Department of Health

Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 2021

Report 2021-S-7 | August 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 April 2021 through September 2021, and certain claims going back to March 2016.

About the Program

The Department administers the State's Medicaid program. The Department's eMedNY computer system processes 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 September 30, 2021, eMedNY processed over 121 million claims, resulting in payments to providers of more than $38 billion. The claims are processed and paid in weekly cycles, which averaged about 4.7 million claims and almost $1.5 billion in payments to providers.

Key Findings

The audit identified over $36.1 million in improper Medicaid payments, as follows:

- $28.5 million was paid for managed care premiums on behalf of enrollees who also had concurrent comprehensive third-party health insurance;
- $3.7 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;
- $1.4 million was paid for claims where Medicaid was incorrectly designated as the primary payer instead of another insurer;
- $847,926 was paid for fee-for-service inpatient claims on behalf of recipients with multiple client identification numbers;
- $714,336 was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $482,074 was paid for practitioner, clinic, inpatient, episodic home health care, and psychiatric claims that did not comply with Medicaid policies, such as billing in excess of permitted limits;
- $354,475 was paid for newborn birth claims that contained inaccurate birth information, such as the newborn's birth weight; and
- $132,108 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 $5.5 million of the improper payments had been recovered.

Auditors also identified seven providers in the Medicaid program 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 the providers from the Medicaid program.

Key Recommendations

We made 18 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

August 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 April 1, 2021 Through September 30, 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

Contents

Glossary of Terms

Term	Description	Identifier
ALC	Alternate Level of Care	*Key Term*
CHHA	Certified Home Health Agency	*Key Term*
CIN	Client Identification Number	*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*
Local Districts	Local Departments of Social Services	*Agency*
MCO	Managed care organization	*Key Term*
MLTC	Managed long-term care	*Key Term*
NYSOH	NY State of Health	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
TPHI	Third-party health insurance	*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. Individuals can enroll in Medicaid through Local Departments of Social Services (Local Districts) or the NY State of Health (NYSOH), the State's online health plan marketplace. 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 September 30, 2021, eMedNY processed over 121 million claims, resulting in payments to providers of more than $38 billion. The claims are processed and paid in weekly cycles, which averaged about 4.7 million claims and almost $1.5 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 September 30, 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 over $36.1 million in improper payments pertaining to: MCO premiums for enrollees with concurrent comprehensive third-party health insurance (TPHI); FFS claims for inpatient services that should have been covered by each recipient's MCO or that were also reimbursed by the MCO; FFS inpatient claims for recipients with multiple client identification numbers that either were paid twice or should have been paid by managed care; 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 where Medicaid was incorrectly designated as the primary payer instead of another insurer; newborn birth claims that contained inaccurate birth information; and other improper clinic, practitioner, inpatient, episodic home health care, and psychiatric claims that did not comply with Medicaid policies.

At the time the audit fieldwork concluded, about $5.5 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $30.6 million and recover funds, as warranted. We note that some overpayments may no longer be recoverable due to regulatory look-back provisions. Therefore, 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 22 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 seven of them from the Medicaid program.

Improper Managed Care Premium Payments for Enrollees With Comprehensive Third-Party Health Insurance

Medicaid recipients may have additional sources of health insurance coverage for medical services (i.e., TPHI). The Department's policy is to exclude Medicaid recipients from enrollment in mainstream managed care when they also have concurrent comprehensive TPHI (TPHI is considered comprehensive if it covers certain types of services, among them: hospital care, physician services, pharmacy, and hospice care). These recipients should instead be enrolled in Medicaid FFS.

In response to the COVID-19 state of emergency, declared under Executive Order 202 on March 7, 2020, the Department paused disenrollment of members with comprehensive TPHI from managed care for the period March 30, 2020 through

February 28, 2021. However, we found problems with the disenrollment process after the pause ended that led to improper managed care premium payments of over $28.5 million between February 28, 2021 and August 31, 2021 (see table).

	Number of Claims	Premium Amount
NYSOH total	54,176	$21,646,835
Non-NYSOH total	11,630	6,890,239
Totals	**65,806**	**$28,537,074**

According to Department procedures, disenrolling managed care enrollees through NYSOH is an automatic process done prospectively at the end of the current month or the end of the following month (based on when TPHI is identified). We found instances where the NYSOH disenrollment process was not done timely. For example, one managed care enrollee's comprehensive TPHI was updated in eMedNY via NYSOH in July 2020. Although the managed care enrollment should have been terminated beginning March 1, 2021 (after the pause was lifted), this recipient's managed care enrollment continued through July 31, 2021. As a result, Medicaid made five improper monthly premium payments totaling $2,089 on behalf of this recipient. Department officials stated they are determining what changes are needed to modify the current process to automatically disenroll members with TPHI from managed care more timely.

