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

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018

Medicaid Program
Department of Health

Report 2017-S-63 February 2019

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 October 1, 2017 through March 31, 2018.

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 March 31, 2018, eMedNY processed over 184 million claims, resulting in payments to providers of more than $31 billion. The claims are processed and paid in weekly cycles, which averaged over 7.1 million claims and $1.2 billion in payments to providers.

Key Findings

The audit identified over $119 million in Medicaid payments that require the Department's prompt attention, as follows:

- $107.7 million in Medicaid managed care premiums were paid on behalf of recipients with concurrent comprehensive third-party health insurance (TPHI);
- $3.2 million was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $2.1 million was paid for claims involving the Medicare Savings Program;
- $1.7 million in fee-for-service claims was paid for recipients enrolled in managed care;
- $1.6 million was paid for newborn birth claims;
- $1.4 million was paid for an inpatient claim that was billed at a higher level of care than what was actually provided;
- $609,915 was paid for Comprehensive Psychiatric Emergency Program claims that were billed in excess of permitted limits; and
- $360,651 was paid for clinic and inpatient claims; $357,020 was paid for drugs purchased through the federal 340B program; and $290,676 was paid for episodic home health care claims that did not comply with Medicaid policies.

By the end of the audit fieldwork, about $6.7 million of the improper payments had been recovered.

Further, of the $107.7 million in premiums paid on behalf of Medicaid recipients with concurrent comprehensive TPHI, about $5.7 million pertained to Nassau County. During the audit, auditors assisted Nassau County officials in identifying Medicaid recipients who had comprehensive TPHI while enrolled in Medicaid managed care. Nassau County officials subsequently disenrolled 619 Medicaid recipients who were improperly enrolled in managed care, saving the Medicaid program

an estimated $2.1 million in managed care premiums for the six-month period April 2018 through September 2018.

Auditors also identified 38 active Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. By the end of the audit fieldwork, the Department terminated 21 of the providers, entered in Medicaid settlements with 14, and needed to make a decision on the program status of the remaining 3 active providers.

Key Recommendations

- We made 14 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, 2016 Through March 31, 2017 (2016-S-66)

Department of Health: Medicaid Claims Processing Activity April 1, 2017 Through September 30, 2017 (2017-S-23)

State of New York
Office of the State Comptroller

Division of State Government Accountability

February 5, 2019

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 October 1, 2017 Through March 31, 2018*. 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

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Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3 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 March 31, 2018, eMedNY processed over 184 million claims, resulting in payments to providers of more than $31 billion. The claims are processed and paid in weekly cycles, which averaged over 7.1 million claims and $1.2 billion in payments to providers.

The Department pays health care providers either directly through fee-for-service payments (for instance, the Department makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients) or through monthly premium payments made to managed care organizations (MCOs). Under managed care, the Department pays each MCO a monthly premium for each Medicaid recipient enrolled in the MCO. The MCOs are then responsible for ensuring recipients have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services provided to recipients, and are required to submit encounter claims to eMedNY to inform the Department about each medical service provided.

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.

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 March 31, 2018, 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.

We also identified the need for improvements in the processing of certain types of claims. We found about $119.4 million in audit findings pertaining to: managed care premiums paid for recipients with comprehensive third-party health insurance (TPHI); claims billed with incorrect information related to other insurance that recipients had; incorrect claims paid under the Medicare Savings Program; inappropriate fee-for-service payments when recipients had managed care; incorrect newborn birth claims; a hospital claim that was billed at a higher level of care than what was actually provided; claims for the Comprehensive Psychiatric Emergency Program paid in excess of the permitted limits; improper clinic and inpatient claims; overpayments for drugs purchased through the federal 340B program; and improper episodic home health care payments.

At the time the audit fieldwork concluded, about $6.7 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $112.7 million and recover funds as warranted.

