Department of Health

Medicaid Program – Medicaid Claims Processing Activity April 1, 2018 Through September 30, 2018

Report 2018-S-13 | July 2019

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

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, 2018 through September 30, 2018.

About the Program

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, 2018, eMedNY processed over 154 million claims, resulting in payments to providers of more than $35 billion. The claims are processed and paid in weekly cycles, which averaged over 5.9 million claims and $1.4 billion in payments to providers.

Key Findings

The audit identified over $134 million in Medicaid payments that require the Department's prompt attention, as follows:

- $123.9 million in Medicaid managed care premiums was paid on behalf of 86,475 Medicaid recipients who had concurrent comprehensive third-party health insurance (TPHI);
- $6.1 million was paid for an inpatient claim that contained an inaccurate deductible amount;
- $1.1 million was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $1 million was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $977,817 was paid for newborn birth claims that contained inaccurate birth information, such as the newborn's birth weight;
- $515,615 was paid for psychiatric claims that were billed in excess of permitted limits; and
- $504,679 was paid for practitioner, pharmacy, and clinic claims and $326,697 was paid for episodic home health care claims that did not comply with Medicaid policies.

By the end of the audit fieldwork, about $8.2 million of the improper payments had been recovered. Also, according to Department officials, as of January 31, 2019, they successfully disenrolled 9,334 individuals from Medicaid managed care due to comprehensive TPHI.

Auditors also identified 32 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 removed 28 of the providers from the Medicaid program, entered into a settlement with 1 provider, and was determining the program status of the remaining 3 providers.

Key Recommendations

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

Office of the New York State Comptroller
Division of State Government Accountability

July 10, 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 April 1, 2018 Through September 30, 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,

Division of State Government Accountability

Contents

Glossary of Terms

Abbreviation	Description	Identifier
ALC	Alternate Level of Care	*Key Term*
CHHA	Certified Home Health Agency	*Key Term*
CPEP	Comprehensive Psychiatric Emergency Program	*Key Term*
Department	Department of Health	*Auditee*
eMedNY	Department's Medicaid claims processing system	*System*
EPS	Episodic Payment System	*System*
ER	Emergency room	*Key Term*
GME	Graduate Medical Education	*Key Term*
LDSS	Local Departments of Social Services	*Agency*
MCO	Managed care organization	*Key Term*
MLTC	Managed long-term care	*Key Term*
NYSOH	NY State of Health	*System*
TPHI	Third-party health insurance	*Key Term*

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 September 30, 2018, eMedNY processed over 154 million claims, resulting in payments to providers of more than $35 billion. The claims are processed and paid in weekly cycles, which averaged over 5.9 million claims and $1.4 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 MCOs a monthly premium for each Medicaid recipient enrolled in the MCOs' managed care plans. 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 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 September 30, 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 $134.4 million in audit findings pertaining to: managed care premiums paid for recipients with comprehensive third-party health insurance; an inpatient claim with an incorrect deductible amount; hospital claims that were billed at a higher level of care than what was actually provided; claims billed with incorrect information related to other insurance that recipients had; incorrect newborn birth claims; claims for the Comprehensive Psychiatric Emergency Program paid in excess of the permitted limits; improper practitioner, pharmacy, and clinic claims; and improper episodic home health care payments.

At the time that audit fieldwork concluded, about $8.2 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $126.2 million and recover funds as warranted.

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 removed 28 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

As of September 2018, about 4.6 million recipients were enrolled in a Medicaid managed care plan – about 2.9 million were enrolled through NY 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. In accordance with New York State Social Services Law, Section 364-j(3)(e)(xx), the Department's policy is to exclude Medicaid recipients from participating in managed care when they have comprehensive third-party health insurance (TPHI). Per the Department's policies, 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.

The Department pays MCOs a monthly premium for each recipient enrolled in a managed care plan. For the audit period, we determined the Department paid $123.9 million in Medicaid managed care premium payments on behalf of 86,475 recipients who had 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 initiated promptly. Since June 2016, the Department has improved payment controls that use TPHI information to prevent such improper premium payments; however, these efforts only target NYSOH-enrolled recipients. In response to the Office of the State Comptroller's audit work on this topic, in October 2018, the Department sent a letter to the LDSS stating the Department would begin working with a contractor to help disenroll recipients with comprehensive TPHI from managed care. According to the Department, as of January 31, 2019, 9,334 individuals with comprehensive TPHI had been successfully disenrolled from Medicaid managed care.

Recommendation

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

Inaccurate Payment for an Inpatient Claim

Billing errors in the amounts claimed for coinsurance, copayments, and deductibles will likely result in improper Medicaid payments. We identified one hospital claim that did not properly report the deductible amount, causing an obvious overpayment.

