Department of Health

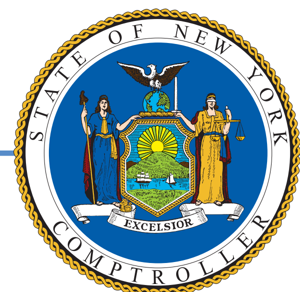
Medicaid Program: Claims Processing Activity April 1, 2019 Through September 30, 2019

Report 2019-S-12 | September 2020

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 (Department) 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, 2019 through September 30, 2019, and select claims going back to October 1, 2015.

About the Program

The 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, 2019, eMedNY processed over 244 million claims, resulting in payments to providers of more than $35 billion. The claims are processed and paid in weekly cycles, which averaged about 9.4 million claims and $1.4 billion in payments to providers.

Key Findings

The audit identified over $8.2 million in Medicaid payments that require the Department's prompt attention, as follows:

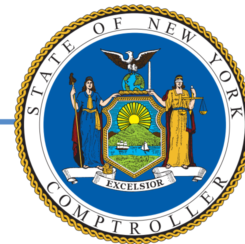
- $3.2 million was paid for clinic, practitioner, managed care capitation, pharmacy, inpatient, durable medical equipment, and dental claims that did not comply with Medicaid policies;
- $2.9 million was paid for maternity and newborn birth claims that contained inaccurate information, such as the diagnosis code or newborn's birth weight;
- $1.1 million was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $767,471 was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $225,862 was paid for episodic home health care claims that did not comply with Medicaid policies; and
- $57,597 was paid for psychiatric claims that were billed in excess of permitted limits.

By the end of the audit fieldwork, about $4.2 million of the improper payments had been recovered.

Auditors also identified 21 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 18 of the providers from the Medicaid program, entered into settlements with 2 providers, and was determining the program status of the remaining provider.

Key Recommendations

- We made 12 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 2, 2020

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 their resources efficiently and effectively. By so doing, it provides accountability for the 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 April 1, 2019 Through September 30, 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 ... 4
Background ... 5
Audit Findings and Recommendations ... 7
Improper Payments for Clinic, Practitioner, Managed Care Capitation, Pharmacy, Inpatient, Durable Medical Equipment, and Dental Claims ... 7
Recommendation ... 8
Incorrect Maternity and Newborn Birth Claims Involving Managed Care ... 8
Recommendations ... 10
Other Insurance on Medicaid Claims ... 10
Recommendations ... 11
Incorrect Billing of Alternate Level of Care ... 11
Recommendation ... 11
Unsupported Refunds ... 11
Recommendation ... 12
Improper Episodic Payments for Home Care ... 12
Recommendation ... 13
Improper Payments for the Comprehensive Psychiatric Emergency Program ... 13
Recommendations ... 14
Status of Providers Who Violate Program Requirements ... 14
Recommendation ... 14
Audit Scope, Objective, and Methodology ... 15
Statutory Requirements ... 16
Authority ... 16
Reporting Requirements ... 16
Exhibit ... 17
Agency Comments ... 18
State Comptroller's Comments ... 23
Contributors to Report ... 24

Glossary of Terms

Term	Description	Identifier
ALC	Alternate Level of Care	*Key Term*
CHHA	Certified Home Health Agency	*Key Term*
CPEP	Comprehensive Psychiatric Emergency Program	*Program*
DAW	Dispense as Written	*Key Term*
Department	Department of Health	*Auditee*
DRG	Diagnosis-related group	*Key Term*
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*
OSC	Office of the State Comptroller	*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 (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 generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2019, eMedNY processed over 244 million claims, resulting in payments to providers of more than $35 billion. The claims are processed and paid in weekly cycles, which averaged about 9.4 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 (OSC) 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, 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 over $8.2 million in audit findings pertaining to: improper clinic, pharmacy, practitioner, managed care capitation, inpatient, durable medical equipment, and dental claims; newborn birth and maternity claims that contained inaccurate birth information or diagnosis codes; unsupported provider refunds; claims billed with incorrect information related to other insurance that recipients had; hospital claims that were billed at a higher level of care than what was actually provided; improper episodic home health care payments; and claims for the Comprehensive Psychiatric Emergency Program (CPEP) that were paid in excess of the permitted limits.

