activity October 1, 2016 through March 31, 2017."

Please feel free to contact Estibaliz Alonso, Acting Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

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

Enclosure

cc: Estibaliz Alonso

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2016-S-66 entitled,
Medicaid Claims Processing Activity
October 1, 2016 through March 31, 2017

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2016-S-66 entitled, "Medicaid Claims Processing Activity October 1, 2016 through March 31, 2017."

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 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1:

Review the remaining approximate $240,000 in identified overpayments and make recoveries, as appropriate.

Response #1:

Only two remaining claims have not had the Medicaid overpayments recouped. OSC estimates the combined total recoupment from these claims to be approximately $240,000. However, because they are Third Party Liability (TPL) claims, actual Medicaid fund recoupment amounts are unknown. Furthermore, final recoupments will likely be less than OSC's estimation because TPL claims are also billed to Medicare. Once the Medicare benefit is exhausted, the claims are then billed to Medicaid. The claims, as submitted by the respective providers, did not reflect the Medicare payment information.

A review of these claims by the Island Peer Review Organization (IPRO), the Department, and the eMedNY claims processing team at CSRA (the Department's Medicaid fiscal agent), determined that Third Party Payer factors are preventing IPRO from successfully adjusting these claims through IPRO's electronic reconciliation process. Accordingly, the Department directed IPRO to send letters to both providers requesting the claims be resubmitted to eMedNY with the Medicare payment information. Upon resubmission, IPRO will confirm the revised Medicaid payment amount and report back to the Department. A decision will then be made as to whether there are Medicaid payments to be recouped.

IPRO sent the letters on December 11, 2017, and both providers advised they are in the process of revising their claims to reflect IPRO's final determination.

Recommendation #2:

Review the remaining $2.8 million in identified overpayments and make recoveries, as appropriate.

Response #2

OMIG's Recovery Audit Contractor (RAC) has recovered $1,494,062, and determined $69,044 had previously been adjusted or voided. OMIG's RAC is continuing to pursue recovery of any payment determined to be inappropriate.

Recommendation #3:

Design and implement eMedNY system changes to prevent multiple CPEP payments for individual episodes of care, and to prevent CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Response #3:

The Department is working with the Office of Mental Health (OMH) on updates to the eMedNY system to prevent future issues. System updates are expected in 2018.

Recommendation #4:

Review the remaining overpayments totaling $571,329 ($372,466 + $198,863) and make recoveries, as appropriate.

Response #4

OMIG's RAC has recovered $383,847, and will continue to pursue recovery of any payment determined to be inappropriate.

Recommendation #5:

Retroactively process the managed care enrollment for the remaining newborn we identified.

Response #5:

The Department has completed research on the enrollment issue for the remaining newborn and has instructed Human Resources Administration to put up an enrollment line for month and year of birth only (September 2014).

Recommendation #6:

Review the remaining $717,266 ($287,449 + $429,817) in identified overpayments and make recoveries, as appropriate.

Response #6:

As part of its routine audit efforts, OMIG will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #7:

Review the remaining $615,244 in identified overpayments and make recoveries, as appropriate.

Response #7:

OMIG has recovered $416,717, and will continue to pursue recovery of any payment determined to be inappropriate.

Recommendation #8:

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

Response #8:

CSRA notified the Department in a transmittal dated September 20, 2017 that the specific providers identified in this audit were educated in the various proper billing procedures identified in the audit findings.

The Department has also issued a Medicaid Update article that can be found at:
http://www.health.ny.gov/health_care/medicaid/program/update/2015/sept15_mu.pdf.

This update reminds all providers on the proper reporting of the birth weight of newborns on inpatient claims billed to Medicaid Fee-for-Service, as well as Medicaid managed care plans. The article above includes a link to the billing guidelines in the provider manual.

Recommendation #9:

Review the $705,466 in improper payments made to the CHHAs and recover overpayments, as appropriate.

Response #9:

OMIG extracted its own data, performed analysis, and is pursuing recovery of any payment determined to be inappropriate.

Recommendation #10:

Review the unresolved overpayments on the 657 claims totaling $404,227 and make recoveries, as appropriate.

Response #10:

The Department has corrected the weighting error on the Procedure Based Weight file for the two dental anesthesia procedure codes (D9223 and D9243) for Ambulatory Patient Groups (APGs) for the period January 1, 2016 through June 30, 2016.

In the preliminary report provided by OSC, OSC identified errors in the Service Intensity Weight file for two dental anesthesia codes for APGs institutional claims for the period January 1, 2016 through June 30, 2016. This file identified 657 claims totaling $404,227 for this period. The Department stated in the preliminary response that the weighting for these claims would be adjusted retroactively to January 1, 2016.

The Department previously adjusted the APG Grouper on July 2016 for prospectively paid claims. No retroactive adjustments were made for claims submitted between January 2016 and June 2016. A subsequent APG change was made in January 2017, to price claims correctly for the period January 2016 through June 2016. However, previously paid claims for this period were not retroactively adjusted. The Department has requested that CSRA reprocess the previously paid claims for this six-month period to recoup any potential overpayments made to providers. It should be noted, that once these claims have been reprocessed, providers will likely review the medical records and readjust some of these claims by reporting the actual total units of anesthesia provided, resulting in a decrease in the projected savings identified by OSC.

Recommendation #11:

Review the unresolved overpayments totaling $49,695 ($49,517 + $178) and make recoveries, as appropriate.

Response #11:

OMIG will review the unresolved overpayments and recover any payment determined to be inappropriate.

Recommendation #12:

Determine the status of the remaining two providers relating to their future participation in the Medicaid program.

Response #12:

OMIG is currently reviewing the remaining two providers.

Office of the State Comptroller's Comment:

OSC Comment #1:

We are pleased the Department corrected the errors on its Procedure Based Weight file. However, the Department surmises that, as a consequence of the needed corrections, providers will resubmit some of their previously paid claims based on their reexamination of the medical records and change the actual units of anesthesia supplied on those adjusted claims. The Department states this will result in a decrease in the savings we identified. We note that the

Department did not provide any basis or reason why the affected providers would change the units of anesthesia they originally reported based on a re-review of their medical records (the providers' medical records should have supported their originally submitted Medicaid claims). Furthermore, the Department should be suspicious of any claims that are, in fact, readjusted and submitted to Medicaid with higher units of anesthesia. Therefore, we believe the $404,227 we identified is accurate.

Response #1:

The Department must correct the premise of OSC's comment. The Department does not anticipate providers changing the actual units of anesthesia on the adjusted claims, it anticipates providers changing the format in which they fill out the adjusted claims, which would change the savings amount.

Specifically, providers will likely readjust some claims by reporting the total units of anesthesia on the first line only (as opposed to reporting one unit of anesthesia per line), resulting in a decrease in the projected savings identified by OSC.

For example, OSC identified claims where the provider billed dental anesthesia using the same procedure code on multiple claim lines. Each claim line had one unit billed. The first claim line paid 100% and each subsequent claim line paid 50% in accordance with APG discounting logic.

As noted in the Department's response, the Department has done a claims reprocessing, paying the first line at 100% at one unit and denying all subsequent claim lines. To reiterate, we expect providers will submit claim adjustments to reflect the actual number of dental anesthesia units on one claim line, up to a maximum of four units. The OSC audit findings accounted only for the multiple claim lines billed, each at one unit. Claim adjustments submitted by the provider will offset the savings projected by OSC. For example, a claim submitted with D9223 on four different lines may be readjusted by the provider to include the four units on one claim line. This will change the adjusted claim and increase the amount paid on the first line with the four units adjusted, thus decreasing the overall savings projected by the OSC.