Further, of the $119.4 million in payments, about $107.7 million involved Medicaid managed care premiums that were paid on behalf of recipients who had comprehensive TPHI, including about $5.7 million that pertained to Nassau County. During our audit, we assisted Nassau County officials in identifying Medicaid recipients who had comprehensive TPHI, which allowed officials to remove ineligible recipients from managed care in a timely manner. As a result, 619 recipients were disenrolled from managed care, saving the Medicaid program about $2.1 million in managed care premiums for the six-month period April 1, 2018 through September 30, 2018.

Auditors also identified providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. The Department terminated 25 of the providers we identified from the Medicaid program, but the status of three other providers was still under review at the time our fieldwork was completed.

Managed Care Recipients With Comprehensive Third-Party Health Insurance

The Department pays MCOs a monthly premium for each recipient enrolled in a Medicaid managed care plan. As of March 2018, about 4.8 million recipients were enrolled in a Medicaid managed care plan – about 2.8 million were enrolled through the New York State of Health (or NYSOH, New York's online health insurance marketplace), and the remainder were enrolled through other means, including Local Departments of Social Services (LDSS).

Many Medicaid recipients have additional sources of health care coverage. Per the Department's

Medicaid policies, the Department excludes recipients from participating in managed care when they have comprehensive TPHI. TPHI is considered comprehensive TPHI if it covers 13 specific types of health services, among them: hospital care, physician services, pharmacy, and hospice care. Conversely, comprehensive TPHI does not include certain partial (or non-comprehensive) coverage such as: accident-only coverage or disability income insurance; liability insurance, including auto insurance; workers' compensation; long-term care insurance; or coverage such as dental-only or prescription-only coverage.

For the period October 1, 2017 through March 31, 2018, we determined the Department paid $107.7 million in Medicaid managed care premiums on behalf of 79,672 recipients who also had concurrent comprehensive TPHI.

The Department, LDSS, and NYSOH are responsible for disenrolling recipients who have comprehensive TPHI from Medicaid managed care. The Managed Care Model Contract also explicitly states the disenrollment should be made promptly. Since June 2016, the Department has improved payment controls that use TPHI information to prevent improper premium payments; however, these efforts only target NYSOH-enrolled recipients. The Department has not implemented similar controls with regard to non-NYSOH-enrolled recipients, such as recipients enrolled through LDSS.

In January 2018, the Department provided the LDSS with a letter reminding them of the policy to disenroll recipients with comprehensive TPHI from managed care and the various information available to assist them with disenrolling. Despite the reminder, however, two LDSS we contacted (New York City Human Resources Administration [HRA] and Nassau) had not established a process on how to effectively identify and disenroll recipients having comprehensive TPHI from managed care (HRA and Nassau accounted for $70.9 million and $5.7 million, respectively, of the $107.7 million identified).

We engaged the two LDSS in discussions about the issue, explained our audit findings, and provided them with lists of recipients in their counties who were found to have concurrent Medicaid managed care coverage and comprehensive TPHI. Local district officials from Nassau reacted promptly and used the information to disenroll 619 recipients with comprehensive TPHI from managed care, and are now working to develop internal automated reports that will be used to identify and disenroll such recipients from managed care going forward. We estimate that Nassau's timely corrective actions helped prevent about $2.1 million in improper premium payments over the next six months, April 2018 through September 2018. HRA is in the process of reviewing our audit findings and determining corrective actions.

In May 2018, the Department requested the methodology that auditors used to identify recipients with concurrent Medicaid managed care coverage and comprehensive TPHI so that the Department could develop reports that produced similar information going forward. Further, as a result of our audit work, the Department's Office of the Medicaid Inspector General (OMIG) began a "clean-up project" to identify recipients currently enrolled in managed care who also had comprehensive TPHI. The OMIG estimated that, by fall 2018, approximately 17,000 recipients would be evaluated to determine the appropriateness of their enrollment in (and, if determined not to be appropriate, subsequent disenrollment from) managed care.

