Department of Health

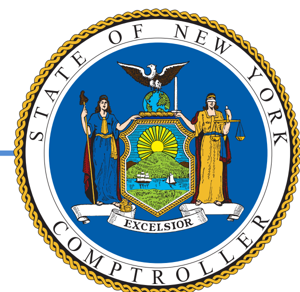
Medicaid Program: Claims Processing Activity October 1, 2020 Through March 31, 2021

Report 2020-S-54 | April 2022

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 from October 2020 through March 2021, and certain claims going back to October 2014.

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 6-month period ended March 31, 2021, eMedNY processed over 313 million claims, resulting in payments to providers of more than $36 billion. The claims are processed and paid in weekly cycles, which averaged about 12.1 million claims and $1.4 billion in payments to providers.

Key Findings

The audit identified nearly $7.4 million in improper Medicaid payments, as follows:

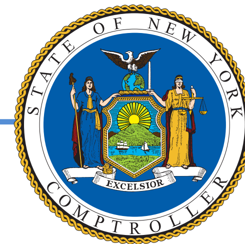
- $3.3 million was paid for fee-for-service inpatient claims that should have been paid by managed care, or that were also reimbursed by managed care;
- $1.5 million was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $1.1 million was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had, or where Medicaid was incorrectly designated as the primary payer instead of another insurer;
- $1 million was paid for practitioner, clinic, inpatient, durable medical equipment, episodic home health care, and psychiatric claims that did not comply with Medicaid policies, such as billing in excess of permitted limits;
- $357,066 was paid for newborn birth claims that contained inaccurate birth information, such as the newborn's birth weight; and
- $46,193 was paid for services rendered prior to, but billed during, the coronavirus disease 2019 state of emergency that would have been denied had certain eMedNY edits not been relaxed in response to the crisis.

By the end of the audit fieldwork, about $5.6 million of the improper payments had been recovered.

Auditors also identified 34 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 providers, and the Department removed eight of them from the Medicaid program.

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

April 19, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Bassett:

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, 2020 Through March 31, 2021*. This audit was performed pursuant to the State Comptroller's authority under 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

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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*
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*
FFS	Fee-for-service	*Key Term*
GME	Graduate medical education	*Key Term*
MCO	Managed care organization	*Key Term*
MLTC	Managed long-term care	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $68.1 billion. The federal government funded about 56.5% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5%.

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 6-month period ended March 31, 2021, eMedNY processed over 313 million claims, resulting in payments to providers of more than $36 billion. The claims are processed and paid in weekly cycles, which averaged about 12.1 million claims and $1.4 billion in payments to providers.

The Medicaid program pays health care providers through the fee-for-service (FFS) method or through managed care. Under FFS, 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 payment 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 6 months ended March 31, 2021, 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.

However, we also identified the need for improvements in the processing of certain types of claims. We found nearly $7.4 million in improper payments pertaining to: FFS claims for inpatient services that should have been covered by the recipient's MCO, or that were also reimbursed by the MCO; hospital claims billed at a higher level of care than what 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 (CPEP) that were paid in excess of the permitted limits; and other improper clinic, practitioner, inpatient, durable medical equipment, and episodic home health care claims that did not comply with Medicaid policies.

At the time the audit fieldwork concluded, about $5.6 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $1.8 million and recover funds, as warranted. We note that some overpayments may no longer be recoverable due to regulatory look-back provisions. We encourage the Department and the Office of the Medicaid Inspector General (OMIG) to take prompt action on the remaining improper payments to prevent any further loss of recoveries.

Auditors also identified 34 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 providers, and the Department removed eight of them from the Medicaid program.

Improper FFS Payments for Inpatient Services Covered by Managed Care

We identified 68 overpayments, totaling $1,655,101, for inpatient claims with service dates between January 1, 2020 and February 2, 2021 where FFS payments were made for recipients with managed care coverage that should have paid for the service. Of these overpayments, 59 were due to retroactive managed care coverage, primarily for newborns. A child born to a mother enrolled in a managed care plan is enrolled in the mother's plan from the child's date of birth. However, the Department does not have a process in place to timely identify and recover improper FFS payments resulting from retroactive updates to a recipient's managed care plan enrollment, including retroactive enrollment of a newborn into their mother's plan. Of the nine remaining overpayments, eight occurred due to providers billing FFS when the recipient had managed care coverage and one was for a graduate medical education (GME) payment the provider erroneously billed. We contacted the

providers for each of the claims we identified, and 53 claims were adjusted, saving Medicaid $1,460,018. However, the remaining 15 claims that overpaid $195,083 still needed to be adjusted.

