Department of Health

Medicaid Program: Claims Processing Activity April 1, 2020 Through September 30, 2020

Report 2020-S-22 | September 2021

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, 2020 through September 30, 2020 and certain claims going back to April 7, 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 providers for their claims. During the six-month period ended September 30, 2020, eMedNY processed over 151 million claims, resulting in payments to providers of more than $38 billion. The claims are processed and paid in weekly cycles, which averaged about 5.6 million claims and $1.4 billion in payments to providers.

Key Findings

The audit identified over $9.7 million in improper Medicaid payments that require the Department's prompt attention, as follows:

- $4.5 million was paid for an incorrect retroactive rate adjustment;
- $2.1 million was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $892,790 was paid for services rendered prior to, but billed during, the Coronavirus Disease state of emergency that would have been denied had certain eMedNY edits not been relaxed in response to the crisis;
- $844,172 was paid for clinic, practitioner, pharmacy, inpatient, managed care capitation, and episodic home health care claims that did not comply with Medicaid policies;
- $738,903 was paid for newborn birth claims that contained inaccurate birth information, such as the newborn's birth weight and diagnosis code;
- $486,951 was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had; and
- $199,943 was paid for psychiatric claims that were billed in excess of permitted limits.

By the end of the audit fieldwork, about $6.8 million of the improper payments had been recovered.

Auditors also identified 13 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 three of the providers from the Medicaid program, and the remaining ten providers entered into federal settlements.

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 21, 2021

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively. 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, 2020 Through September 30, 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*
COVID-19	Coronavirus Disease 2019	*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 and Payment 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 September 30, 2020, eMedNY processed over 151 million claims, resulting in payments to providers of more than $38 billion. The claims are processed and paid in weekly cycles, which averaged about 5.6 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 rendered 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 September 30, 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 over $9.7 million in claims pertaining to: an incorrect retroactive rate adjustment; hospital claims billed at a higher level of care than was actually provided; services rendered prior to, but billed during, the Coronavirus Disease 2019 (COVID-19) state of emergency; claims billed with incorrect information related to other insurance that recipients had; newborn birth claims that contained inaccurate birth information; claims for the Comprehensive Psychiatric Emergency Program that were paid in excess of the permitted limits; and other improper clinic, practitioner, managed care capitation, pharmacy, inpatient, and episodic home health care claims that did not comply with Medicaid policies.

At the time the audit fieldwork concluded, about $6.8 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining payments totaling about $2.9 million and recover funds as warranted.

Auditors also identified 13 providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. We advised Department officials of the 13 providers, and the Department removed 3 providers from the Medicaid program. The remaining providers entered into federal settlements, so no action was taken by the Department.

Incorrect Retroactive Rate Adjustment

Reimbursement rates paid for Medicaid services are developed and periodically revised by the Department. When the Department issues a rate adjustment, eMedNY reprocesses providers' previously paid claims affected by the rate change.

Our review of retroactive rate adjustments identified an input error for a single provider that resulted in an overpayment of $4,493,808. The rate adjustment impacted claims for dates of service between January 1, 2018 and December 31, 2018. According to Department officials, rate adjustments are typically processed electronically. However, due to technical issues, this rate was manually processed at $220.08 rather than $22.08, overstating the rate by $198. We notified the Department when the error was identified, and officials quickly corrected the rate and reprocessed all affected claims.

Reports are available to verify the accuracy of Medicaid reimbursement rates. Use of these reports would allow the Department to identify disproportionate rate changes, particularly those processed manually.

Recommendation

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

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 34 overpayments, totaling $2,129,986, to nine providers who billed for a higher (and more costly) level of care than what was actually provided to the Medicaid recipients. Nearly 80 percent of the claims identified, totaling almost $1.4 million, were submitted by two hospitals. For example, Medicaid originally paid one hospital $925,289 for an inpatient stay of acute care that lasted 1,159 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 545 days. The hospital rebilled the claim, which resulted in a savings of $654,302. As a result of our review, nine claims were adjusted, saving Medicaid $1,349,659. However, the remaining 25 claims that were overpaid by $780,327 still need to be adjusted.