Recommendations

1. Work with the LDSS to implement processes that allow for more effective, efficient, and timely identification and disenrollment of recipients with comprehensive TPHI from managed care.

2. Review the managed care premium payments we identified and make recoveries, as appropriate.

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, health care providers must verify whether such recipients had other insurance coverage on the dates services were provided. If a recipient had other insurance coverage, the other insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the recipient'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.

Errors in the amounts claimed for coinsurance, copayments, or deductibles and/or in the designation of the primary payer result in improper Medicaid payments. We identified such errors on 81 claims that resulted in overpayments totaling about $3.2 million. Providers adjusted 36 claims, resulting in Medicaid savings of about $2.1 million.

Designation of Primary Payer

We identified overpayments totaling $3,176,892 on 79 claims in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. Typically, primary payers pay more than secondary payers do. We contacted the providers and advised them that the recipients had other insurance coverage at the time the services were provided and, therefore, Medicaid was incorrectly billed as the primary payer. At the time our audit fieldwork concluded, providers had adjusted 34 claims, saving Medicaid $2,057,779. However, the remaining 45 claims that were overpaid by an estimated $1,119,113 still needed to be adjusted.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $2,189 on two claims that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and they adjusted both claims, saving Medicaid $2,189.

Recommendation

3. Review the $1,119,113 in overpayments and make recoveries, as appropriate.

Medicare Savings Program

Medicare is the federal health care program for people 65 years of age and older and people under 65 years old with certain disabilities. Medicare requires enrollees to pay certain out-of-pocket costs, such as monthly premiums, annual deductibles, and coinsurance for covered services. The Medicare Savings Program (MSP) is a Medicaid-administered program that allows individuals to have these Medicare expenses paid by Medicaid. Individuals whose income or resources exceed the standard Medicaid thresholds – and thus do not qualify for basic Medicaid coverage – but who meet other income and program eligibility standards can qualify for Medicaid under the MSP program as a Qualified Medicare Beneficiary (QMB) only.

For individuals qualifying as a QMB only, Medicaid pays their monthly Medicare premiums and deductibles, coinsurance, and copayments on claims for Medicare services furnished by Medicare providers. For the period January 1, 2013 through March 31, 2018, we found that eMedNY inappropriately paid about $2.1 million in claims, on behalf of QMB-only recipients, that were not for deductibles, coinsurance, or copayments. Rather, Medicaid paid as the primary payer on these claims.

Typically, in order for a deductible, coinsurance, or copayment to be included on a claim, a Medicare-approved amount is also needed. The eMedNY system has a processing control in place (i.e., an edit) to analyze claims on behalf of QMB-only recipients to identify claims that do not report a Medicare-approved amount. However, the Department has not activated the edit to deny claims that do not report a Medicare-approved amount. Had this edit been activated, about $1.6 million of the $2.1 million could have been prevented. The Department should review the remaining approximate $500,000 in claims to determine what other controls can be established to prevent further improper payments.

Recommendations

4. Review the $2.1 million in improper payments and make recoveries, as appropriate.

5. Strengthen eMedNY controls over claims on behalf of QMB-only recipients to ensure that only correct claims for deductibles, coinsurance, or copayments are paid, including, but not limited to, re-evaluating the existing eMedNY edit to determine whether it can be activated to deny claims.

Improper Fee-for-Service Payments Covered by Managed Care

We determined Medicaid overpaid $1,733,023 for 13 fee-for-service claims submitted by 11 hospitals. In each case, Medicaid made a fee-for-service payment to a hospital while the recipient was enrolled in an MCO. The inappropriate payments occurred primarily because Medicaid eligibility files were not updated with managed care enrollment information in a timely manner. As a result, eMedNY system edits did not deny the improper fee-for-service payments. At the time our audit fieldwork concluded, providers had adjusted ten claims, saving Medicaid $1,391,014. However, the remaining three claims totaling $342,009 were still in the process of being corrected.

