New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2016 Through March 31, 2017

Medicaid Program
Department of Health

Report 2016-S-66 December 2017

Executive Summary

Purpose

To determine whether the Department of Health's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The audit covered the period October 1, 2016 through March 31, 2017.

Background

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients, and it generates payments to reimburse the providers for their claims. During the six-month period ended March 31, 2017, eMedNY processed over 192 million claims, resulting in payments to providers of more than $29 billion. The claims are processed and paid in weekly cycles, which averaged over 7.4 million claims and $1.1 billion in payments to providers.

Key Findings

The audit identified approximately $12.4 million in improper Medicaid payments, as follows:

- $4.58 million in overpayments for long-stay inpatient claims that were billed at higher levels of care than what was allowed;
- $2.9 million in overpayments for Comprehensive Psychiatric Emergency Program claims that were billed in excess of permitted limits;
- $1.4 million in overpayments for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $1.1 million in improper inpatient claims for newborns who were not enrolled into managed care in a timely manner;
- $1 million in overpayments for newborn claims that were submitted with incorrect birth weights;
- $705,466 in improper episodic payments to home health care providers;
- $404,227 in overpayments for dental anesthesia claims that were reimbursed excessive amounts due to flaws in the processing and payment of the claims; and
- $274,390 in overpayments for other inpatient, clinic, and durable medical equipment claims.

By the end of the audit fieldwork, about $6.3 million of the overpayments had been recovered.

Auditors also identified providers in the Medicaid program who were charged with or found guilty of crimes that violated health care programs' laws or regulations. The Department terminated 22 of the providers we identified from the Medicaid program, but the status of two providers was still under review at the time our fieldwork was completed.

Key Recommendations

- We made 12 recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claims processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity October 1, 2015 Through March 31, 2016 (2015-S-74)

Department of Health: Medicaid Claims Processing Activity April 1, 2016 Through September 30, 2016 (2016-S-12)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 8, 2017

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for 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 *Medicaid Claims Processing Activity October 1, 2016 Through March 31, 2017*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York State Medicaid program is a federal, state, and locally 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 year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $58 billion. The federal government funded about 55.3 percent of New York's Medicaid claim costs, the State funded about 29.0 percent, and the localities (City of New York and counties) funded the remaining 15.7 percent.

The Department of Health's (Department) Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the six-month period ended March 31, 2017, eMedNY processed over 192 million claims, resulting in payments to providers of more than $29 billion. The claims are processed and paid in weekly cycles, which averaged over 7.4 million claims and $1.1 billion in payments to providers.

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. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller (OSC) performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, our auditors work with Department staff to resolve the exceptions in a timely manner so payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended March 31, 2017, 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.

In addition, we identified the need for improvements in the processing of certain types of claims. We found about $12.4 million in improper payments pertaining to: hospital claims that were billed at a higher level of care than what was actually provided; claims for the Comprehensive Psychiatric Emergency Program paid in excess of the permitted time limits; claims with incorrect information pertaining to other insurance recipients had; inappropriate claims for newborns covered by managed care enrollment due to delays in enrollment; claims with incorrect newborn birth weights; improper episodic home health care payments; improper clinic claims for dental anesthesia; and other improper claims.

At the time the audit fieldwork concluded, about $6.3 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $6.1 million and recover funds as warranted.

Auditors also identified providers in the Medicaid program who were charged with or found guilty of crimes that violate health care programs' laws or regulations. The Department terminated 22 of the providers we identified from the Medicaid program, but the status of two providers was still under review at the time our fieldwork was completed.

Incorrect Billing of Alternate Level of Care

According to the Department's Medicaid inpatient policies, hospitals must indicate a patient's "level of care" on claims to ensure accurate processing and payment. Certain levels of care are more intensive and, therefore, more expensive than others. 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 coordinated with the Department and its contractor, Island Peer Review Organization (IPRO), to evaluate whether certain inpatient claims we identified were appropriately billed. IPRO reviewed a sample of 278 long-stay inpatient claims (psychiatric hospital claims and Diagnosis Related Group [DRG] hospital claims) that had dates of service between April 1, 2013 and March 31, 2015. Based on its review, IPRO concluded that hospitals incorrectly billed 68 (24.5 percent) of the 278 selected hospitals stays. In 58 cases, the hospitals billed days at higher levels of care that should have been billed at lower levels of care. In the remaining 10 cases, hospitals lacked sufficient evidence to support their claims. IPRO determined these claims were overpaid by $4.58 million. At the time our audit fieldwork ended, IPRO recovered nearly $4.34 million of the overpayments, and two claim overpayments totaling approximately $240,000 still needed to be recovered.