The Department published billing guidance in a June 2020 Medicaid Update, reminding hospitals to accurately report the ALC status of a patient when billing Medicaid to ensure appropriate payment. However, the claims we identified were billed after the guidance was published and providers continued to incorrectly bill for ALC services.

Recommendations

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

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 that accounted for the majority of the findings.

Improper Payments for Services Billed During the COVID-19 State of Emergency

Medicaid claims processed in eMedNY are subject to various automated edits to determine eligibility for reimbursement. When information submitted on a claim triggers an edit, eMedNY looks to the edit status for direction on how to proceed with claims processing. The edit status instructs eMedNY to pay, deny, or suspend a

claim or take other actions such as pay and report (pay the claim but report the claim details on a special report).

In response to the COVID-19 state of emergency, declared under Executive Order 202 and effective March 7, 2020, the Department authorized changes to the edit status of 13 claim edits from deny, to pay and report. This was done to allow for continuity of care for Medicaid recipients. However, we found that the Department improperly paid $892,790 for 7,835 claims billed during the COVID-19 emergency, but for services rendered between April 2, 2018 and December 31, 2019 (prior to the emergency). Had these claims been adjudicated in a timely manner, the COVID-19-related edit changes would not have been in effect and the claims would have been denied.

We asked Department officials if they had assessed the risk that the change would allow payment for services performed outside of the scope of COVID-19. Department officials were unable to confirm any testing or assessment of that risk and upon request were unable to offer input on whether the claims we identified could be recovered.

Recommendation

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

Improper Payments for Clinic, Practitioner, Pharmacy, Inpatient, and Managed Care Capitation Claims

We identified $756,085 in overpayments on 1,338 clinic claims, 238 practitioner claims, 4 pharmacy claims, 2 inpatient claims, and 1 managed care capitation claim that resulted from errors in billing. At the time our fieldwork concluded, 153 claims had been adjusted, saving Medicaid $252,563. However, actions are still required to address the remaining 1,430 claims that were overpaid $503,522.

The overpayments occurred under the following scenarios:

- Providers may be entitled to reimbursement of drug administration charges for drugs obtained at no cost. For correct reimbursement, providers should submit the claim using modifier code “FB” to inform eMedNY that the facility did not pay for the drug, which results in payment for the injection service only. We identified $318,272 in Medicaid overpayments on 1,126 claims submitted by multiple hospitals for drugs obtained at no cost but billed without the “FB” modifier. Ten of the 49 providers accounted for $302,325 (95 percent) of the overpayments we identified. At the end of our fieldwork, 24 claims had been adjusted, saving Medicaid $43,035. However, the remaining 1,102 claims totaling $275,237 have yet to be adjusted.

- Providers are responsible for submitting claims with correct information. We identified $276,755 in overpayments resulting from providers who reported inaccurate codes on 196 claims. For example, hospitals bill Medicaid using different rate codes depending on the type of service provided. We identified a hospital that submitted an incorrect rate code for an emergency room visit. Had the hospital submitted the claim using the correct rate code, Medicaid would have paid a lower amount. Upon our inquiry, the provider acknowledged the error and voided the claim, saving Medicaid $6,793. At the completion of our fieldwork, providers had adjusted five claims, saving Medicaid $108,824. The remaining 191 claims totaling overpayments of $167,931 still need to be adjusted.

- Providers should only bill once for services provided. We identified $74,729 in overpayments on 21 claims that duplicated charges already reimbursed under other claims. Seventeen claims have been adjusted, saving Medicaid $65,386. However, the remaining four claims overpaid by $9,343 still need to be adjusted.

- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $50,842 in overpayments on 238 claims in which the providers billed more than the acquisition costs for practitioner-administered drugs. Providers adjusted 107 claims, saving Medicaid $35,318. However, the remaining 131 claims overpaid by $15,524 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 a pharmacy that billed two claims, totaling $48,687, for brand name drugs when the prescriber had not written DAW on the prescription. Had the pharmacy submitted those claims using the available generic drug, Medicaid would have saved $35,487.

Recommendation

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

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. However, if a newborn weighs less than 1,200 grams (approximately 2.64 pounds) at birth, Medicaid pays MCOs a one-time Supplemental Low Birth Weight Newborn Capitation Payment. The low birth weight payment is intended to cover the higher cost of care these newborns require. In addition to the supplemental payment 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 paid $738,903 for six Supplemental Low Birth Weight Newborn Capitation claims to four MCOs where the birth information on the claim was inconsistent with the GME claim (e.g., hospitals may have reported inaccurate birth weights or other incorrect information to MCOs). For example, one MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 602 grams. We reviewed the corresponding GME claim and noted the hospital had reported a birth weight of 1,200 grams. When we brought the discrepancy to the attention of the MCO, they reviewed the medical support, acknowledged the error, and reversed the claim, saving Medicaid $123,092.

We requested the MCOs review the medical support for each of the six claims and upon further review three of the MCOs agreed that the plan was not entitled to three claims totaling $362,288. However, one MCO did not respond to multiple requests for additional documentation to substantiate the remaining three claims totaling $376,615. At the time our fieldwork ended, two of the six claims had been corrected for a cost savings of $246,184. However, four claims totaling $492,719 still needed to be corrected.

Recommendations

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

7. Formally advise MCOs 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 date services were provided. If a recipient had other insurance coverage, the other insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the recipient's normal financial obligation, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer.

Errors in the amounts claimed for coinsurance, copayments, or deductibles or in the designation of the primary payer result in improper Medicaid payments. We identified such errors on seven claims that resulted in overpayments totaling $486,951. Providers adjusted six claims, resulting in Medicaid savings of $465,724.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $252,084 on four claims that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and three of the four claims were adjusted, saving Medicaid $230,857. However, the remaining claim overpaid by $21,227 still needs to be adjusted.

Designation of Primary Payer

We identified overpayments totaling $234,867 for three claims on which Medicaid was incorrectly designated as the primary payer when the primary payer was another insurer. Typically, primary payers pay more than secondary payers. We contacted the providers and advised them Medicaid was incorrectly billed as the primary payer. At the conclusion of our audit fieldwork, the providers had adjusted all three claims, saving Medicaid $234,867.

Recommendation

8. Review the $21,227 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 requiring 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 Medicaid reimbursement rate for CPEP is 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 140 CPEP claims for which Medicaid paid $199,943 in excess of the permitted limits:

- $166,897 for 111 claims that contained multiple CPEP days of service per episode of care on a single claim.
- $26,443 for 23 CPEP claims that occurred on the same date of service as a psychiatric hospital stay.

- $6,603 for 6 claims where the provider billed multiple CPEP days of service per episode of care on different claims.

According to Department officials, the overpayments occurred because the eMedNY claims processing logic allows one CPEP payment per calendar day rather than 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.

In May 2019, the Department completed a project that changed the CPEP rate code type from daily to monthly. This change was expected to prevent the types of overpayments identified in this audit. However, according to Department officials, CPEP rate transmittal processing after May 2019 mistakenly reverted certain rate code types back to daily. At the time our audit fieldwork was completed, Department officials explained that the Office of Mental Health was planning to process a transmittal package to correct this issue.

Recommendations

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

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

Improper Episodic Payments for Home Care

Certified Home Health Agency (CHHA) providers receive payments under the Episodic Payment System (EPS) to provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care in the home. The payment is based on a price for 60-day episodes of care. CHHAs can be paid for a full episode (when the episode of care is 60 days) or for a partial episode (when the episode of care is less than 60 days). Payments for a partial episode may be pro-rated based on the number of days of care (full payments may occur in certain circumstances, such as when the patient is transferred to a hospital or hospice, or in cases of death). We found Medicaid overpaid $88,087 for 41 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 13 CHHAs that received overpayments totaling $85,566 (38 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 episode payment instead of the appropriate partial pro-rated episodic payment.

