Department of Health

Medicaid Program: Claims Processing Activity October 1, 2018 Through March 31, 2019

Report 2018-S-55 | September 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 October 1, 2018 through March 31, 2019.

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 March 31, 2019, eMedNY processed over 142 million claims, resulting in payments to providers of more than $36 billion. The claims are processed and paid in weekly cycles, which averaged about 5.5 million claims and $1.4 billion in payments to providers.

Key Findings

The audit identified over $5.7 million in Medicaid payments that require the Department's prompt attention, as follows:

- $1.9 million was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $1.4 million was paid for newborn birth claims that contained inaccurate birth information, such as the newborn's birth weight;
- $1 million was paid for practitioner, pharmacy, inpatient, lab, and clinic claims that did not comply with Medicaid policies;
- $852,295 was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $278,850 was paid for psychiatric claims that were billed in excess of permitted limits;
- $215,673 was paid for episodic home health care claims that did not comply with Medicaid policies; and
- $32,326 in costs were avoided due to an averted overpayment of a provider refund.

By the end of the audit fieldwork, about $3.9 million of the improper payments had been recovered.

Auditors also identified 29 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 22 of the providers from the Medicaid program,

entered into settlements with 6 providers, and was determining the program status of 1 remaining provider.

Key Recommendations

- We made 10 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

September 27, 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 *Claims Processing Activity October 1, 2018 Through March 31, 2019*. 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	*Program*
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*
MCO	Managed care organization	*Key Term*
MLTC	Managed long-term care	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*

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, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5 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, 2019, eMedNY processed over 142 million claims, resulting in payments to providers of more than $36 billion. The claims are processed and paid in weekly cycles, which averaged about 5.5 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. 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 March 31, 2019, 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 $5.7 million in audit findings pertaining to: hospital claims that were billed at a higher level of care than what was actually provided; newborn birth claims that contained inaccurate birth information; claims billed with incorrect information related to other insurance that recipients had; claims for the Comprehensive Psychiatric Emergency Program that were paid in excess of the permitted limits; improper practitioner, pharmacy, inpatient, lab, clinic, and episodic home health care payments; and an averted overpayment of a provider refund.

At the time the audit fieldwork concluded, about $3.9 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $1.8 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 22 of the providers we identified from the Medicaid program and entered into settlements with 6 providers.

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 $1,933,945 to eight providers that billed for a higher (and more costly) level of care than what was actually provided to the Medicaid recipients. For example, Medicaid originally paid a hospital $600,593 for an inpatient stay of acute care that lasted 794 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 108 days. The hospital then rebilled the claim, which

resulted in a savings of $518,941. As a result of our review, all eight claims were adjusted, saving Medicaid $1,933,945.

Recommendation

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

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 $1,359,070 for 13 Supplemental Low Birth Weight Newborn Capitation claims. These overpayments occurred because inaccurate birth information (e.g., birth weight) was reported on the claims. For example, an MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 680 grams. We reviewed the corresponding GME claim and noted the hospital had reported a birth weight of 1,310 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 $110,677 for its claim. However, based on the correct weight (1,310 grams), Medicaid paid the MCO only $4,879, saving Medicaid $105,798. At the time our fieldwork ended, 12 of the 13 claims were corrected for a cost savings of $1,250,674. However, one claim with an estimated cost savings of $108,396 still needed to be recovered.

The amount paid for GME claims can also be affected by the birth weights. In addition to the incorrect birth weights we found on the Supplemental Low Birth Weight Newborn Capitation Payments, three corresponding GME claims were submitted with the same incorrect birth weights. As a result of our review, all three claims were corrected for a cost savings of $33,381.

Recommendations

2. Review the $108,396 in overpayments and make recoveries, as appropriate.

3. Formally advise the hospitals to accurately report newborn claim information 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, 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 62 claims that resulted in overpayments totaling about $852,295. Providers adjusted 22 claims, resulting in Medicaid savings of about $344,203.