Recommendation

1. Review the remaining approximate $240,000 in identified overpayments and make recoveries, as appropriate.

Improper Payments for the Comprehensive Psychiatric Emergency Program

The Comprehensive Psychiatric Emergency Program (CPEP) was established to allow for better care of people needing psychiatric emergency care. CPEP objectives include providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services.

The New York State Office of Mental Health's policy states that the CPEP Medicaid reimbursement rate may be used for the first 24 hours of emergency room (ER) care, after which the patient should be either admitted or released, unless the patient is kept for an extended observation (a separate rate code is used to reimburse for extended observation). The CPEP rate is intended to pay only once per episode of care, so only one payment should be made regardless of the patient's length of stay in the ER. When a patient is admitted to the hospital following a CPEP ER visit on the same day, the inpatient rate is intended to cover all services and no separate CPEP payment should be made.

During the audit period, October 1, 2016 through March 31, 2017, we identified CPEP claims that paid in excess of the permitted limits, including CPEP payments paid for multiple days during the same episode of care and CPEP payments on the same day as an inpatient psychiatric admission. We identified nine claims that overpaid a total of $69,111. We contacted the providers and all nine claims have since been corrected. In one case, a claim covered a 15-day ER stay and the eMedNY system made 15 CPEP payments to the provider.

We expanded the scope of our review to identify other improper payments for CPEP claims with service dates after January 1, 2012. We identified an additional 2,599 claims that overpaid about $2.8 million:

- 2,279 claims totaling $2.56 million in overpayments to providers that received multiple payments for individual CPEP ER episodes of care; and
- 320 claims for CPEP ER visits billed on the same day as a psychiatric admission to the hospital. Since the inpatient rate is inclusive of the ER services, these CPEP claims totaling $269,131 should not have been paid.

The overpayments occurred because the eMedNY system claims processing logic allows one CPEP payment per calendar day instead of per episode of care. When a CPEP ER stay spans two or more days, a separate payment is calculated for each day of service. Additionally, when a provider bills for a CPEP ER visit and a psychiatric inpatient admission on the same day, the system does not recognize the CPEP payment as duplicate. In February 2017, we notified the Department of these weaknesses in the existing claims processing logic.

Recommendations

2. Review the remaining $2.8 million in identified overpayments and make recoveries, as appropriate.

3. Design and implement eMedNY system changes to prevent multiple CPEP payments for individual episodes of care, and to prevent CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, providers must verify whether such recipients have other insurance coverage on the dates of service in question. If the individual has other insurance coverage, that insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the recipient's normal financial obligation, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer and should be billed first.

Errors in the amounts claimed for coinsurance, copayments, or deductibles and/or in the designation of the primary payer will likely result in improper Medicaid payments. We identified such errors on 150 claims that resulted in overpayments totaling about $1.4 million.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $389,829 on 13 claims (for which Medicaid originally paid $542,892) that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and, because of our inquiry, they adjusted seven of the claims, saving Medicaid $190,966. However, the remaining six claims that were overpaid by an estimated $198,863 still needed to be adjusted.

Designation of Primary Payer

We identified 137 claims (for which Medicaid originally paid about $1 million) in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. Generally, primary payers pay more than secondary payers. We contacted the providers and advised them that the recipients had other insurance coverage at the time the services were provided and, therefore, Medicaid was incorrectly designated as the primary payer.

At the time our audit fieldwork concluded, providers had adjusted eight claims, saving Medicaid $632,124. However, the remaining 129 claims that were overpaid by an estimated $372,466 still needed to be adjusted.

Recommendation

4. Review the remaining overpayments totaling $571,329 ($372,466 + $198,863) and make recoveries, as appropriate.

Newborns Covered by Managed Care Enrollment

Medicaid reimburses providers for newborn services using the fee-for-service and managed care payment methods. Under fee-for-service, Medicaid pays providers (such as hospitals) directly for Medicaid-eligible services. Under managed care, Medicaid pays managed care plans (Plans) a fixed monthly capitation payment for each newborn enrolled in the Plan. The Plan, in turn, is responsible for the provision of covered health care services. Plans have networks of participating providers that they reimburse directly for services provided. According to the Department's policy, newborns of women enrolled in Medicaid managed care will be enrolled in the same Plan as their mother from their date of birth. Once enrolled, the Plan is responsible for the provision of care to the newborn and for paying the service providers.

Delays in enrolling newborns into managed care create an environment in which inaccurate payments can occur, including situations where both hospitals and Plans can be paid for the child's birth. We found $1.1 million in inaccurate payments for 13 newborn hospital admissions.

