Department of Health

Medicaid Program: Claims Processing Activity October 1, 2019 Through March 31, 2020

Report 2019-S-53 | October 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 October 1, 2019 through March 31, 2020.

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 March 31, 2020, eMedNY processed over 227 million claims, resulting in payments to providers of more than $36 billion. The claims are processed and paid in weekly cycles, which averaged about 8.7 million claims and $1.4 billion in payments to providers.

Key Findings

The audit identified about $2.9 million in improper Medicaid payments that require the Department's prompt attention, including:

- $978,966 was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $740,920 was paid for newborn birth claims that contained inaccurate information, such as the newborn's birth weight and diagnosis code;
- $513,427 was paid for practitioner, clinic, inpatient, pharmacy, and episodic home health care claims that did not comply with Medicaid policies, such as claims for services that were already paid and claims that contained incorrect billing codes;
- $479,907 was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had; and
- $136,257 was paid for psychiatric claims that were billed in excess of permitted limits.

By the end of the audit fieldwork, nearly $2.1 million of the improper payments had been recovered.

Auditors also identified 14 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 11 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 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

October 20, 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 October 1, 2019 Through March 31, 2020*. 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

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*
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*

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, 2020, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $69.8 billion. The federal government funded about 56.3 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.7 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, 2020, eMedNY processed over 227 million claims, resulting in payments to providers of more than $36 billion. The claims are processed and paid in weekly cycles, which averaged about 8.7 million claims and $1.4 billion in payments to providers.

The Medicaid program pays health care providers through the fee-for-service method or through managed care. Under fee-for-service, the Department makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, the Department pays managed care organizations (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, 2020, 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 $2,849,477 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 and diagnosis codes; claims that were 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; and improper practitioner, clinic, inpatient, pharmacy, and episodic home health care claims that did not comply with Medicaid policies.

At the time the audit fieldwork concluded, $2,073,032 of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling $776,445 and recover funds as warranted.

Auditors also identified 14 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 11 of the providers from the Medicaid program, entered into settlements with 2 providers, and had to make a final determination on the remaining provider.

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 ten overpayments, totaling $978,966, to three providers who 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 $762,886 for an inpatient stay of acute care that lasted 718 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 43 days. The hospital then rebilled the claim, which resulted in a savings of $545,019. As a result of our review, three claims were adjusted, saving Medicaid $858,865. However, the remaining seven claims that were overpaid by $120,101 still need to be adjusted.

Recommendations

1. Review the $120,101 in overpayments and make recoveries, as appropriate.
2. 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 monthly premium payments, Medicaid pays MCOs a one-time Supplemental Newborn Capitation Payment for the inpatient birthing costs of each newborn enrolled. 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. The low birth weight payments are intended to cover the higher cost of care these newborns require. In addition to the supplemental payments to the MCOs, Medicaid also pays hospitals a fee-for-service Graduate Medical Education (GME) claim (hospitals receive GME payments for care provided to recipients enrolled in MCOs to cover the costs of training residents).

Medicaid overpaid $740,920 for six Supplemental Low Birth Weight Newborn Capitation claims. The overpayments occurred because MCOs reported inaccurate birth information on the claims (e.g., hospitals may have reported inaccurate birth weights to MCOs). In one case, an MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 690 grams. We reviewed the corresponding GME claim and noted the hospital had reported a birth weight of 2,729 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 $127,017 for the claim. However, based on the correct weight (2,729 grams), Medicaid should have paid the MCO much less. The MCO reversed this claim, saving Medicaid $127,017. At the time our fieldwork ended, all six of the claims were corrected for a cost savings of $740,920.

Recommendation

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

Other Insurance on Medicaid Claims

Medicaid recipients may have additional 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 designation of the primary payer or in the amounts claimed for coinsurance, copayments, or deductibles result in improper Medicaid payments. We identified such errors on 11 claims that resulted in overpayments totaling $479,907. Providers adjusted eight claims, resulting in Medicaid savings of $190,146.

Designation of Primary Payer

We identified overpayments totaling $458,546 on seven 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, the providers had adjusted four claims, saving Medicaid $168,785. However, the remaining three claims that were overpaid by $289,761 still needed to be adjusted.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $21,361 on four claims that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and they adjusted all four claims, saving Medicaid $21,361.

Recommendations

4. Review the $289,761 in overpayments and make recoveries, as appropriate.
5. Remind providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid.

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

We identified $417,683 in overpayments on 98 practitioner claims, 28 clinic claims, 3 inpatient claims, and 1 pharmacy claim that resulted from errors in billing. At the time our fieldwork concluded, 78 claims had been adjusted, saving Medicaid $264,968. However, actions are still required to address the remaining 52 claims with overpayments totaling $152,715.