Medicaid originally paid the hospital $6,081,993 for an inpatient claim with submitted charges of $53,539. The provider erroneously entered a date (6-8-2018) into the patient deductible amount field, causing the amount of $6,082,018 to be processed. The correct deductible amount for this claim should have been $1,650. Upon our inquiry, the provider adjusted the claim, resulting in a Medicaid cost savings of $6,080,368 ($6,082,018 - $1,650).

We concluded that the Department could have prevented such an

overpayment with more effective eMedNY controls. For example, the claim hit eMedNY edit 02144 “Medicare/MCO Payer Amounts Not Reasonable.” However, the edit disposition was set to pay (as opposed to pend or deny). If this edit disposition was set to pend or deny payment, eMedNY would have prevented the overpayment (totaling $6,080,368) when a date was entered into the field designated for the deductible. We have identified similar errors in prior audits. Thus, the Department needs to take prompt actions to ensure that eMedNY prevents these types of overpayments in the future.

Recommendation

2. Implement a maximum threshold for the deductible amount in eMedNY edit 02144 for institutional claims, and set the corresponding edit disposition to pend or deny.

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 eight overpayments totaling $1,137,292 to six providers that billed for a higher (and more costly) level of care than what was actually provided to a Medicaid recipient. For example, Medicaid originally paid a hospital $125,816 for an inpatient stay of acute care that lasted 121 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 36 days. The hospital then rebilled the claim, which resulted in a savings of $82,449. As a result of our review, four of the eight claims were adjusted, saving Medicaid $388,033. However, four claims still have to be adjusted for an estimated cost savings of $749,259.

Recommendations

3. Review the $749,259 in overpayments and make recoveries, as appropriate.

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

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 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 37 claims that resulted in overpayments totaling about $1 million. Providers adjusted 16 claims, resulting in Medicaid savings of about $716,525.

Designation of Primary Payer

We identified overpayments totaling $767,985 on 28 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 11 claims, saving Medicaid $485,366. However, the remaining 17 claims that were overpaid by an estimated $282,619 still needed to be adjusted.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $249,407 on nine claims that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and they adjusted five of the claims, saving Medicaid $231,159. However, the remaining four claims that were overpaid by an estimated $18,248 still needed to be adjusted.

Recommendation

5. Review the $300,867 ($282,619 + $18,248) 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 also 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 $977,817 for six Supplemental Low Birth Weight Newborn Capitation claims and three fee-for-service hospital claims that covered the same period as the 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 Newborn Capitation payment erroneously reporting a birth weight of 1,056 grams instead of 4,050 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 4,050 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 $108,370 for its claim. However, based on the correct weight (4,050 grams), Medicaid paid the MCO only $4,189, saving Medicaid $104,181. At the time our fieldwork ended, all nine of the claims were corrected for a cost savings of $977,817.

Recommendation

6. Formally advise the hospitals to accurately report newborn claim information 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. We found Medicaid improperly paid $515,615 for CPEP claims.

We identified 450 CPEP claims for which Medicaid paid $483,850 in excess of the permitted limits:

- $423,026 for 391 claims that contained multiple CPEP days of service per episode of care on a single claim.
- $32,688 for 33 CPEP claims on the same date of service as a psychiatric hospital stay.
- $28,136 for 26 claims where the provider billed multiple CPEP days of service per episode of care on different claims.

Additionally, we found two claims from one provider who billed multiple days of CPEP when they should have only billed CPEP for one day. Upon our inquiry, the provider adjusted both claims, resulting in Medicaid savings of $31,765.

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. As of December 2018, the Department estimated this project would be implemented in early 2019. Therefore, overpayments will continue to occur until the Department can strengthen claims processing controls.

Recommendations

7. Review the $483,850 in overpayments and make recoveries, as appropriate.

8. Ensure the planned eMedNY system project 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 Practitioner, Pharmacy, and Clinic Claims

We identified $504,679 in overpayments on 38 practitioner claims, 12 clinic claims, and 3 pharmacy claims that resulted from errors in billing. At the time our fieldwork concluded, 11 claims had been adjusted, saving Medicaid $25,358. However, actions are still required to address the remaining 42 claims with overpayments totaling $479,321.

The overpayments occurred under the following scenarios:

- 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 records for 40 claims from 14 different providers, who did not respond to our record requests. As a result, we consider the services unsupported. One provider is responsible for 16 of these 40 claims. Medicaid paid $431,814 for the 40 claims.

- Prescribers must be enrolled in Medicaid to order prescription drugs for recipients. Medicaid paid one pharmacy $24,355 for a pharmacy claim where the prescribing provider (a physician's assistant) was not enrolled in Medicaid. The claim was denied multiple times until the pharmacy overrode the error code to get the claim paid. If a prescriber is not enrolled in Medicaid, they are not allowed to prescribe Medicaid services for patients; therefore, the pharmacy is not entitled to the Medicaid payment.