Our audit also identified improper premium payments on behalf of non-NYSOH-enrolled recipients (recipients enrolled in Medicaid by Local Districts) who had comprehensive TPHI. According to Department procedures, a query is used each month to identify these members for disenrollment. However, during our audit, Department officials stated that a system change implemented in January 2021 impacted the accuracy of this process and they were working to correct it.

Recommendations

1. Review the $28.5 million in overpayments, make recoveries, and disenroll the members from managed care, as appropriate.

2. Update the disenrollment procedures to ensure accurate and timely disenrollment of recipients with comprehensive TPHI from managed care.

Improper Fee-for-Service Payments for Inpatient Services Covered by Managed Care

We identified 141 overpayments, totaling $3,006,474, for inpatient claims with service dates between July 5, 2019 and May 11, 2021, where FFS payments were made for recipients enrolled in a managed care plan that should have paid for the service. Of these overpayments, 121 were due to retroactive managed care coverage, primarily for newborns. For instance, 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. The remaining 20 overpayments occurred due to providers incorrectly billing FFS when the recipient had managed care coverage. We contacted the providers for each of the claims we identified, and 116 claims were adjusted, saving Medicaid $2,473,997. However, the remaining 25 claims totaling $532,477 still need to be adjusted.

We also identified 42 overpayments, totaling $721,920, for inpatient claims with service dates between March 21, 2016 and March 5, 2021, where providers received two payments for the same service – one FFS and one from the recipient's MCO. 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. We contacted each of the providers and 28 claims were adjusted, saving Medicaid $530,975. However, the remaining 14 claims totaling $190,945 still need to be adjusted.

Recommendation

3. Review the $723,422 ($532,477 + $190,945) in overpayments and make recoveries, as appropriate.

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 designation of the primary payer may result in improper Medicaid payments. We identified overpayments, totaling $1,350,076, for 15 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 nine claims, resulting in Medicaid savings of $1,309,209. However, the remaining six claims overpaid by $40,867 still need to be adjusted.

Recommendations

4. Review the $40,867 in overpayments and make recoveries, as appropriate.

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

Improper Payments for Recipients With Multiple Client Identification Numbers

Individuals have several options for enrolling in Medicaid, including through Local Districts and NYSOH. Local Districts use the State's downstate Welfare Management System (WMS) to process enrollment data for individuals in New York City, and use the upstate WMS for individuals in the rest of the State. Each individual who applies for Medicaid benefits is assigned a client identification number (CIN), a unique identifier. However, recipients may have more than one CIN assigned during the time they are in receipt of benefits. Only one CIN should have active eligibility at a time to prevent duplication of payments. When an individual is assigned multiple CINs, each with its own record of eligibility, Medicaid is at risk of making improper payments for the duplication of benefits.

Prior Office of the State Comptroller audits found that incorrect/missing recipient demographic information and limited access to the multiple eligibility systems during application lead to the improper creation of multiple CINs. Our current audit identified 32 FFS claims totaling overpayments of $847,926 on behalf of 30 recipients with multiple CINs, as follows:

- 14 claims totaling $382,484 with service dates between November 9, 2016 and October 25, 2020 where inpatient claims were billed twice for the same service, for the same recipient using two different CINs; and

- 18 claims totaling $465,442 with service dates between April 3, 2020 and May 24, 2021 where the recipient had multiple CINs (one managed care and one FFS), and claims were paid by FFS that should have been covered by managed care.

After reaching out to each of the providers, eight of the claims were adjusted, saving Medicaid $184,715. However, the remaining 24 claims totaling $663,211 still need to be adjusted at the conclusion of our audit. Additionally, by the end of the audit fieldwork, the Department resolved 25 of the 30 recipients' multiple CINs and five recipients' multiple CINs remained active.

Recommendations

6. Review the $663,211 in improper payments and make recoveries, as appropriate.

7. Ensure all multiple CINs identified in this report have been resolved to prevent future improper payments.

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.

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. We identified 20 overpayments, totaling $714,336, to providers who billed for a higher (and more costly) level of care than what was actually provided to the Medicaid recipients. For example, Medicaid originally paid a hospital $225,030 for an inpatient stay of acute care that lasted 150 days. Upon our inquiry, the hospital acknowledged the recipient was at an acute care level for only 27 days. The hospital rebilled the claim, which resulted in a savings of $140,291. As a result of our review, nine of the 20 claims were adjusted, saving Medicaid $358,715. However, 11 claims that were overpaid by $355,621 still need to be adjusted.

