NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

March 2, 2021

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

Dear Ms. Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2019-S-12 entitled, "Medicaid Program-Claims Processing Activity April 1, 2019 Through September 30, 2019."

Please feel free to contact Michelle Newman, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Lisa J. Pino, M.A., J.D.
Executive Deputy Commissioner

Enclosure

cc: Ms. Newman

Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2019-S-12 entitled, "Medicaid Program: Claims Processing Activity April 1, 2019 Through September 30, 2019"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2019-S-12 entitled, "Medicaid Program: Claims Processing Activity April 1, 2019 Through September 30, 2019."

Recommendation #1:

Review the $2,013,611 ($1,705,150 + $15,081 + $167,494 + $99,406 + $20,798 + $5,682) in overpayments and make recoveries, as appropriate.

Response #1:

The Department disagrees with the OSC pharmacy claims findings for the following reasons:

- *All Medicaid pharmacy providers shall substitute a generic drug whenever available unless the prescriber writes "DAW" (Dispense As Written) on the prescription. We identified $397,411 on 15 claims in which the pharmacy submitted a claim for the brand name drug when the prescriber had not written DAW anywhere on the prescription. Had the pharmacy providers submitted the 15 claims using the available generic drug, Medicaid would have saved $262,703.*

  Dispense as Written is not required for these drugs. The claims for Epclusa and Remodulin were reimbursed correctly as these drugs were in our Brand Less than Generic Program (BLTG) on the date of service of the claim.

- *Prescribers must be enrolled in Medicaid to order prescription drugs for beneficiaries. 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 paid $167,494 for three claims from three pharmacies in which the prescribers were not enrolled in Medicaid.*

  The claims submitted by providers Natures Cure Pharmacy and Walgreen Eastern Pharmacy meet the program rules for prescribers not enrolled in Medicaid, as more fully described in the Department's response to OSC's comments. These two claims originated from New York Presbyterian Hospital under a Resident who is covered under Medicaid.

Additionally, the Office of the Medicaid Inspector General (OMIG) has previously performed audits of clinic, practitioner, pharmacy, inpatient, durable medical equipment, and dental claims. OMIG extracts its own data, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and accurate. OMIG is in the process of pursuing recovery of payments it determines to be inappropriate as a result of that analysis. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2:

Review the $769,168 in overpayments and make recoveries, as appropriate.

Response #2:

OMIG has previously performed audits of supplemental maternity capitation payments. OMIG extracts its own data, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and accurate. OMIG is in the process of pursuing recovery of payments it determines to be inappropriate as a result of that analysis. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #3:

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

Response #3:

The Department published a Medicaid Update reminder in June 2020 entitled *Billing Guidance for Reporting Newborn Birth Weights*, which addresses the OSC recommendation. The article can be found in Volume 36 Number 11:
https://www.health.ny.gov/health_care/medicaid/program/update/2020/no11_2020-06.htm#newborn

Recommendation #4:

Ensure the errors in the MCO's systems relating to improper Supplemental Maternity Capitation Payments are corrected so that claims are grouped to the correct DRG.

Response #4:

The Department has reviewed claims/encounter detail from OSC that identifies errors and is conducting outreach with those MCOs regarding requirements to ensure claims processing systems are accurately adjudicating claims. The Department requires these MCOs to submit a corrective action plan describing how they are correcting their systems to ensure that claims are grouped to the correct diagnosis-related group going forward.

Recommendation #5:

Review the $918,877 ($417,319 + $493,766 + $7,792) in overpayments and make recoveries, as appropriate.

Response #5:

OMIG has previously performed audits of other insurance claims. OMIG extracts its own data, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and accurate. OMIG is in the process of pursuing recovery of payments it determines to be inappropriate as a result of that analysis. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #6:

Remind providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid. Ensure attention is paid to dental providers.

Response #6:

The Department published two Medicaid Update reminders in July 2020 and September 2020, which address this recommendation and are specific to dental providers and third-party insurers. The articles can be found at:
https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no12_jul20.pdf
https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no14_sep20.pdf

Recommendation #7:

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

Response #7:

The Department published a Medicaid Update in June 2020 entitled *Billing Guidance for Reporting Alternate Level of Care*, which address this recommendation. The article can be found in Volume 36 - Number 11:
https://www.health.ny.gov/health_care/medicaid/program/update/2020/no11_2020-06.htm#alc

Recommendation #8:

Maintain records in accordance with State and federal requirements and provide to OSC upon request so OSC can ensure all payments made are reasonable and appropriate, including the $5,918 in unsupported refunds.

Response #8:

The Department maintains records in accordance with State and federal requirements and provides the records to OSC upon request. OMIG has, and adheres to, established processes for record maintenance, consistent with State and federal requirements. OMIG compiled the appropriate records to support the remaining refunds and provided them to OSC.

Recommendation #9:

Review the $225,862 ($114,931 + $69,652 + $41,279) in overpayments and make recoveries, as appropriate.