- Medicaid pharmacies are required to obtain a signature from the Medicaid recipient, their caregiver, or designee to confirm receipt of prescription drugs. This documentation must be maintained by the pharmacy for six years and must be retrievable for audit purposes. Claim submission is not proof that the prescription was actually furnished. We requested a signature log for one claim from a pharmacy that was unable to provide the requested documentation. As a result, we consider

the prescription unsupported. Medicaid paid $23,152 for the claim and the amount should be recovered.

- We determined four providers incorrectly reported the medical services provided on five clinic claims. Upon our inquiry, the providers corrected all five of the claims, resulting in Medicaid savings of $15,876.
- We found six clinic claims that duplicated charges already reimbursed under another claim. In all six instances, the providers corrected their claims, resulting in Medicaid savings of $9,482.

Recommendation

9. Review the $479,321 ($431,814 + $24,355 + $23,152) 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 $326,697 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 Medicaid home care and other community services. Therefore, a premium payment to a 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 during the audit period, 20 CHHAs received overpayments totaling $197,234 (79 claims) for recipients discharged from a CHHA to a MLTC plan. In each instance, the CHHAs submitted a claim with an incorrect discharge code (that did not indicate the patient was discharged to a 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 $129,463 in overpayments 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 Medicaid 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 (78 claims) resulted in Medicaid overpayments of $111,008 to 18 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 $18,455 (10 claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

10. Review the $326,697 ($197,234 + $111,008 + $18,455) in overpayments 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 40 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 40 providers, 39 had an active status in the Medicaid program and 1 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). We advised Department officials of the 40 providers, and the Department removed 28 of them from the Medicaid program. In addition, 1 provider entered into a settlement with the Department. At the time our audit fieldwork ended, the Department determined that 8 providers should not be terminated and had not resolved the program status of the 3 remaining active providers.

Recommendation

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

Audit Scope, Objective, and Methodology

The objective of our audit was 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. Our audit covered the period April 1, 2018 through September 30, 2018.

To accomplish our audit objective 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 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.

Statutory Requirements

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.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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.

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 concurred with the audit recommendations and indicated the actions they will take to address them.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

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 9, 2019

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 2018-S-13 entitled, "Medicaid Program – Medicaid Claims Processing Activity April 1, 2018 Through September 30, 2018."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
Erin Ives
Brian Kiernan
Timothy Brown
Amber Rohan
Elizabeth Misa
Geza Hrazdina
Daniel Duffy
Jeffrey Hammond
Jill Montag
Ryan Cox
James Dematteo
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Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2018-S-13 entitled, "Medicaid Program – Medicaid Claims Processing Activity April 1, 2018 Through September 30, 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 2018-S-13 entitled, "Medicaid Program - Medicaid Claims Processing Activity April 1, 2018 Through September 30, 2018."

Recommendation #1:

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

Response #1:

The Office of the Medicaid Inspector General's (OMIG) contractor will review the premium payments identified and determine an appropriate course of action.

Recommendation #2:

Implement a maximum threshold for the deductible amount in eMedNY edit 02144 for institutional claims, and set the corresponding edit disposition to pend or deny.

Response #2:

The Department is currently reviewing the existing eMedNY functions and edit 02144 for institutional claims and will continue to work on system enhancements to prevent overpayments on Medicare Part B deductible claims. The Department has already taken proactive steps to fully recover the identified overpayment.

Recommendation #3:

Review the $749,259 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:

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

Response #4:

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

Recommendation #5:

Review the $300,867 ($282,619 + $18,248) in overpayments and make recoveries, as appropriate

Response #5:

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

Recommendation #6:

Formally advise the hospitals to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Response #6:

The Department will reach out to our Fiscal Agent (CSRA) and request communication outreach to inform hospital providers of the need to accurately report newborn claim information when billing Medicaid.

Recommendation #7:

Review the $483,850 in overpayments and make recoveries, as appropriate.

Response #7:

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

Recommendation #8:

Ensure the planned eMedNY system project 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 #8:

The Office of Mental Health is working with the Department to update the process for billing Comprehensive Psychiatric Emergency Program (CPEP) to prevent multiple CPEP evaluation payments for an individual episode of care, and to ensure that CPEP claims are not paid for the same date of service as a psychiatric inpatient admission. A change request 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 #9:

Review the $479,321 ($431,814 + $24,355 + $23,152) in overpayments and make recoveries, as appropriate.

Response #9:

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

Recommendation #10:

Review the $326,697 ($197,234 +$111,008 +$18,455) in overpayments and make recoveries, as appropriate.

Response #10:

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

Recommendation #11:

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

Response #11:

OMIG has determined the three remaining providers are under review.

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