Designation of Primary Payer

We identified overpayments totaling $821,268 on 56 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 18 claims, saving Medicaid $321,291. However, the remaining 38 claims that were overpaid by an estimated $499,977 still needed to be adjusted.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $31,027 on six claims that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and they adjusted four of the claims, saving Medicaid $22,912. However, the remaining

two claims that were overpaid by an estimated $8,115 still needed to be adjusted.

Recommendation

4. Review the $508,092 ($499,977 + $8,115) in overpayments and make recoveries, as appropriate.

Improper Payments for Practitioner, Pharmacy, Inpatient, Lab, and Clinic Claims

We identified $1,020,082 in overpayments on 35 practitioner claims, 25 clinic claims, 5 inpatient claims, 3 pharmacy claims, and 2 lab claims that resulted from errors in billing. At the time our fieldwork concluded, 16 claims had been adjusted, saving Medicaid $257,766. However, actions are still required to address the remaining 54 claims with overpayments totaling $762,316.

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 31 claims from 22 different providers, who did not respond to our record request. As a result, we consider the services unsupported. Medicaid paid $666,992 for these 31 unsupported claims, and this amount should be followed up on for recovery.
- Medicaid overpaid $213,578 for three claims that were submitted as fee-for-service when the recipient was enrolled in an MCO. Two claims have been adjusted, saving Medicaid $207,680. However, the remaining claim that was overpaid by $5,898 still needs to be adjusted.
- Prescribers must be enrolled in NYS Medicaid to order prescription drugs for recipients. Medicaid paid one pharmacy $48,710 for two pharmacy claims where the prescribing provider was not enrolled in Medicaid. Under fee-for-service, prescribers not enrolled in Medicaid are not allowed to prescribe Medicaid services for patients; therefore, the pharmacy is not entitled to the Medicaid payment.
- We identified $29,174 in overpayments on eight claims in which the providers entered incorrect information on the claims. These errors included incorrect coding, units entered in excess of permitted limits, and transpositions of numbers and fields. Six claims have been adjusted, saving Medicaid $28,938. However, the remaining two claims that were overpaid by $236 still need to be adjusted.

- We identified $28,652 in overpayments on seven claims that duplicated charges already reimbursed under other claims. Five claims have been adjusted, saving Medicaid $20,374. However, the remaining two claims that were overpaid by $8,278 still need to be adjusted.
- Claims must be submitted within 90 days of the date of medical care, unless the submission is delayed due to circumstances beyond the provider's control. All claims submitted after 90 days must be accompanied by a statement of the reason for the delay and must be submitted within 30 days from the time claim submission came within control of the provider. We identified $24,636 on one claim in which the provider submitted a pharmacy claim more than 30 days after the claim came within control of the provider without providing a reason for the delay.
- Practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $8,340 in overpayments on 18 claims in which the providers billed more than the acquisition costs for practitioner-administered drugs. Three claims have been adjusted, saving Medicaid $774. However, the remaining 15 claims that were overpaid by $7,566 still need to be adjusted.

Recommendation

5. Review the $762,316 ($666,992 + $5,898 + $48,710 + $236 + $8,278 + $24,636 + $7,566) in overpayments and make recoveries, as appropriate.

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 care. 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 identified 256 CPEP claims for which Medicaid paid $278,850 in excess of the permitted limits:

- $225,220 for 206 claims that contained multiple CPEP days of service per episode of care on a single claim.
- $37,341 for 35 CPEP claims on the same date of service as a psychiatric hospital stay.
- $16,289 for 15 claims where the provider billed multiple CPEP days of service per episode of care on different claims.

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. On March 21, 2019, the Department implemented a project to prevent these types of overpayments from occurring in the future. The Department does not plan to retroactively adjust improper CPEP payments; rather, the project will be prospective.

Recommendations

6. Review the $278,850 in overpayments and make recoveries, as appropriate.
7. Ensure the implemented eMedNY system controls prevent multiple CPEP payments for an individual episode of care and prevent CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

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 $215,673 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, 15 CHHAs received overpayments totaling $73,068 (39 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 $142,605 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 (54 claims) resulted in Medicaid overpayments of $96,612 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 12 CHHAs $45,993 (21 claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

8. Review the $215,673 ($73,068 + $96,612 + $45,993) in overpayments and make recoveries, as appropriate.

Prevented Overpayment of Refund

The Department may conduct a prepayment review to ensure accurate and appropriate payments are made to providers. When such reviews find that provider claims for services are inconsistent with Medicaid program regulations or standards of care, the Department may withhold part or all of the payments for submitted claims, pending completion of an investigation.