Recommendations

8. Review the $355,621 in overpayments and make recoveries, as appropriate.
9. Advise the providers identified in this report to bill claims at the appropriate level of care.

Improper Payments for Practitioner, Clinic, and Inpatient Claims

We identified $386,685 in overpayments on 128 clinic claims, 10 practitioner claims, and two inpatient claims that resulted from errors in billing. At the time our fieldwork concluded, three claims had been adjusted, saving Medicaid $301,355. However, actions are still required to address the remaining 137 claims with overpayments totaling $85,330.

The overpayments occurred under the following scenarios:

- Providers are responsible for submitting claims with correct information. We identified $299,903 in overpayments on two inpatient claims in which the providers entered incorrect discharge code information on the claims. At the end of our fieldwork, the providers had adjusted both claims, saving Medicaid $299,903.

- Providers may be entitled to reimbursement of drug administration charges for drugs obtained at no cost. For correct reimbursement of certain claims, providers should submit the claim using either 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 $78,533 in overpayments on 125 clinic claims where Medicaid paid providers for drugs obtained at no cost. Of these, 96 claims totaling $69,427 were for one provider. These overpayments occurred because providers failed to follow applicable Medicaid policy guidance. One provider adjusted one claim, saving Medicaid $1,452. However, the remaining 124 claims totaling $77,081 still need to be adjusted.

- Medicaid providers are required to maintain all records for a period of 6 years and have them readily accessible for audit purposes. We requested records for three clinic claims from three providers who did not respond to our records request. As a result, we consider the services unsupported. Medicaid paid $4,997 for the unsupported claims, and this amount should be followed up on for recovery.

- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $3,252 in overpayments on 10 claims where the providers billed more than the acquisition costs for practitioner-administered drugs. All 10 claims still need to be adjusted.

Recommendations

10. Review the $85,330 ($77,081 + $4,997 + $3,252) in overpayments and make recoveries, as appropriate.

11. Work with the provider identified in this report to ensure they are properly billing no-cost drugs.

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 Graduate Medical Education (GME) claim. Hospitals receive GME payments for care provided to Medicaid recipients to cover the costs of training residents.

Medicaid overpaid $354,475 for three Supplemental Low Birth Weight Newborn Capitation claims 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 incorrectly reported a birth weight of 1,054 grams. When we brought the claim to the attention of the MCO, officials stated the payment was billed in error and reversed the claim, saving Medicaid $116,698. At the time our fieldwork ended, all three claims had been corrected, for a cost savings of $354,475.

Recommendation

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

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

Medicaid claims processed in eMedNY are subject to various automated edits that 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 the claim's processing. The edit disposition instructs eMedNY to either pay, deny, or suspend a claim or take other action 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 and effective through June 24, 2021, the Department requested to change the edit disposition 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. As of January 13, 2021, all edits have been changed back to their original status to deny payment with one exception: edit code 01155. According to the Department, it will not change edit 01155's disposition because additional threshold visits for certain services can be authorized by the Local Districts, which is done on a case-by-case basis. However, we found the Department improperly paid $132,108 on 1,966 claims with service dates prior to COVID-19, between April 16, 2019 and December 31, 2019, for edit code 01155. Had these claims been adjudicated timely, the COVID-19 edit change would not have been in effect and the claims would have been denied.

Recommendation

13. Review the 1,966 claims totaling $132,108 and make recoveries, as appropriate.

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 $82,059 for 24 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 from a CHHA 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 12 CHHAs that received overpayments totaling $68,887 (18 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 $13,172 in overpayments to CHHAs that improperly received a full episodic payment for patients admitted to a different CHHA within 60 days of their original 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 five CHHAs $13,172 (six claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

14. Review the $82,059 ($68,887 + $13,172) 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 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 14 CPEP claims for which Medicaid paid $13,330 in excess of the permitted limits:

- $10,044 for 11 CPEP claims on the same date of service as a psychiatric hospital stay.
- $3,286 for three claims where the provider billed multiple days of service per episode of care on different claims.

According to the Department, eMedNY system flaws that allowed these claims to be paid have been corrected to prevent future improper payments.

Recommendations

15. Review the $13,330 in overpayments and make recoveries, as appropriate.
16. Ensure the implemented eMedNY system updates prevent the improper payment of CPEP claims identified in this audit.