At the time the audit fieldwork concluded, about $4.2 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $4 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 18 of the providers we identified from the Medicaid program and entered into settlements with 2 providers.

Improper Payments for Clinic, Practitioner, Managed Care Capitation, Pharmacy, Inpatient, Durable Medical Equipment, and Dental Claims

We identified $3,154,589 in overpayments on 32 clinic claims, 17 practitioner claims, 15 managed care capitation claims, 9 pharmacy claims, 8 inpatient claims, 4 durable medical equipment claims, and 1 dental claim. At the time our fieldwork concluded, 27 claims had been adjusted, saving Medicaid $1,140,978. However, actions are still required to address the remaining 59 claims with overpayments totaling $2,013,611.

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 28 claims from 12 different providers who did not respond to our record requests. As a result, we consider the services unsupported. One provider (an MCO) is responsible for 15 of the 28 claims (the 15 claims totaled $1,618,506). In total, Medicaid paid $1,705,150 for the 28 unsupported claims, and this amount should be followed up on for recovery.

- Medicaid overpaid $796,632 for five claims that were submitted as fee-for-service when the recipient was enrolled in an MCO. All five claims have been adjusted, saving Medicaid $796,632.
- Providers are responsible for submitting claims with correct information. We identified $284,671 in overpayments on 22 claims in which the providers entered incorrect information. These errors included incorrect coding, such as claims billed without a modifier code and transpositions of numbers and fields. Providers adjusted 14 claims, saving Medicaid $269,590. However, the remaining eight claims that were overpaid by $15,081 still needed to be adjusted.
- Prescribers must be enrolled in Medicaid to order prescription drugs for recipients. Medicaid paid three pharmacies $167,494 for three claims where the prescribing provider was not enrolled in Medicaid. Because the prescribers were not enrolled in Medicaid, the pharmacies are not entitled to the payments.
- Pharmacies shall substitute a generic drug whenever available unless the prescriber writes DAW (Dispense as Written) on the prescription. We identified five claims totaling $154,114 in which the pharmacy reported the brand-name drug, but the prescriber had not written DAW anywhere on the prescription. Had the pharmacies submitted the five claims using the available generic drug, Medicaid would have only paid $54,708, saving $99,406.
- Providers should only bill once for services provided. We identified $73,025 in overpayments on 13 claims that duplicated charges already reimbursed under other claims. Seven claims have been adjusted, saving Medicaid $52,227. However, the remaining six claims that were overpaid by $20,798 still needed to be adjusted.
- Practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $28,211 in overpayments on ten claims in which the providers billed more than the acquisition costs for practitioner-administered drugs. One claim has been adjusted, saving Medicaid $22,529. However, the remaining nine claims that were overpaid by $5,682 still needed to be adjusted.

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.

Incorrect Maternity and Newborn Birth Claims Involving Managed Care

In addition to monthly premium payments, Medicaid pays MCOs a one-time Supplemental Maternity Capitation Payment for the inpatient birthing costs of each newborn as long as it is a live birth or a still birth. If the pregnancy ends in a termination or miscarriage, the MCO shall not receive the Supplemental

Maternity Capitation Payment. Additionally, if a newborn weighs less than 1,200 grams (approximately 2.64 pounds) at birth, Medicaid also pays MCOs a one-time Supplemental Low Birth Weight Newborn Capitation Payment to cover the higher cost of care these newborns require. In addition to the supplemental payments 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).

Errors in reporting information, such as incorrect birth weight or diagnosis code, on newborn and maternity claims can result in improper Medicaid payments. We identified such errors on 253 claims that resulted in overpayments totaling $2,917,081. Providers adjusted 162 claims, resulting in Medicaid savings of $2,147,913.