Recommendation

6. Review the $342,009 in overpayments and make recoveries, as appropriate.

Incorrect Newborn Birth Claims Involving Managed Care

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

Medicaid overpaid $1,619,052 for 14 Supplemental Low Birth Weight Newborn Capitation claims and 2 fee-for-service hospital claims that covered the same period as a Supplemental Low Birth Weight Newborn Capitation claim. These overpayments generally occurred because hospitals reported inaccurate birth information (e.g., birth weight) to the MCOs, or the costs of the newborn's birth were previously reimbursed under another claim. For example, in one instance, an MCO submitted a claim for a supplemental low birth weight payment erroneously reporting a birth weight of 285 grams instead of 2,875 grams. After reviewing the corresponding GME claim, we noted the length of stay was not indicative of a premature low birth weight newborn, and the hospital had reported a birth weight of 2,875 grams on the newborn's inpatient GME claim. We contacted the MCO and notified it of the discrepancy, and the MCO corrected its claim. Medicaid originally paid the MCO $108,306 for its claim. However, based on the correct weight (2,875 grams), Medicaid paid the MCO only $3,477, saving Medicaid $104,829. At the time our fieldwork ended, 15 of the 16 claims were corrected for a cost savings of $1,521,699. However, one claim with an estimated cost savings of $97,353 still needed to be recovered.

Recommendation

7. Review the one claim that overpaid $97,353 and make recoveries, as appropriate.

Incorrect Billing of Alternate Level of Care

Certain levels of care are more intensive and, therefore, more expensive than others. 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. 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 $1,432,462 to one hospital that billed for a higher (and more costly) level of care than what was actually provided to a Medicaid recipient. Medicaid

originally paid the hospital $1,445,474 for an inpatient stay of acute care that lasted nearly five years (1,795 days). Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 16 days. The hospital then rebilled the claim in question, resulting in a Medicaid savings of $1,432,462.

Recommendation

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

Improper Payments for the Comprehensive Psychiatric Emergency Program

The Comprehensive Psychiatric Emergency Program (CPEP) was established to allow for better care of people needing psychiatric emergency services. CPEP objectives include providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services.

The New York State Office of Mental Health's policy states that the CPEP Medicaid reimbursement rate may be used for the first 24 hours of emergency room (ER) care, after which the patient should be either admitted or released, unless the patient is kept for an extended observation (a separate rate code is used to reimburse for extended observation). The CPEP rate is intended to pay only once per episode of care, so only one payment should be made regardless of the patient's length of stay in the ER. When a patient is admitted to the hospital following a CPEP ER visit on the same day, the inpatient rate is intended to cover all services, and no separate CPEP payment should be made.

For the period January 1, 2012 through March 31, 2018, we identified 588 CPEP claims for which Medicaid paid $609,915 in excess of the permitted limits:

- $493,180 for 462 claims that contained multiple CPEP days of service per episode of care on a single claim.
- $94,327 for 105 claims where the provider billed multiple days of service per episode of care on different claims.
- $22,408 for 21 CPEP claims on the same date of service as a psychiatric hospital stay.

The overpayments occurred because the eMedNY claims processing logic allows one CPEP payment per calendar day instead of per episode of care. When a CPEP ER stay spans two or more days, a separate payment is calculated for each day of service. Additionally, when a provider bills for a CPEP ER visit and a psychiatric inpatient admission on the same day, the system does not recognize the CPEP payment as a duplicate. The Department is working on a project to prevent these types of overpayments. However, the Department has not established a completion date for this project. Therefore, overpayments will continue to occur until the Department can strengthen claims processing controls.

Recommendations

9. Review the $609,915 in overpayments and make recoveries, as appropriate.

10. Ensure the planned eMedNY system change prevents multiple CPEP payments for an individual episode of care, and prevents CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Improper Payments for Clinic and Inpatient Claims

We identified $360,651 in overpayments on eight clinic claims and one inpatient claim that resulted from errors in billing. At the time our fieldwork concluded, four claims had been adjusted, saving Medicaid $10,212. However, actions are still required to address the remaining five claims with overpayments totaling $350,439.