The overpayments occurred under the following scenarios:

- Providers should only bill once for services provided. We identified $259,245 in overpayments on nine claims that duplicated charges already reimbursed under other claims. Providers adjusted five claims, saving Medicaid $170,152.

However, the remaining four claims that were overpaid by $89,093 still need to be adjusted.

- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $68,328 in overpayments on 95 claims in which the providers billed more than the acquisition costs for practitioner-administered drugs. Providers adjusted 57 claims, saving Medicaid $53,000. However, the remaining 38 claims that were overpaid by $15,328 still need to be adjusted.
- Providers are responsible for submitting claims with correct information. We identified $50,385 in overpayments on 21 claims in which the providers entered incorrect information on the claims. The errors included incorrect coding, claims billed without a modifier, and transpositions of numbers and fields. Providers adjusted 16 claims, saving Medicaid $41,816. However, the remaining 5 claims that were overpaid by $8,569 still need to be adjusted.
- Pharmacies should substitute a generic drug whenever available unless the prescriber writes “DAW” (Dispense as Written) on the prescription. We identified one claim, totaling $24,307, where a pharmacy submitted the claim for a brand name drug when the prescriber had not written DAW on the prescription. Had the pharmacy submitted the claim using the available generic drug, Medicaid would have saved $17,707.
- 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 four claims from three different providers who did not respond to our record request. As a result, we consider the services unsupported. Medicaid paid $22,018 for the four unsupported claims, and this amount should be followed up on for recovery.

Recommendation

6. Review the $152,715 ($89,093 + $15,328 + $8,569 + $17,707 + $22,018) 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 113 CPEP claims for which Medicaid paid $136,257 in excess of the permitted limits, as follows:

- $110,935 for 89 claims where the provider billed multiple CPEP days of service per episode of care on a single claim.
- $20,940 for 20 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.

Upon our inquiry, one provider adjusted two of the claims, resulting in Medicaid savings of $18,133.

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. However, we identified one provider who billed the majority of claims (85 of the 89 claims reported above) who was not included in the Department's March project. As a result of our audit work, the Department implemented a subsequent system change on July 21, 2020 to prevent further improper CPEP payments to this provider.

Recommendations

7. Review the $118,124 in overpayments and make recoveries, as appropriate.
8. 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 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 $95,744 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, seven CHHAs received overpayments totaling $66,075 (29 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 $29,669 in overpayments to CHHAs that improperly received full payments for patients who were readmitted within 60 days of their original episode start date.

- Many of the overpayments 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 (five claims) resulted in Medicaid overpayments of $5,198 to four 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 nine CHHAs $24,471 (nine claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

9. Review the $95,744 ($66,075 + $5,198 + $24,471) in overpayments and make recoveries, as appropriate.

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 14 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 14 providers, 3 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 14 providers and the Department removed 11 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

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. The audit covered the period October 1, 2019 through March 31, 2020.

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 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 2,798 claims, totaling $175,415,646, and reviewed them for accuracy and appropriateness. We used a risk-based approach to judgmentally sample different claim types. 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. Due to the COVID-19 pandemic, we experienced delays in contacting providers and, therefore, we were unable to resolve the disposition of nine claims. As a result, we will cover those nine claims in a subsequent audit of Medicaid claims processing activity.

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. 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 indicated that certain actions have been and will be taken to address the audit recommendations. Our rejoinder to the Department's response related to CPEP overpayments is included in the report's State Comptroller's Comment.

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
Various claim types	2,642	157
CPEP	113	113
EPS	43	43
Totals	**2,798**	**313**

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

October 16, 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-53** entitled, **"Medicaid Program: Claims Processing Activity October 1, 2019 Through March 31, 2020."**

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Diane Christensen
Elizabeth Misa
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Jonah Bruno
Jill Montag
Brian Kiernan
Timothy Brown
Amber Rohan
Robert Schmidt
Lori Conway
Michael Spitz
OHIP Audit

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2019-S-53 entitled, "Medicaid Program: Claims Processing Activity October 1, 2019 Through March 31, 2020"

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-53 entitled, "Medicaid Program: Claims Processing Activity October 1, 2019 Through March 31, 2020."

Recommendation #1:

Review the $120,101 in overpayments and make recoveries, as appropriate.

Response #1:

The Department does not concede the identified amount in overpayments. The Office of the Medicaid Inspector General (OMIG) is conducting an ongoing review and audit of the Medicaid payments. Due to the complexity of the calculations and the audit process pertaining to this review, OMIG will extract its own data, perform analysis, and determine an appropriate course of action. The Department will make recovery for any confirmed overpayments.

