NEW YORK STATE OF OPPORTUNITY. Department of Health

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January 20, 2022

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 2020-S-22 entitled, "Department of Health/Medicaid program - Claims Processing Activity April 1, 2020, Through September 30, 2020."

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

Sincerely,

Kristin M. Proud

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Ms. Chun

# Department of Health Comments on the Final Audit Report OSC 2020-S-22 entitled, "Medicaid Program: Claims Processing Activity April 1, 2020 Through September 30, 2020" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (Department) Final Audit Report 2020-S-22 entitled, "Medicaid Program: Claims Processing Activity April 1, 2020 Through September 30, 2020" by the Office of the State Comptroller (OSC).

**Recommendation #1:**

Routinely monitor available reports to ensure accuracy of retroactive rate changes that are manually entered into the eMedNY system.

**Response #1:**

The majority of rates loaded to the eMedNY payment system are done electronically, eliminating the possibility of errors due to manual rate entry. The Department has recently implemented changes in the electronic loading of rates that will significantly reduce, and potentially eliminate entirely, the need for manual intervention with rate loads. However, if a manual rate does need to be entered, the staff person that requested the manual rate will be required to review eMedNY for accuracy prior to implementation. Accordingly, this recommendation is addressed through these changes in the electronic loading process, which makes routine monitoring of manually entered rates in eMedNY unnecessary.

**Recommendation #2:**

Review the $780,327 in overpayments and make recoveries, as appropriate.

**Response #2:**

The Office of the Medicaid Inspector General (OMIG) continuously performs audits of alternate level of care (ALC) claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse (MDW), which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. 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 nine hospitals we identified to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment, with specific attention to the two providers who accounted for the majority of the findings.

**Response #3:**

It should be noted that the claims identified by OSC as having been submitted by the nine hospitals appear to have been submitted after the Department issued clear guidance regarding the ALC billing requirements. As part of their enrollment in the Medicaid program, the Department and OMIG expect that all providers, including these hospital providers identified by

the OSC audit, review and understand *Medicaid Updates* and other guidance issued by the Department on its website and through eMedNY. Accordingly, these providers had constructive notice of the billing rules they should have followed at the time that these hospital claims were billed, and thus the claims will be reviewed as part of OMIG's audit process. If OMIG determines the claims to be inappropriate, the providers will be notified and directed to accurately report alternate levels of patient care when billing Medicaid, and the inappropriate payments will be recovered. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. Accordingly, OMIG's audit and overpayment recovery process will serve as further notice to these nine hospitals of these billing rules. Based on the foregoing, the Department determined it is neither necessary nor appropriate for these individual providers to be informed of their potential non-compliance with Medicaid billing rules outside of the audit process.

**Recommendation #4:**

Review the 7,835 claims totaling $892,790 and make recoveries, as appropriate.

**Response #4:**

OMIG performed analysis on the OSC data and will perform its own extraction of data from the MDW, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #5:**

Review the $503,522 ($275,237 + $167,931 + $9,343 + $15,524 + $35,487) in overpayments and make recoveries, as appropriate.

**Response #5:**

OMIG continuously performs audits of practitioner, clinic, and pharmacy claims. OMIG will perform its own extraction of data from the MDW, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #6:**

Review the four claims totaling $492,719 and make recoveries, as appropriate.

**Response #6:**

OMIG continuously performs audits of supplemental low birth weight newborn capitation payments. OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #7:**

Formally advise Managed Care Organizations (MCOs) to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

**Response #7:**

The Department is in the process of issuing a reminder to MCOs, through routine MCO communication channels, to report newborn claim information accurately when billing Medicaid outside of their capitated payment structure.

**Recommendation #8:**

Review the $21,227 in overpayments and make recoveries, as appropriate.

**Response #8:**

OMIG continuously performs audits of other insurance claims, to ensure Medicaid is the payor of last resort. OMIG will perform its own extraction of data from the MDW, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #9:**

Review the $199,943 in overpayments and make recoveries, as appropriate.

**Response #9:**

OMIG has Comprehensive Psychiatric Emergency Program (CPEP) audit protocols which address the findings in this OSC report. OMIG has previously performed audits of CPEP claims. OMIG will perform its own extraction of data from the MDW, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit

period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #10:**

Verify the Office of Mental Health's (OMH) proposed transmittal package was processed and corrected the issues that led to the overpayments we identified.

**Response #10:**

As stated in the response to OSC's draft audit report, OMH's proposed transmittal package was processed and corrected the issues (i.e., rate codes that had been mistakenly been changed back to "daily" from "monthly") that had previously resulted in some of OSC's identified overpayments. This process change is working as intended with very minimal exceptions. However, the "overpayments" identified by OSC in this draft report were not related to these now corrected rate code types.

**State Comptroller's Comment** – The Department stated the overpayments identified by the audit were not related to the OMH transmittal package that corrected the rate code types. However, most of the overpayments we identified were due to the rate code type error. In fact, during the audit, we provided Department officials with the claim details that supported our findings and officials stated that OMH's transmittal package should correct the improperly paid claims we identified. According to the Department, OMH's transmittal package was submitted with an effective date of December 1, 2020 and the claims were reprocessed using the monthly rate code type, which canceled the duplicate payments we identified. We commend the Department for its prompt action in response to our recommendation.

Details surrounding the results of OMH's claim-by-claim review were included in the response to the draft audit report. Additionally, OMH began working with the Department in August 2021 to add the affected CPEP rate codes to Rate Category Code R124 for CPEP claims that occurred on the same date of service as an inpatient psychiatric hospital stay. This should prevent CPEP claims from overlapping with rate code 2852 for an inpatient stay going forward.

**Recommendation #11:**

Review the $88,087 ($85,566 + $2,521) in overpayments and make recoveries, as appropriate.

**Response #11:**

OMIG has Certified Home Health Agency episodic payment audit protocols which address the findings in this OSC report. OMIG has previously performed audits of episodic payments. OMIG will perform its own extraction of data from the MDW, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #12:**

Ensure providers who violate Medicaid or other health insurance program provisions are subject to appropriate and timely sanctions, including removal from the program.

**Response #12:**

OMIG sanctions individuals based on unacceptable practices discovered during investigations or audits of providers, as well as taking derivative actions that originate from other agencies including Office of Professional Discipline, Office of Professional Medical Conduct, US Health and Human Services - Office of Inspector General, and NYS Attorney General's Medicaid Fraud Control Unit. OMIG also performs searches of the internet to identify providers that have been arrested or convicted of health care related crimes, determines if they are participating in the Medicaid program and appropriately sanctions them. OMIG excludes providers from the Medicaid program under the provisions of 18 NYCRR § 515.3 and/or 18 NYCRR § 515.7. OMIG maintains an exclusion list that is updated on the OMIG website, which contains both enrolled providers and non-enrolled persons/entities.