The overpayments occurred under the following scenarios:

- A hospital was overpaid $341,106 because it billed the same claim under both fee-for-service and managed care. The recipient had two active Medicaid recipient identification numbers at the time of service: one was for the recipient's enrollment in fee-for-service and the other for enrollment in managed care. The hospital was reimbursed $341,106 on a fee-for-service claim for the recipient's hospital stay, and the recipient's MCO reimbursed the hospital $252,243. The hospital should not have been reimbursed twice for the same service, and the Department should recover the $341,106.
- Three clinics incorrectly reported the medical service provided on four claims, which resulted in Medicaid overpayments of $10,412. For example, one clinic incorrectly billed a hearing aid check as a pacemaker removal, resulting in Medicaid overpaying $4,812. At the time our fieldwork ended, two claims had been corrected, saving Medicaid $6,940. However, two claims still needed to be adjusted, which will save Medicaid $3,472.
- Medicaid providers are required to maintain all records for a period of six years and to have them readily accessible for audit purposes. We requested supporting records for two claims from one clinic, which did not respond to our record request. As a result, we consider the services unsupported. Medicaid paid $5,861 for the two claims, and this amount should be recovered.
- We found two claims that duplicated the services already reimbursed under another claim. In both instances, the clinics corrected the issue, saving Medicaid $3,272.

Recommendation

11. Review the $350,439 ($341,106 + $3,472 + $5,861) in overpayments and make recoveries, as appropriate.

Improper Payments to 340B Providers

In 1992, Congress created the 340B Drug Pricing Program (340B Program), which requires drug manufacturers to provide outpatient drugs to eligible health care organizations (i.e., covered entities) at significantly reduced prices. Medicaid providers who qualify for the 340B Program receive discounts from drug manufacturers at the time they purchase program-eligible drugs. The discounts are then passed on to Medicaid – thus reducing Medicaid costs.

Medicaid requires providers to bill the costs of the drugs at their actual acquisition costs. Since the drugs provided by the 340B Program are sold at significantly reduced prices, the expectation is the reported costs would be below the normal cost for the drug.

The Medicaid program reimburses outpatient services using the Ambulatory Patient Groups (APG) payment methodology. In order to arrive at an accurate payment, this methodology requires providers to a report a modifier code on their claims to indicate a drug was purchased through the 340B Program. The eMedNY system uses the modifier in determining the appropriate payment. The methodology also relies on providers to properly report the actual acquisition cost of the drug purchased through the 340B Program.

We identified $357,020 in overpayments on 794 APG claims that resulted from providers not using the required modifier or reporting an inaccurate drug acquisition cost. At the time our fieldwork ended, 730 claims had been corrected, for a savings of $310,559. However, 64 claims with an estimated cost savings of $46,461 still needed to be corrected.

Inaccurate Drug Acquisition Costs Reported

We identified 684 APG claims that overpaid $248,619 because the providers did not supply the correct drug acquisition cost. The providers reported their costs at an amount greater than the actual cost. For example, a 340B provider reported paying about $17,000 for a drug, while the actual cost was $820. The eMedNY system originally paid $3,130 for the claim based on the inaccurate information. Once the provider correctly reported its actual acquisition cost of $820, the revised claim only paid $820, resulting in a savings of $2,310.

Modifiers Not Reported

We identified 110 APG claims that overpaid $108,401 because the providers did not properly report the required modifier on their claims. Had the modifier been properly recorded on the claims, eMedNY would have reduced the payment by 25 percent. At the time our fieldwork concluded, providers had corrected 46 claims, saving Medicaid $61,940. However, 64 claims still needed to be adjusted, for an estimated savings of $46,461.