Recommendation #2:

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

Response #2:

The Department issued guidance formally advising hospitals to report alternate levels of patient care in the June 2020 Medicaid Update:
https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no11_jun20.pdf

Recommendation #3:

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

Response #3:

The Department issued a Medicaid Update in June 2020 advising hospitals to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment. (See link in Response #2.)

The Department has also drafted guidance to Managed Care Organizations (MCOs) advising them to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment.

Recommendation #4:

Review the $289,761 in overpayments and make recoveries, as appropriate.

Response #4:

The Department does not concede the identified amount in overpayments. The Office of the Medicaid Inspector General (OMIG) is conducting an ongoing review and audit of the Medicaid payments. Due to the complexity of the calculations and the audit process pertaining to this review, OMIG will extract its own data, perform analysis, and determine an appropriate course of action. The Department will make recovery for any confirmed overpayments.

Recommendation #5:

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

Response #5:

The Department issued a Medicaid Update in July 2020 to remind Medicaid providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid. https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no12_jul20.pdf

Recommendation #6:

Review the $152,715 ($89,093 + $15,328 + $8,569 + $17,707 + $22,018) in overpayments and make recoveries, as appropriate.

Response #6:

The Department does not concede the identified amount in overpayments. The Office of the Medicaid Inspector General (OMIG) is conducting an ongoing review and audit of the Medicaid payments. Due to the complexity of the calculations and the audit process pertaining to this review, OMIG will extract its own data, perform analysis, and determine an appropriate course of action. The Department will make recovery for any confirmed overpayments.

Recommendation #7:

Review the $118,124 in overpayments and make recoveries, as appropriate.

Response #7:

The Department does not concede the identified amount in overpayments. The Office of the Medicaid Inspector General (OMIG) is conducting an ongoing review and audit of the Medicaid payments. Due to the complexity of the calculations and the audit process pertaining to this review, OMIG will extract its own data, perform analysis, and determine an appropriate course of action. The Department will make recovery for any confirmed overpayments.

Recommendation #8:

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 #8:

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 was January 1, 2019.

Comment 1

Recommendation #9:

Review the $95,744 ($66,075 + $5,198 + $24,471) in overpayments and make recoveries, as appropriate.

Response #9:

The Department does not concede the identified amount in overpayments. The Office of the Medicaid Inspector General (OMIG) is conducting an ongoing review and audit of the Medicaid payments. Due to the complexity of the calculations and the audit process pertaining to this review, OMIG will extract its own data, perform analysis, and determine an appropriate course of action. The Department will make recovery for any confirmed overpayments.

Recommendation #10:

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

Response #10:

The provider has been in status 33-INACTV-2 YR since 2007, which means the provider is currently inactive, would not have been allowed to bill Medicaid since 2007, and would have to apply for reinstatement in order to be actively enrolled and bill Medicaid again. A reinstatement application would go through the normal screening processes, and the provider's record and license surrender would be discovered, prohibiting the provider from being actively enrolled again. In addition, if the provider applies for reinstatement, the provider should answer "yes" to the disclosure questions. This would prompt completion of the full Prior Conduct Questionnaire and further review by the Department's Bureau of Provider Enrollment (BPE) Program Integrity Unit which would result in enrollment being prohibited. Lastly, a note was added to the provider's file stating that if this provider does apply for reinstatement, the application is to be referred to the BPE's Program Integrity Unit.

The remaining provider is still under review by OMIG.

State Comptroller's Comment

1. We found several of the 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.

Contributors to Report

Executive Team

Tina Kim - *Deputy Comptroller*

Ken Shulman - *Assistant Comptroller*

Audit Team

Andrea Inman - *Audit Director*

Warren Fitzgerald - *Audit Manager*

Rebecca Tuczynski - *Audit Supervisor*

Nareen Jarrett - *Examiner-in-Charge*

Emily Proulx - *Examiner-in-Charge*

Suzanne Loudis, RN - *Supervising Medical Care Representative*

Dawn Daubney, RN - *Medical Care Representative*

Caitlin Colacino - *Senior Examiner*

Misty Daiyan - *Senior Examiner*

Tracy Glover - *Senior Examiner*

Michael Gouvakis - *Senior Examiner*

Yueting Luo - *Senior Examiner*

Linda Thipvoratrum - *Senior Examiner*

Danhua Zhang - *Senior Examiner*

Jeremy Glazer - *Staff Examiner*

Emily Schwartz - *Staff Examiner*

Contact Information
(518) 474-3271
StateGovernmentAccountability@osc.ny.gov
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Like us on Facebook at facebook.com/nyscomptroller
Follow us on Twitter @nyscomptroller
For more audits or information, please visit: www.osc.state.ny.us/audits/index.htm