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 22 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 22 providers, 21 had an active status in the Medicaid program and one provider 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 22 providers. The Department removed seven of them from the Medicaid program, and OMIG determined no action was necessary on the remaining 15 providers. Based on our review, the Department was not previously aware of these 22 providers. As a result, it appears additional resources could be used by OMIG to identify problematic providers and impose timely and appropriate sanctions. For example, we identified 19 of the 22 providers using one website (Justice.gov).

Recommendations

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

18. Expand the Department's search to include additional resources, such as Justice.gov, to ensure the Department is identifying all providers who are potentially abusing the Medicaid program.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The audit covered the period from April 2021 through September 2021, and certain claims going back to March 2016.

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 2,496 claims, totaling $155,591,796, and reviewed them for accuracy and appropriateness. We used a risk-based approach to judgmentally sample different claim types, including selecting the highest dollar claims and claims identified as a risk area in prior audits. We selected 100% of the claims that did not follow payment rules pertaining to claims that were submitted after eMedNY system edit controls were changed from "deny" to "pay" in response to COVID-19, comprehensive TPHI claims, CPEP claims, and EPS claims. (A summary of the sampled claims is presented in the Exhibit.) The results of our samples cannot be projected to the population.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. 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 April 1, 2021 through September 30, 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 the audit recommendations and indicated that certain actions have been and will be taken to address them.

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
Comprehensive TPHI	65,806	65,806
Various claim types	2,496	393
Services billed during COVID-19	1,966	1,966
EPS	24	24
CPEP	14	14
Totals	**70,306**	**68,203**

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

August 4, 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 2021-S-7 entitled, "Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 2021."

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Frank Walsh
Amir Bassiri
Geza Hrazdina
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Department of Health Comments to Draft Audit Report 2021-S-7 entitled, "Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 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 2021-S-7 entitled, "Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 2021" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $28.5 million in overpayments, make recoveries, and disenroll the members from managed care, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) continuously performs audits of Medicaid payments on behalf of recipients with third-party health insurance (TPHI). 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 #2:

Update the disenrollment procedures to ensure accurate and timely disenrollment of recipients with comprehensive TPHI from managed care.

Response #2:

For Medicaid members not enrolled through the NY State of Health (NYSOH), the Department is aware that the current process of using the MDW to pull data is not as accurate as the process that was in place prior to the January 2021 implementation of the standard Health Insurance Portability and Accountability Act-compliant 834 electronic enrollment transaction for Welfare Management System cases. The MDW process removed certain reports from the Health Commerce System that had previously been used to pull data. The Department is reviewing the current process and looking into other avenues to pull the data for the monthly Disenrollment List to create a more timely and comprehensive monthly disenrollment file for New York Medicaid Choice.

Third Party Liability (TPL) data is transmitted from eMedNY to NYSOH via the Recipient Restriction Exception/TPL service update. The Department opened and completed a system project to address the issues raised by OSC. When the file received indicates that the individual has Medicare coverage the system will re-determine eligibility based on current rules for Medicare coverage and all other programs. If there is a conflict in information between any two sources, back-office staff have the ability to override and update, if necessary. The Department has shared a use case document that explains in detail the modified or new steps taken in

determining the end date for the Medicaid Managed Care coverage, updating the eligibility information and sending the response to NYSOH.

Recommendation #3:

Review the $723,422 ($532,477 + $190,945) in overpayments and make recoveries, as appropriate.

Response #3:

OMIG is performing analysis on the OSC-identified inpatient 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #4:

Review the $40,867 in overpayments and make recoveries, as appropriate.

Response #4:

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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #5:

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

Response #5:

The Department published a Medicaid Update reminder in April 2022 entitled *Reminder to Providers: New York State Medicaid Requires Coordination of Benefits*, which addresses the OSC recommendation. The article can be found in Volume 38 – Number 4: https://health.ny.gov/health_care/medicaid/program/update/2022/no04_2022-04.htm#benefits

Recommendation #6:

Review the $663,211 in improper payments and make recoveries, as appropriate.

Response #6:

OMIG continuously performs audits of multiple client identification numbers (CIN). 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #7:

Ensure all multiple CINs identified in this report have been resolved to prevent future improper payments.

Response #7:

All 14 duplicate CIN pairs identified by OSC as having duplicate fee-for-service (FFS) inpatient claims were identified by the Department through ongoing internal control practices and duplicate coverage was terminated prior to receipt of the audit findings. As of June 30, 2022, the consumers who remain eligible for Medicaid continue to only have one active CIN which will prevent future improper payments.

Of the 16 duplicate CIN pairs OSC identified as having FFS claims paid in addition to managed care claims:

- Ten were identified by the Department through ongoing internal control practices and duplicate coverage was terminated prior to the receipt of the audit findings. As of June 30, 2022, the consumers who remain eligible for Medicaid continue to only have one active CIN which will prevent future improper payments.