Recommendation

12. Review the $46,461 in overpayments and make recoveries, as appropriate.

Improper Episodic Payments for Home Care

Certified Home Health Agency (CHHA) providers receive payments under the Episodic Payment System (EPS) to provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care in the home. The payment is based on a price for 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). Payments for a partial episode may be pro-rated based on the number of days of care (full payments may occur in certain circumstances, such as when the patient is transferred to a hospital or hospice or in cases of death). We found Medicaid overpaid $290,676 in episodic home health care payments.

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 Medicaid managed long-term care (MLTC) plan. All MLTC plans provide home care and other community services. Therefore, a premium payment to an MLTC plan and a full episodic payment to a CHHA for the same recipient and overlapping service dates are duplicative. For claims processed by eMedNY for the period October 1, 2017 to March 31, 2018, 18 CHHAs received overpayments totaling $143,922 (69 claims) for recipients discharged from a CHHA to an MLTC plan. In each instance, the CHHAs submitted a claim with an incorrect discharge code (that did not indicate the patient was discharged to an MLTC plan), causing a full episodic payment instead of the appropriate partial pro-rated episodic payment.

Multiple Episodic Payments Within 60 Days

We also identified $146,754 in overpayments processed during the period October 1, 2017 through March 31, 2018, which were made to CHHAs that improperly received a full payment for patients readmitted within 60 days of their original episode start date.

- Many of the overpayments we identified occurred when a recipient had multiple episodes with the same provider. In these scenarios, the CHHA should have submitted an adjustment claim to include all services within 60 days of the first episode start date and a second claim for a partial pro-rated payment. These improper claims (73 claims) resulted in overpayments of $117,361 to 17 CHHAs.
- 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 seven CHHAs $29,393 (15 claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

13. Review the $290,676 ($143,922 + $117,361 + $29,393) in improper payments and make recoveries, as appropriate.

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 43 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 43 providers, 39 had an active status in the Medicaid program, 3 providers had an inactive status (i.e., two or more years of no claims activity and, therefore, they would be required to seek reinstatement from Medicaid to submit new claims), and 1 provider had a voluntary terminated status. We advised Department officials of the 43 providers, and the Department terminated 25 of them (21 with an active status and 4 with an inactive status) from the Medicaid program. In addition, 14 of the providers entered into settlements with the Department. At the time our audit fieldwork ended, the Department determined that 1 provider should not be terminated, and had not resolved the program status of the 3 remaining providers.

Recommendation

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

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 October 1, 2017 through March 31, 2018. In some instances, we observed a pattern of problems and high risk of overpayment and, therefore, examined claims and transactions outside of the audit period. For those instances where our findings include claims and transactions prior to October 1, 2017 or subsequent to March 31, 2018, we noted the period covered as part of our discussion of the findings in the body of this report.

To accomplish our audit objectives and assess relevant internal controls, 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, CSRA (the Department's Medicaid fiscal agent), and the OMIG. 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 the report. In their response, Department officials generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our responses to certain Department comments are included in the report's State Comptroller's Comments.

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.

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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 and State Comptroller's Comments

ANDREW M. CUOMO
Governor

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

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

November 7, 2018

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 2017-S-63 entitled, "Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018."

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 2017-S-63 entitled, Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2017-S-63 entitled, "Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018."

General Comments:

Individuals with comprehensive third-party health insurance (TPHI) are eligible for Medicaid if they otherwise meet income and other eligibility criteria. Under New York's current Medicaid managed care policies, an individual confirmed to have comprehensive TPHI, defined as including thirteen specific services, is not enrolled in a Medicaid Managed Care (MMC) plan and instead receives coverage through Medicaid fee-for-service (FFS).