Supplemental Maternity Capitation Payments

For the period October 1, 2015 through July 26, 2019, we identified 245 claims totaling $2,161,626 for improper Supplemental Maternity Capitation Payments to MCOs. In each case, the pregnancy ended in either a termination or miscarriage and, therefore, the MCOs were not eligible for the supplemental payment. According to the MCOs we contacted, the payments occurred because of errors in their billing system that caused the claims to group to the incorrect diagnosis-related group (DRG). At the time our fieldwork concluded, MCOs adjusted 154 of the claims, saving Medicaid $1,392,458. However, the remaining 91 claims totaling $769,168 still needed to be adjusted.

Supplemental Low Birth Weight Newborn Capitation Payments

Medicaid overpaid $748,974 for seven Supplemental Low Birth Weight Newborn Capitation claims. The overpayments occurred because MCOs reported inaccurate birth information on claims (e.g., incorrect newborn birth weight) or because hospitals reported inaccurate birth weights to MCOs. For example, an MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 780 grams. We reviewed the corresponding GME claim and noted the hospital had reported a birth weight of 3,635 grams on the newborn's inpatient GME claim. We contacted the MCO and notified it of the discrepancy, and the MCO admitted its error and corrected the claim. Medicaid originally paid the MCO $108,436 for the claim, but, based on the correct weight (3,635 grams), Medicaid should have paid the MCO much less. The MCO reversed the claim, saving Medicaid $108,436. At the time our fieldwork ended, all seven of the claims were corrected for a savings of $748,974.

Graduate Medical Education

The amount paid for GME claims can also be affected by birth weights. In addition to the incorrect Supplemental Low Birth Weight Newborn Capitation Payments made

due to incorrect birth weights, one corresponding GME claim was submitted with the same incorrect birth weight. As a result of our review, the claim was corrected, resulting in a savings of $6,481.

Recommendations

2. Review the $769,168 in overpayments and make recoveries, as appropriate.
3. Formally advise the MCOs and hospitals to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment.
4. Ensure the errors in the MCOs’ systems relating to improper Supplemental Maternity Capitation Payments are corrected so that claims are grouped to the correct DRG.

Other Insurance on Medicaid Claims

Many Medicaid recipients have additional health insurance coverage provided by Medicare and other insurance carriers. When submitting Medicaid claims, health care providers must verify whether 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 deductibles, coinsurance, and copayments. 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 deductibles, coinsurance, or copayments and/or in the designation of the primary payer result in improper Medicaid payments. We identified such errors on 3,667 claims that resulted in overpayments totaling $1,078,901. Providers adjusted four claims, resulting in Medicaid savings of $160,024.

Designation of Primary Payer

We identified overpayments totaling $569,379 on 17 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 two claims, saving Medicaid $152,060. However, the remaining 15 claims that were overpaid by an estimated $417,319 still needed to be adjusted.

Under Medicare Part C, private companies administer Medicare benefits by offering different health care plans (referred to as Medicare Advantage plans) tailored to the specific needs of Medicare enrollees. We found that, during the period August

1, 2017 through September 30, 2019, Medicaid was the primary payer on 3,646 dental claims (totaling $493,766) for services that are typically covered by Medicare Advantage plans.

Deductibles, Coinsurance, and Copayments

We identified overpayments totaling $15,756 on four claims that resulted from excessive charges for deductibles, coinsurance, and copayments for recipients covered by other insurance. We contacted the providers and they adjusted two of the claims, saving Medicaid $7,964. However, the remaining two claims that were overpaid by an estimated $7,792 still needed to be adjusted.

Recommendations

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

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 seven overpayments totaling $767,471 to seven 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 $199,185 for an inpatient stay of acute care that lasted 224 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 39 days. The hospital then rebilled the claim, which resulted in a savings of $115,475. As a result of our review, all seven claims were adjusted, saving Medicaid $767,471.