Multiple Episodic Payments Within 60 Days

We also identified $2,521 in overpayments to CHHAs that improperly received a full episodic payment for patients readmitted within 60 days of their original episode start date. These overpayments occurred when recipients were 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 three CHHAs $2,521 (three claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

11. Review the $88,087 ($85,566 + $2,521) 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 13 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 13 providers, eight had an active status in the Medicaid program and five 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 13 providers, and the Department removed three providers from the Medicaid program. The remaining providers entered into federal settlements, so no action was taken by the Department.

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.

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, 2020 through September 30, 2020 and certain claims going back to April 7, 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 spoke to 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 4,638 claims, totaling $189,988,830, 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 claims affected by the incorrect retroactive rate adjustment, claims submitted after eMedNY system edit controls were changed from deny to pay in response to COVID-19, CPEP claims, and EPS claims that did not follow payment rules. (A summary of the sampled claims is presented in the Exhibit at the end of the report.) The results of our samples cannot be projected to the population. Due to the COVID-19 pandemic, we experienced delays in contacting providers and, therefore, we were unable to resolve the disposition of nine claims in our previous audit *Medicaid Program: Claims Processing Activity October 1, 2019 Through March 31, 2020* (2019-S-53). As a result, we have included those nine claims in this audit, even though they were made prior to April 1, 2020. Additionally, we were unable to resolve the disposition of 303 claims in this audit (*Medicaid Program: Claims Processing Activity April 1, 2020 Through September 30, 2020*). As a result, we will cover those 303 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 professional judgment, these functions do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of Medicaid Claims Processing Activity from April 1, 2020 through September 30, 2020.

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 it. In their response, Department officials indicated that certain actions have been and will be taken to address the audit recommendations. Our rejoinder to Department comments related to CPEP payments is embedded in the Department's response as a 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
Incorrect Retroactive Rate	3,454	3,454
Various Claim Types	4,638	1,630
Services Billed During COVID-19	7,835	7,835
CPEP	140	140
EPS	41	41
Totals	**16,108**	**13,100**

Agency Comments and State Comptroller's Comment

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

June 14th, 2021

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2020-S-22 entitled, "Medicaid Program: Claims Processing Activity April 1, 2020 Through September 30, 2020."

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen
Frank Walsh
Brett Friedman
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Jonah Bruno
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Department of Health Comments on the Draft 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) Draft 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. 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. 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 is currently performing 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. 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. 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. 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. 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. 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:

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. However, the "overpayments" identified by OSC in this draft report were not related to these now corrected rate code types.

This process change is working as intended, with very minimal exceptions. This determination is borne out by the following claim-by-claim review findings:

- 149 claims (totaling $162,499) where duplicate payments did not exist (i.e., there were multiple claims paid, however, they totaled one rate amount);
- 29 claims (totaling $31,946) where more information (i.e., case record) is required to determine if an overpayment exists. In these instances it would need to be determined whether or not the multiple CPEP claims were for separate episodes (in which case the claim in question would be allowable) or whether the individual was admitted to inpatient before or after the CPEP (if the individual was admitted to inpatient after the CPEP, the CPEP is entitled to 4008 payments prior to inpatient billing beginning);
- Three claims (totaling $3,297) where we were unable to locate the claim in MDW; and
- Two claims (totaling $2,201) where the claim in date of service in MDW did not align with OSC's claims detail.

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's response, OMH's transmittal package did correct the incorrectly processed claims we found. For instance, the duplicate payments referenced in the first bullet of the Department's response were identified because they were processed with a daily rate code type rather than a monthly rate code type, which caused the duplicate payments. After we identified these payments, a correction request 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 commend the Department for its prompt action in response to our recommendation. We have also reached out to the Department to provide additional information to help it identify the claims it was unable to locate.

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. 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.

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