We found that not all newborns who were eligible for managed care enrollment at birth were enrolled timely. We identified seven newborns who should have been enrolled into managed care, but were not. We notified the Department of these cases, and as of the completion of our audit fieldwork, six of the newborns were enrolled into managed care and one still needed to be.

In the seven cases, we determined the amount that Medicaid inappropriately paid under fee-for-service for the first month for each newborn, and compared that with the amount Medicaid would have paid for the newborn if the child had been properly enrolled in managed care at birth. We accounted for additional financial liabilities, such as monthly capitation payments, newborn supplemental payments to the Plans, and Graduate Medical Education (GME) claims (hospitals receive fee-for-service GME payments for care provided to recipients enrolled in Plans to cover the costs of training residents). We estimated that had the seven newborns been enrolled in managed care, Medicaid would have saved about $439,523. At the conclusion of our audit fieldwork, one provider (a hospital) adjusted its claim, saving Medicaid $152,074; however, $287,449 still needed to be recovered.

In the additional six (of the 13) cases, we found that both the hospital and the Plan were paid for the birth of the child, resulting in duplicate payments. In these cases, we considered the hospital's payment to be the payment in error. We identified $675,012 in incorrect payments, of which $245,195 had been recovered and $429,817 still needed to be recovered.

Recommendations

5. Retroactively process the managed care enrollment for the remaining newborn we identified.

6. Review the remaining $717,266 ($287,449 + $429,817) in identified overpayments and make recoveries, as appropriate.

Incorrect Birth Weights on Newborn Birth Claims

As previously stated, under managed care, Medicaid pays Plans a fixed monthly capitation payment for each newborn enrolled in the Plan. In addition to the monthly capitation payments, Medicaid pays Plans a one-time Supplemental Newborn Capitation Payment for the inpatient birthing costs of each newborn enrolled. If, however, a newborn weighs less than 1,200 grams at birth (or approximately 2.64 pounds), Medicaid pays the Plans a one-time Supplemental Low Birth Weight Newborn Capitation Payment for each enrolled newborn. The low birth weight payments are intended to cover the higher cost of care these newborns require.

Medicaid overpaid four Plans $1,037,457 for ten Supplemental Low Birth Weight Newborn Capitation claims paid for newborns weighing more than 1,200 grams. The overpayments generally occurred because hospitals reported inaccurate birth weight information to the Plans or the Plans entered erroneous birth weights on their claims. For example, one hospital's billing department erroneously used a birth weight of 879 grams instead of 3,880 grams. The hospital submitted the incorrect birth weight to the Plan and an incorrect GME claim to Medicaid. After reviewing the GME claim, we noted the diagnoses on the claim were not indicative of a premature low birth weight newborn; rather, they showed this newborn was full term and appeared healthy. The Plan billed Medicaid for a low birth weight claim since it appeared the newborn weighed less than 1,200 grams. Medicaid paid the Plan $109,533 for its claim. However, based on the correct birth weight (3,880 grams), Medicaid should not have paid the Plan for a low birth weight claim.

Four of the ten claims were voided or rebilled by the providers because of our review, saving Medicaid $422,213. However, the remaining six claims that were overpaid by an estimated $615,244 still needed to be adjusted.

Recommendations

7. Review the remaining $615,244 in identified overpayments and make recoveries, as appropriate.

8. Formally advise the hospitals in question to report accurate birth weight information on their claims.

Improper Episodic Payments for Home Care

Effective May 1, 2012, the Department implemented the Episodic Payment System (EPS) to reimburse Certified Home Health Agencies (CHHAs) for health care services provided to Medicaid recipients in the home. The EPS is based on 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). Payment for a partial episode may be pro-rated based on the number of days of care on the claim. For the period October 1, 2016 through March 31, 2017, we determined Medicaid overpaid 48 CHHAs a total of $705,466 under the EPS.

Transfer to 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 managed long term care (MLTC) plan within 60 days of the recipient's episode start date. All MLTC plans provide Medicaid home care and other long term care services. Therefore, a Medicaid capitation payment to an MLTC plan and a full episodic payment to a CHHA for the same recipient during overlapping service dates is duplicative. From October 1, 2016 through March 31, 2017, 32 CHHAs received Medicaid overpayments totaling $435,860 (189 claims) for recipients discharged from a CHHA to an MLTC plan. In each instance, the CHHAs submitted a claim with an incorrect discharge code, causing a full episode payment instead of the appropriate partial pro-rated episode payment.