Recommendation

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

Unsupported Refunds

The Department may conduct prepayment reviews of provider claims to ensure overpayments are not made to providers. Additionally, providers can be owed money due to stipulations, investigations, and bankruptcies. We requested supporting

documentation for various refunds totaling $5,918 during this audit. The Department was unable to produce adequate documentation to support these refunds and, as a result, we were unable to determine the reasonableness and appropriateness of these funds.

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.

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 for episodes less than 60 days 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 $225,862 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. We identified 18 CHHAs that received overpayments totaling $114,931 (57 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 $110,931 in overpayments to CHHAs that improperly received a full episodic 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 (39 claims) resulted in Medicaid overpayments of $69,652 to 14 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 $41,279 (14 claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

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

Improper Payments for 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 52 CPEP claims for which Medicaid paid $57,597 in excess of the permitted limits:

- $30,211 for 27 claims that contained multiple CPEP days of service per episode of care on a single claim.
- $23,004 for 21 CPEP claims on the same date of service as a psychiatric hospital stay.
- $4,382 for 4 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. However, the issue is still present and the overpayments are still occurring.

Recommendations

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

Status of Providers Who Violate Program Requirements

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 21 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 21 providers, 10 had an active status in the Medicaid program and 11 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 21 providers, and the Department removed 18 of them from the Medicaid program. In addition, two providers entered into a settlement with the Department. At the time our audit fieldwork ended, the Department had not resolved the program status of the one remaining inactive provider.

Recommendation

12. 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. The audit covered the period April 1, 2019 through September 30, 2019, and select claims going back to October 1, 2015.

To accomplish our audit objective and assess related 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 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. We judgmentally sampled 8,307 claims, totaling $165,417,326, 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 we tested. (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 many of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

Within 180 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
Dental – Medicare Part C	5,212	3,646
Various claim types	2,637	112
Supplemental Maternity Capitation Payments	252	245
EPS	110	110
CPEP	52	52
Medicaid claims with other insurance	44	10
Totals	**8,307**	**4,175**

Agency Comments

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 27, 2020

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 2019-S-12 entitled, "Medicaid Program: Claims Processing Activity April 1, 2019 Through September 30, 2019."

Thank you for the opportunity to comment.

Sincerely,

Marybeth Hefner for

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

Enclosure

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Geza Hrazdina
Dan Duffy
James Dematteo
James Cataldo
Jeffrey Hammond
Jill Montag
Brian Kiernan
Amber Rohan
Timothy Brown
Michael Spitz
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Department of Health Comments on the Office of the State Comptroller's Draft 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) Draft 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 as follows:

- *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 on the date of service of the claim.

  Comment 1

- *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. These two claims originated from New York Presbyterian Hospital under a Resident who is covered under Medicaid.

  Comment 2

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

Recommendation #2:

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

Response #2:

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

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 will publish a reminder Medicaid Update advising hospitals to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment. A Medicaid Update has been drafted and will be issued to providers when routine publications resume after the COVID-19 response. The Department is drafting guidance to Managed Care Organizations (MCOs) advising them to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate capitation payment.

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 will review claims/encounter detail from OSC that identifies errors and will conduct outreach with those MCOs regarding requirements to ensure claims processing systems are accurately adjudicating claims. The Department will also require that these MCOs 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 will review the identified overpayments and determine an appropriate course of action.

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 will remind Medicaid providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid by publishing a Medicaid Update article. The article will also advise dental providers that it is the provider's responsibility to bill the Plans or the Plans Dental Benefit Administrators for dental services, on behalf of dual eligible recipients covered by a Plan that offers supplemental dental insurance. A Medicaid Update has been drafted and will be issued to providers when routine publications resume after the COVID-19 response.

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 will publish a reminder Medicaid Update advising hospitals to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment. A Medicaid Update has been drafted and will be issued to providers when routine publications resume after the COVID-19 response.

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 $248,242 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.

Comment 3

Recommendation #9:

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

Response #9:

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 #10:

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

Response #10:

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

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 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.

Comment 4

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.

4

State Comptroller's Comments

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.
2. 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.
3. 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.
4. 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.

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