We also identified 43 overpayments, totaling $1,644,353, for inpatient claims with service dates between April 1, 2015 and January 22, 2021 where providers received two payments for the same service – one FFS and one from the recipient's MCO. We contacted each of the providers and 28 claims were adjusted, saving Medicaid $1,356,215. However, the remaining 15 claims totaling overpayments of $288,138 still needed to be adjusted.

The duplicative payments occurred because the Department does not have sufficient controls in place to prevent providers from receiving FFS and managed care payments for the same service. FFS payments are made by the Department's eMedNY system, while MCOs make managed care payments and report the payments to the Department through a separate system called the Encounter Intake System. A systematic crosswalk between the two systems does not currently exist; therefore, duplicate FFS and managed care payments can occur.

Recommendations

1. Review the $483,221 ($195,083 + $288,138) in overpayments and make recoveries, as appropriate.
2. Develop a process to timely identify and recover improper Medicaid payments for managed care services resulting from retroactive updates to recipients' managed care eligibility.

Incorrect Billing of Alternate Level of Care

Certain levels of care are more intensive and, therefore, more expensive than others. Hospitals are required to 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 20 overpayments, totaling $1,541,898, to five 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 one hospital $269,612 for an inpatient stay of acute care that reportedly lasted 271 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 34 days. The hospital rebilled the claim, which resulted in a savings of $172,811. As a result of our review, 11 of the 20 overpayments were adjusted, saving Medicaid $1,079,718. However, nine claims that were overpaid by $462,180 still needed to be adjusted.

We also identified a billing issue with one provider, which prevented it from receiving payment using the lower ALC per diem rates. Upon our request, the provider reviewed a recipient's inpatient stay and identified dates when the recipient was

in ALC status. However, upon billing Medicaid using the ALC rate code, the claim was denied. According to Department officials, the claim was denied because the recipient's Medicaid coverage type does not include ALC. As such, this provider could not bill for the ALC level of care provided to the recipient, and instead billed the higher rate. Department officials were unaware of this issue until we brought it to their attention, and they were unable to provide a resolution at the time our audit concluded. Of the nine ALC claims we identified that have not been adjusted, seven claims (totaling $318,335) were billed by this provider.

The Department published billing guidance in the July 2019, June 2020, and October 2021 Medicaid Updates reminding hospitals to accurately report the ALC status of a patient when billing Medicaid to ensure appropriate payment. Despite the Department issuing guidance, providers continue to bill claims at the incorrect level of care.

Recommendations

3. Review the $462,180 in overpayments and make recoveries, as appropriate.
4. Work with providers identified in this report to ensure they bill claims at the appropriate level of care, including developing a remedy for the provider unable to bill for ALC services due to the recipient's coverage type.

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 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. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer.

Errors in the amount claimed for coinsurance or in the designation of the primary payer may result in improper Medicaid payments. We identified overpayments, totaling $973,098, for nine claims on which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. We contacted the providers and advised them Medicaid was incorrectly billed as the primary payer. At the conclusion of our audit fieldwork, providers had adjusted six claims, resulting in Medicaid savings of $950,627. However, the remaining three claims overpaid by $22,471 still needed to be adjusted. We also identified overpayments, totaling $167,084, on one claim that resulted from excessive charges for coinsurance for recipients covered by other insurance. We contacted the provider, and the claim was adjusted, saving Medicaid $167,084.

Recommendation

5. Review the $22,471 in overpayments and make recoveries, as appropriate.

Improper Payments for Practitioner, Clinic, Inpatient, and Durable Medical Equipment Claims

We identified $916,063 in overpayments on 234 practitioner claims, 83 clinic claims, five inpatient claims, and three durable medical equipment claims that resulted from errors in billing. At the time our fieldwork concluded, eight claims had been adjusted, saving Medicaid $184,287. However, actions were still required to address the remaining 317 claims with overpayments, totaling $731,776.