Due to a pending Office of the Medicaid Inspector General (OMIG) investigation, the Department withheld $32,326 on August 27, 2018 and $30,335 on September 3, 2018 from a provider. There was a court order to pay the funds withheld by the Department after August 27, 2018; however, OMIG requested the Department to pay the total amount withheld rather than the $30,335 the provider was entitled to. As a result of our inquiry, OMIG and the Department promptly adjusted the amount to be paid to the provider before the payment was released. This resulted in a savings of $32,326.

Recommendation

9. Ensure OMIG refunds are accurate and appropriate before processing the payments.

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 30 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 30 providers, 24 had an active status in the Medicaid program and 6 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). We advised Department officials of the 30 providers, and the Department removed 22 of them from the Medicaid program. In addition, six providers entered into a settlement with the Department. At the time our audit fieldwork ended, the Department determined that one provider should not be terminated and had not resolved the program status of one remaining active provider.

Recommendation

10. Determine the status of the remaining provider 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 October 1, 2018 through March 31, 2019.

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 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. We judgmentally sampled 3,111 claims, totaling $167,713,518, and reviewed them for accuracy and appropriateness. We used a risk-based approach to judgmentally sample different claim types and Medicaid claims with other insurance. We selected 100 percent of the CPEP and EPS claims that did not follow payment rules. (A summary of the sampled claims is presented in the Exhibit at the end of the report.) The results of our samples cannot be projected to the population.

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.

Exhibit

Summary of Sampled Claims

Sample Category	Claims Sampled	Claims With Findings
Various claim types	2,678	134
Medicaid claims with other insurance	63	22
CPEP	256	256
EPS	114	114
Totals	**3,111**	**526**

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

July 29, 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-55 entitled, "Medicaid program: Claims Processing Activity October 1, 2018 Through March 31, 2019."

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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Elizabeth Misa
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Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2018-S-55 entitled, "Medicaid Program: Claims Processing Activity October 1, 2018 Through March 31, 2019"

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-55 entitled "Medicaid Program: Claims Processing Activity October 1, 2018 Through March 31, 2019."

Recommendation #1

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

Response #1

The Department will publish a Medicaid Update advising hospitals to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment.

Recommendation #2

Review the $108,396 in overpayments and make recoveries, as appropriate.

Response #2

The Office of Medicaid Inspector General (OMIG) will review the identified overpayment and determine an appropriate course of action.

Recommendation #3

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

Response #3

The Department will publish a Medicaid Update advising hospitals to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Recommendation #4

Review the $508,092 ($499,977 + $8,115) in overpayments and make recoveries, as appropriate.

Response #4

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

Recommendation #5

Review the $762,316 ($666,992 + $5,898 + $48,710 + $236 + $8,278 + $24,636 + $7,566) in overpayments and make recoveries, as appropriate.

Response #5

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

Recommendation #6

Review the $278,850 in overpayments and make recoveries, as appropriate.

Response #6

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

Recommendation #7

Ensure the implemented eMedNY system controls prevent multiple CPEP payments for an individual episode of care and prevent CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Response #7

The Office of Mental Health has worked 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 was submitted to update the rate type for rate codes 4007 and 4008 to a “monthly” rate type on May 6, 2019 which will prevent the double payment issue. The effective date of the change is January 1, 2019.

Recommendation #8

Review the $215,673 ($73,068 + $96,612 + $45,993) in overpayments and make recoveries, as appropriate.

Response #8

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

Recommendation #9

Ensure OMIG refunds are accurate and appropriate before processing the payments.

Response #9

In coordination with the Department, OMIG has revised its process to include an additional layer of review to ensure that the accuracy and appropriateness of refunds are confirmed more than once before processing.

Recommendation #10

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

Response #10

The remaining provider is still under review by OMIG.

Contributors to Report

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