In this audit, the identified premiums are not offset by Medicaid FFS payments that would have occurred**.** Most Medicaid eligible individuals not enrolled in managed care still have access to covered services through Medicaid FFS. However, the audit's projection does not recognize the fact that if the individual was in Medicaid FFS, Medicaid would not have paid a managed care premium, but it would have paid for covered services not reimbursed by the TPHI and, if cost effective, the premium for the TPHI.

Because monthly premium payments made to managed care plans are based on averages, as are all insurance premiums, the amount paid by FFS could have been greater than the payment to the managed care plan in some instances. The offset should be recognized by OSC to provide the full picture of potential costs to the Medicaid program.

State Comptroller's Comment - If a Medicaid recipient has comprehensive third-party health insurance (TPHI), that insurance covers 13 specific types of health services, including (but not limited to) hospital services, physician services, clinic services, pharmacy, and hospice care. Therefore, the expectation is that the outside comprehensive insurance would cover most services for many, thereby avoiding costly Medicaid fee-for-service (FFS) payments.

Recommendation #1

Work with the LDSS to implement processes that allow for more effective, efficient, and timely identification and disenrollment of recipients with comprehensive TPHI from managed care.

Response #1

The Department has in place resources and guidance for Local Department of Social Services (LDSS) regarding comprehensive TPHI and MMC. Reports are generated monthly to identify

managed care enrollees with TPHI. The TPHI indicator appears on the monthly rosters, and the Enrollment Broker produces monthly reports that identify current MMC enrollees with TPHI. The Department will continue to work with LDSS regarding its roles and responsibilities in disenrolling individuals no longer eligible for managed care coverage due to comprehensive TPHI. The Department sent out a letter to the Managed Care Coordinators on January 10, 2018 reminding them of the policy and procedures for disenrolling consumers who are also in receipt of comprehensive TPHI. Another reminder letter was sent to the LDSS on October 18, 2018.

State Comptroller's Comment - While the monthly reports referred to in the Department's response can be used to identify managed care enrollees who have TPHI, the reports do *not* indicate if the TPHI is comprehensive. As noted on page 9 of our report, we found that neither of the two LDSS we contacted had established a process on how to effectively identify and disenroll recipients having comprehensive TPHI from managed care – despite having access to the monthly reports referenced by the Department. We are pleased the Department started taking new steps to work with the LDSS to disenroll individuals no longer eligible for managed care coverage due to comprehensive TPHI, including initiating a new monthly disenrollment process with its enrollment broker, New York Medicaid Choice.

The Department continues to work with the Office of the Medicaid Inspector General (OMIG) and the Enrollment Broker to identify and disenroll MMC enrollees with comprehensive TPHI. Disenrollments were entered for July 31, 2018, August 31, 2018 and September 30, 2018 resulting in approximately 6,800 consumers successfully disenrolled. A list of those disenrolled will be provided to LDSS. The LDSS will be directed to review these lists and determine if a retroactive disenrollment would be appropriate. The Department is concerned that OSC's identification of nearly 80,000 consumers with comprehensive TPHI over six months from 2017 to 2018 is not aligned with the 6,800 successful 2018 disenrollments due to verified comprehensive TPHI.

State Comptroller's Comment - The statement "The Department is concerned that OSC's identification of nearly 80,000 consumers with comprehensive TPHI over six months from 2017 to 2018 is not aligned with the 6,800 successful 2018 disenrollments due to verified comprehensive TPHI" is misleading. The Department does not explain that its analysis is limited to only one month, whereas our analysis addressed six months. Additionally, the Department's reported total of 6,800 only represented New York City enrollees who were, at the time of the Department's review, still Medicaid-eligible and enrolled in a Medicaid managed care plan. The Department's reported number does not account for all identified members, both throughout the rest of the State and those no longer eligible for Medicaid or Medicaid managed care (in which case, retroactive recoveries would need to be made). When we followed up with Department officials about the 6,800 enrollees they reported on, officials stated the actual total number of all enrollees identified as having comprehensive TPHI was approximately 19,000. Therefore, after all factors are considered, the total number of enrollees we identified appears more in line with the Department's totals. We encourage the Department to review all of the identified enrollees and take appropriate action to make prompt disenrollments and recoveries.