The overpayments occurred under the following scenarios:

- Medicaid providers are required to maintain all records for a period of 6 years and to have them readily accessible for audit purposes. We requested records for 10 claims from nine providers who did not respond to our record requests. As a result, we consider the services unsupported. Medicaid paid $652,747 for these unsupported claims, and this amount should be followed up on for recovery.
- Providers are responsible for submitting claims with correct information. We identified $184,216 in overpayments on seven claims in which the providers entered incorrect information on the claims. For example, one provider submitted two claims for the same recipient, with overlapping services on the same date because the recipient had two account numbers in the provider's system. We brought this to the provider's attention, and they acknowledged and corrected the error, saving Medicaid $1,478. At the end of our fieldwork, providers had adjusted all seven claims, saving Medicaid $184,216.
- Providers may be entitled to reimbursement of drug administration charges for drugs obtained at no cost. For correct reimbursement, providers should submit the claim either using modifier code "FB" (for non-psychotropic medication) or an injection-only procedure code (for psychotropic medication) to inform eMedNY that the facility did not pay for the drug, which results in payment for the injection service only. We identified $58,292 in overpayments on 78 claims where Medicaid paid providers for drugs obtained at no cost. These overpayments occurred because providers failed to follow applicable Medicaid policy guidance. All 78 claims still needed to be adjusted.
- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $20,808 in overpayments on 230 claims with service dates between October 29, 2014 and January 13, 2021 where the providers billed more than the acquisition costs for practitioner-administered drugs. One claim was adjusted, saving Medicaid $71. However, the remaining 229 claims overpaid by $20,737 still needed to be adjusted.

Recommendation

6. Review the $731,776 ($652,747 + $58,292 + $20,737) 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. 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 GME claim. Hospitals receive GME payments for care provided to recipients enrolled in MCOs to cover the costs of training residents.

Medicaid overpaid $357,066 for three Supplemental Low Birth Weight Newborn Capitation claims to three 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 payment claim that reported a birth weight of 480 grams. When we brought the claim to the attention of the MCO, they provided the hospital's medical records, which confirmed a birth weight of 3,480 grams. The MCO acknowledged the error and reversed the claim, saving Medicaid $123,092. At the time our fieldwork ended, all three claims had been corrected for a cost savings of $357,066.

Recommendation

7. Formally advise the MCOs and hospitals identified in this audit to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

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 $81,762 for 31 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 six CHHAs that received overpayments, totaling $63,156 (24 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 $18,606 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 six CHHAs a total of $18,606 (seven claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

8. Review the $81,762 ($63,156 + $18,606) in overpayments and make recoveries, as appropriate.

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 disposition for direction on how to proceed with claims processing. The edit status instructs eMedNY to either 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 on March 7, 2020, the Department requested to change the edit disposition status of 13 eMedNY claim edits from “deny” to “pay” or “pay and report.” This was done to allow for continuity of care for Medicaid recipients. However, we found the Department improperly paid $46,193 on 332 claims billed during the COVID-19 emergency but for services rendered between October 29, 2018 to December 31, 2019 (prior to the emergency). Had these claims been adjudicated timely, the

COVID-19 edit changes would not have been in effect and the claims would have been denied.

Recommendation

9. Review the 332 claims totaling $46,193 and make recoveries, as appropriate.

Improper Payments for 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 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 nine CPEP claims for which Medicaid paid $8,835 in excess of permitted limits, as the claims occurred on the same date of service as a psychiatric hospital stay. In May 2019, the Department completed an evolution project to prevent multiple CPEP days of service per episode of care on a single claim. However, according to Office of Mental Health officials, separate efforts are underway to address CPEP claims that overlap with psychiatric inpatient admissions.

Recommendations

10. Review the $8,835 in overpayments and make recoveries, as appropriate.
11. Implement controls to prevent Medicaid payments for CPEP services that occur on the same date of service as a psychiatric hospital stay.

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 34 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 34 providers, 25 had an active status in the Medicaid program and nine providers had an inactive status (i.e., 2 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 34 providers. The Department removed eight of them from the Medicaid program, 19 providers entered into a settlement with the federal government or Attorney General, and OMIG determined no action was necessary on the remaining seven providers.

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 from October 2020 through March 2021, and certain claims going back to October 2014.

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. Based on our audit work, we believe the data obtained was sufficiently reliable for the purposes of this audit. We judgmentally sampled 2,627 claims, totaling $169,204,933, and reviewed them for accuracy and appropriateness. We used a risk-based approach to judgmentally sample different claim types. We selected 100% of the claims submitted after eMedNY system edit controls were changed from "deny" to "pay" in response to COVID-19, and CPEP and EPS claims that did not follow payment rules. (A summary of the sampled claims is presented in the Exhibit.) 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 303 claims in our previous audit, *Medicaid Program: Claims Processing Activity April 1, 2020 Through September 30, 2020* (2020-S-22). As a result, we have included those 303 claims in this audit even though they were made prior to October 1, 2020.

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 could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of Medicaid claims processing activity from October 1, 2020 through March 31, 2021.

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 agreed with many of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to one OMIG comment is included in the report's State Comptroller's Comment, which is embedded in the Department's response.