- Five were referred for termination of the duplicate coverage.
    - One was terminated as of June 16, 2022
    - One was terminated as of June 17, 2022
    - Two were terminated as of June 30, 2022
    - One will be terminated as of August 31, 2022

- The remaining CIN pair belongs to two discrete individuals (i.e., the CINs are not assigned to the same individual as indicated by OSC). Therefore, the FFS payment and managed care payment are appropriate.

Recommendation #8:

Review the $355,621 in overpayments and make recoveries, as appropriate.

Response #8:

OMIG continuously performs audits of alternate level of care 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #9:

Advise the providers identified in this report to bill claims at the appropriate level of care.

Response #9:

The Department is publishing a Medicaid Update in July 2022. The article formally advises the hospitals to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment and reiterates Medicaid program policy and rules for billing of alternate level of care.

Recommendation #10:

Review the $85,330 ($77,081 + $4,997 + $3,252) in overpayments and make recoveries, as appropriate.

Response #10:

The Department has reviewed the pharmacy claim in question. This claim was reversed on 5/26/21.

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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #11:

Work with the provider identified in this report to ensure they are properly billing no-cost drugs.

Response #11:

The Department is reviewing the recommendation and if warranted, will draft correspondence to the provider identified by OSC in this audit to reiterate Medicaid program policy and rules for billing no-cost drugs.

Recommendation #12:

Formally advise the managed care organizations (MCO) and hospitals identified in this audit to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Response #12:

The Department is 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.

The Department published a Medicaid Update reminder in June 2020 entitled *Billing Guidance for Reporting Newborn Birth Weights*, which addresses the OSC recommendation. The article can be found in Volume 36 - Number 11:
https://www.health.ny.gov/health_care/medicaid/program/update/2020/no11_2020-06.htm#newborn

Recommendation #13:

Review the 1,966 claims totaling $132,108 and make recoveries, as appropriate.

Response #13:

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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #14:

Review the $82,059 ($68,887 + $13,172) in overpayments and make recoveries, as appropriate.

Response #14:

OMIG has Certified Home Health Agency episodic payment audit protocols which address the findings in this OSC report and 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after

submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #15:

Review the $13,330 in overpayments and make recoveries, as appropriate.

Response #15:

The Office of Mental Health (OMH) has reviewed the 11 claims totaling $10,044 for Comprehensive Psychiatric Emergency Program (CPEP) claims on the same date of service as a psychiatric hospital stay and agree with OSC's conclusion. It should be noted that these claims were all for dates of service prior to adding the CPEP rate codes to Rate Category Code R124, which went in to effect on July 28, 2021. OMH will contact those providers with duplicative claims and request that they review and void claims as appropriate. Additionally, regarding the three claims totaling $3,286 where the provider billed multiple days of service per episode of care on different claims, OMH will work with the OMIG to review the claims in question and make any necessary recoveries.

OMIG has CPEP audit protocols which address the findings in this OSC report and 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #16:

Ensure the implemented eMedNY system updates prevent the improper payment of Comprehensive Psychiatric Emergency Program (CPEP) claims identified in this audit.

Response #16:

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. As indicated in our response to recommendation #15, the CPEP claims that were duplicative to a psychiatric hospital stay all occurred prior to the addition of CPEP rate codes to Rate Category Code R124, indicating that this change is now working as intended.

Additionally, OMH's transmittal package was processed and corrected the issues identified (i.e., rate codes that had been mistakenly changed back to "daily" from "monthly") which had previously resulted in some of OSC's identified overpayments. This process is working as intended, with very few exceptions. In this case, there were only three claims totaling $3,286 which occurred prior to the original transmittal on May 6, 2019.

Recommendation #17:

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

Response #17:

OMIG sanctions individuals based on findings of 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 (Sanctions for Unacceptable Practices), 18 NYCRR § 515.7 (Immediate Sanctions), and/or 18 NYCRR § 515.8 (Mandatory Exclusions). OMIG maintains an exclusion list that is updated on the OMIG website, which contains both enrolled providers and non-enrolled persons/entities.

Recommendation #18:

Expand the Department's search to include additional resources, such as Justice.gov, to ensure the Department is identifying all providers who are potentially abusing the Medicaid program.

Response #18:

In January 2022, OMIG implemented changes to the process which resulted in an increase in the scope and frequency of reviews. These reviews were expanded to include reviewing additional federal and district attorney websites, including Justice.gov, to assist in identifying New York health care providers who have either been charged with or convicted of a crime related to health care.

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