Response #9:

OMIG has previously performed audits of certified home health agency episodic payment claims. OMIG has audit protocols that address the findings in this OSC final audit report. OMIG extracts its own data, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and accurate. OMIG is in

the process of pursuing recovery of payments it determines to be inappropriate as a result of that analysis. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #10:

Review the $57,597 in overpayments and make recoveries, as appropriate.

Response #10:

OMIG is currently in the process of updating the Comprehensive Psychiatric Emergency Program (CPEP) audit protocols, which will address the findings in this OSC final audit report. OMIG extracts its own data, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and accurate. Once the analysis is completed, OMIG will pursue recovery of payments it determines to be inappropriate. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #11:

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 #11:

The Office of Mental Health (OMH) worked with the Department to update the process for billing 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 prevents the double payment issue. The effective date of the change was January 1, 2019.

Recommendation #12:

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

Response #12:

The remaining provider is still under review by OMIG.

OSC Comment #1 (Refers to Response #1):

The Department's response is incorrect. Our audit accounted for the Brand Less than Generic Program and, in doing so, 10 of the 15 claims were already removed from our findings. Four of the remaining five claims were for drugs that were not included in the Brand Less than Generic Program. The final claim was for Remodulin and was filled on April 3, 2019; however, Remodulin was not added to the Brand Less than Generic Program until April 19, 2019.

Response to Comment #1:

The Remodulin claim was paid correctly because the generic formulation was not open on the formulary until April 19, 2019. Only the brand formulation was available to bill at the time of the claim. The remaining four claims were not removed from the BLTG program in sync with the BLTG notice of removal and are therefore not recoverable. The OSC audit findings should be adjusted to reflect the ten claims OSC removed because of BLTG status, as the Department identified, and to reflect the one additional claim for Remodulin noted above.

OSC Comment #2 (Refers to Response #1):

The two claims referenced by the Department did not meet the program rules for prescribers not enrolled in Medicaid. The eMedNY Pharmacy Manual states that when a prescription is written by an unlicensed intern or resident, the supervising physician's National Provider Identifier should be entered on the claim. The prescriptions for the two claims were written by unlicensed interns and did not include the supervising physician's National Provider Identifier.

Response to Comment #2:

Of the three non-enrolled providers cited by OSC, two were residents, which meet the program rules for coverage as originally noted by the Department. The other provider was from out of state (PA) and the pharmacy used an override which allowed this claim to be reimbursed. It is unclear if this was due to an emergency.

As noted in the Pharmacy Manual Policy Guidelines, unlicensed interns and residents may prescribe drugs (under the supervision of a licensed physician or dentist) as part of their official duties as members of hospital staff, per NYS Education Law. New York Medicaid, however, does not allow for the enrollment of *unlicensed* practitioners (which includes unlicensed residents, interns and foreign physicians in training programs). The Manual outlines the requirements for claim submission to allow payment for prescriptions written by unlicensed residents, interns and foreign physicians in training programs, under the supervision of a licensed practitioner.

The eMedNY Pharmacy Billing Guidelines were incorrectly referenced by OSC. This Manual is directed towards paper claims and does not include all the required fields for electronic claim submission. The Department does not typically direct pharmacies to this Manual for our policy guidance. That said, it was updated in September 2020 to indicate that the supervising physician's National Provider Identifier is not required with the claim submission for claim submissions for prescriptions written by Ordering/Referring/Attending Prescribing Providers.

As noted in the June 23, 2017 update of the Medicaid Provider Enrollment Compendium (MPEC) on page 38 at Section 1.5.1 B. 2., to the extent a provider type is not eligible to enroll in a State's Medicaid Program, the State Medicaid Agency is not required to begin to enroll that provider type for purposes of complying with 42 CFR § 455.410(b) or § 455.440.

OSC Comment #3 (Refers to Response #8):

The Office of the Medicaid Inspector General provided additional refund documentation after we issued our draft report. Our office had been requesting part of this documentation since June

2019. We reviewed the documentation and found adequate support for $242,324 of the $248,242. We were not provided with adequate support for the remaining $5,918 in refunds, and we modified Recommendation 8 accordingly.

Response to Comment #3:

See response to Recommendation #8.

OSC Comment #4 (Refers to Response #11):

We found 42 of the 52 claims in our findings were for services after the effective date of the process change cited by the Department. As such, the Department still needs to take action to implement this recommendation.

Response to Comment #4:

OMH's review of the 52 claims identified in the audit report found:

- 1 instance where the claim in question occurred prior to the effective date of the change detailed above (1/1/2019);
- 26 instances of duplicate payment for the same claim where the change in rate code type resulted in a net correction of payment;
- 4 instances with multiple claims occurring on consecutive days, which will require further review;
- 20 instances of claims with overlapping rate code 4008 and rate code 2852 dates of service. The category of service for rate code 4008 was changed to "outpatient" in mid-2019, and eMedNY edit 02286 prevents duplicate payment of rate codes 4008 and 4049/2852 for the same date of services which should correct this issue going forward; and
- 1 instance with overlapping rate codes 4008 and 2852 dates of service, which could not be found in the Medicaid Data Warehouse.

OMH continues to research the four instances identified above as requiring further review.