Within 180 days after 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	2,627	469
Services Billed During COVID-19	332	332
EPS	31	31
CPEP	9	9
Totals	**2,999**	**841**

Agency Comments and State Comptroller's Comment

Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

February 3, 2022

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 2020-S-54 entitled, "Department of Health: Claims Processing Activity October 1, 2020 Through March 31, 2021."

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Frank Walsh
Amir Bassiri
Brett Friedman
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Jill Montag
Brian Kiernan
Timothy Brown
Amber Rohan
Melissa Fiore
Collin Gulczynski
OHIP Audit

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

Department of Health Comments on the Draft Audit Report 2020-S-54 entitled, "Medicaid Program: Claims Processing Activity October 1, 2020 Through March 31, 2021" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2020-S-54 entitled, "Medicaid Program: Claims Processing Activity October 1, 2020 Through March 31, 2021" by the Office of the State Comptroller (OSC).

General Comments:

Audit Findings (page 9)

The Department is heartened that OSC "*concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers",* however, the Department asks that finding be included in the Audit Highlights section (page 1) of the report and the OSC website when the report is posted, to be able to highlight to the reader that the Department satisfied the OSC audit objective.

Objective (page 1):

- *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 from October 1, 2020 through March 31, 2021 and certain claims going back to October 29, 2014.*

The Office of the Medicaid Inspector General (OMIG) recognizes the identified areas of concern by OSC in this audit, as they are recurring in other claims processing audits. In accordance with OMIG's understanding of auditing principles regarding the original scope period of this audit, OMIG is concerned that there are claims that were added by OSC and reflect a period prior to the original scope of the review. Additionally, some identified claims are older than the 6-year lookback period to recover as outlined in State regulations.

State Comptroller's Comment – As we mentioned in our report, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant expanded 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. Additionally, regarding look-back provisions, we strongly encourage the OMIG to take prompt action on the remaining improper payments to prevent any further loss of recoveries.

Recommendation #1:

Review the $483,221 in overpayments and make recoveries, as appropriate.

Response #1:

OMIG performed analysis on the OSC data and 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 #2:

Develop a process to timely identify and recover improper Medicaid payments for managed care services resulting from retroactive updates to recipients' managed care eligibility.

Response #2:

OMIG routinely performs audits of retroactive beneficiary disenrollments. However, based upon the ongoing public health emergency (PHE) and programmatic accommodations that needed to be made in response to the PHE, which align with the OSC scope period, OMIG will be limited as to its audit and recovery efforts to avoid impacting a recipient's ability to access necessary medical care.

OMIG is collaborating with the Department to explore opportunities to help prevent these improper Medicaid payments, including issuing additional guidance to providers and MCOs.

Recommendation #3:

Review the $462,180 in overpayments and make recoveries, as appropriate.

Response #3:

OMIG continuously performs audits of alternate level of care (ALC) 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 #4:

Work with providers identified in this report to ensure they bill claims at the appropriate level of care, including developing a remedy for the provider unable to bill for ALC services due to the recipient's coverage type.

Response #4:

The Department is drafting correspondence to the providers identified by OSC in this audit to reiterate Medicaid program policy and rules for billing for ALC services.

Recommendation #5:

Review the $22,471 in overpayments and make recoveries, as appropriate.

Response #5:

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 #6:

Review the $731,776 ($652,747 + $58,292 + $20,737) in overpayments and make recoveries, as appropriate.

Response #6:

OMIG continuously performs audits of practitioner, clinic, and durable medical equipment 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 #7:

Formally advise the Managed Care Organizations (MCOs) and hospitals identified in this audit 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 $81,762 ($63,156 + $18,606) in overpayments and make recoveries, as appropriate.

Response #8:

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 #9:

Review the 332 claims totaling $46,193 and make recoveries, as appropriate.

Response #9:

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 #10:

Review the $8,835 in overpayments and make recoveries, as appropriate.

Response #10:

The Office of Mental Health (OMH) has reviewed the nine Comprehensive Psychiatric Emergency Program (CPEP) claims identified by OSC and agrees that these claims occurred on the same date of service as a psychiatric inpatient admission. OMH will contact those providers with duplicative claims requesting that they review and void claims as appropriate.

OMIG has 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 #11:

Implement controls to prevent Medicaid payments for CPEP services that occur on the same date of service as a psychiatric hospital stay.

Response #11:

OMH worked with the Department to add the affected CPEP rate codes to Rate Category Code R124. This change went into effect on July 28, 2021 and should prevent CPEP claims from overlapping with rate code 2852 for an inpatient stay.

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 the 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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