Similar projects like this have been done in the past, once in 2013 and again in 2016. In May 2018, the Department requested the methodology that OSC used to identify consumers with concurrent MMC coverage and comprehensive TPHI as another avenue to develop reports that

would produce similar outcomes. The Department is examining ways to increase the frequency of its disenrollment efforts and will inform LDSS of these efforts.

Recommendation #2

Review the managed care premium payments we identified and make recoveries, as appropriate.

Response #2

OMIG's contractor will review the premium payments identified, and determine an appropriate course of action.

Recommendation #3

Review the $1,119,113 in overpayments and make recoveries, as appropriate.

Response #3

OMIG's contractor will review the identified overpayments, and determine an appropriate course of action.

Recommendation #4

Review the $2.1 million in improper payments and make recoveries, as appropriate.

Response #4

OMIG's contractor will review the identified overpayments for those recipients who gain Medicare coverage, and determine an appropriate course of action.

Recommendation #5

Strengthen eMedNY controls over claims on behalf of QMB-only recipients to ensure that only correct claims for deductibles, coinsurance, or copayments are paid, including, but not limited to, re-evaluating the existing eMedNY edit to determine whether it can be activated to deny claims.

Response #5

The Department activated the eMedNY edit (01027) on October 17, 2018 to strengthen controls over claims for QMB-only recipients.

Recommendation #6

Review the $342,009 in overpayments and make recoveries, as appropriate.

Response #6

OMIG reviewed the identified payments, and determined the three claims were paid appropriately.

State Comptroller's Comment - We disagree with the Department's conclusion that the three claims were paid appropriately. As noted on page 11 of our report, Medicaid made a fee-for-service payment while the recipient was enrolled in an MCO. The MCOs are responsible for reimbursing the services provided to recipients enrolled in their plans. The eMedNY system edits did not deny the inappropriate payments because the recipients' eligibility files were not updated with their managed care enrollment information in a timely manner. The Department should re-evaluate its decision on the appropriateness of these payments.

Recommendation #7

Review the one claim that overpaid $97,353 and make recoveries, as appropriate.

Response #7

OMIG reviewed the identified payment, and recovered $97,353.

Recommendation #8

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

Response #8

The Department is in the process of determining an appropriate course of action to advise the hospital to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment.

Recommendation #9

Review the $609,915 in overpayments and make recoveries, as appropriate.

Response #9

OMIG's contractor will review the identified overpayments, and determine an appropriate course of action.

Recommendation #10

Ensure the planned eMedNY system change prevents multiple CPEP payments for an individual episode of care, and prevents CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Response #10

The Office of Mental Health is working with the Department to ensure that the process for billing Comprehensive Psychiatric Emergency Program (CPEP) is updated to prevent multiple CPEP evaluation payments for an individual episode of care, and that CPEP claims are not paid for the same date of service as a psychiatric inpatient admission. A change will be submitted to update the rate type for rate codes 4007 and 4008 to a "monthly" rate type which will prevent the double

payment issue.

Recommendation #11

Review the $350,439 ($341,106 + $3,472 + $5,861) in overpayments and make recoveries, as appropriate.

Response #11

OMIG will review the identified overpayments, and determine an appropriate course of action.

Recommendation #12

Review the $46,461 in overpayments and make recoveries, as appropriate.

Response #12

OMIG will review the identified overpayments, and determine an appropriate course of action.

Recommendation #13

Review the $290,676 ($143,922 + $117,361 + $29,393) in improper payments and make recoveries, as appropriate.

Response #13

Due to the complexity of the claims and services provided, OMIG will extract their own data and perform analysis, and determine an appropriate course of action.

Recommendation #14

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

Response #14

Of the three providers, OMIG has determined that two have been excluded, and one is under review.