Multiple Episodic Payments Within 60 Days

From October 1, 2016 through March 31, 2017, we also identified $269,606 in overpayments to 42 CHHAs that improperly received duplicate full payments for patients who were readmitted within 60 days of their original episode start date. These overpayments occurred because the CHHAs did not follow the Department's billing guidelines for the EPS. Specifically, we identified 111 claims totaling $207,603 paid to 25 CHHAs that billed multiple episodes of services for the same recipient within 60 days of the recipient's original episode start date. Each CHHA should have submitted an adjustment claim to include all services within 60 days of the first episode start date, and then a second (pro-rated) claim for the remaining service dates after the 60-day episode. We also identified overpayments for recipients discharged from one CHHA and admitted to a different CHHA within 60 days of the first episode start date. Department guidelines require the first CHHA to adjust the original claim and submit for a partial pro-rated payment; however, we found this was not always done. As a result, Medicaid overpaid 26 claims to 17 CHHAs totaling $62,003 for services provided to recipients who subsequently received additional services from a different CHHA within 60 days of the first episode.

As a result of OSC's prior audit work, on March 1, 2017, the Department issued a letter to CHHAs. The letter explained the overpayment scenarios identified in our audits, directed CHHAs to review the existing billing guidelines, and encouraged CHHAs to review their billing systems to ensure compliance.

Recommendation

9. Review the $705,466 in improper payments made to the CHHAs and recover overpayments, as appropriate.

Incorrect APG Reimbursement Methodology for Dental Anesthesia

The Ambulatory Patient Groups (APG) reimbursement methodology is used to pay most medical outpatient services. It reimburses based on patient condition and severity of the medical condition, and is designed to reimburse medical services requiring a higher level of professional care a higher amount than those requiring lower levels of care. The APG Procedure Based Weight file is used to determine the level of care for certain procedures. The file contains Service Intensity Weights (SIW) that indicate the complexity of the service being performed – the greater the weight, the greater the payment. Therefore, errors in this file can cause inaccurate Medicaid payments.

We identified errors in the SIW file for two dental anesthesia procedure codes (D9223, D9243). Both codes are used to bill sedation in 15-minute increments. For the period January 1, 2016 through June 30, 2016, both of these procedures had a SIW of 5.6506. However, since the procedures are for 15 minutes (quarter of an hour), the APG system should have taken the original weight of 5.6506 and divided it by 4 to arrive at the weight for each 15 minutes. Based on the incorrect weights, each claim paid four times the actual allowed weight for the procedure.

We contacted Department officials, who agreed that the weight of 5.6506 was incorrect and should have been 1.413 (5.6506 ÷ 4) instead. This error resulted in $404,227 in incorrect payments for 657 claims during the period January 1, 2016 through June 30, 2016.

The Department corrected the error for claims paid after June 30, 2016, and planned on recovering overpayments on the identified claims paid in error. However, at the time our audit fieldwork ended, the Department had not corrected the claims paid in error.

Recommendation

10. Review the unresolved overpayments on the 657 claims totaling $404,227 and make recoveries, as appropriate.

Improper Payments for Inpatient, Clinic, and DME Claims

We identified $274,390 in overpayments that resulted from excessive charges on inpatient, clinic, and durable medical equipment (DME) claims. At the time our audit fieldwork concluded, $224,695 of the overpayments had been recovered. However, actions were still required to address the balance of the overpayments totaling $49,695.

The overpayments occurred under the following scenarios:

- A hospital's adjustment to a previously paid claim resulted in an increased payment. Upon our request, the hospital reviewed the claim and identified a coding error that caused the increase. The hospital corrected the claim, saving Medicaid $166,301.
- Medicaid made a fee-for-service payment to a hospital for $187,659. We determined this claim was an adjustment to a previously paid claim of $138,142, which had a different DRG code. We asked the hospital to review the two claims to confirm that the change in the DRG was warranted. At the time our audit fieldwork ended, the hospital was unable to provide documentation to support the appropriateness of the increased payment of $49,517 ($187,659 - $138,142).
- A hospital billed two inpatient claims for a recipient using two different provider IDs. When the provider was contacted and questioned, the provider voided the first claim, stating that the two claims should have been combined into one full DRG. Voiding the incorrect claim resulted in a savings of $44,195.
- One provider submitted a clinic claim for a pacemaker two days in a row. Upon our inquiry, the provider realized the claim was erroneously billed. The provider voided the claim, saving Medicaid $14,199.
- One provider submitted a claim for a speech-generating device (SGD) and related accessories. Medicaid paid $8,516 for this claim. The reimbursement for the accessories included an added option of pictures/symbols for speech generation even though all necessary software is already included in the SGD reimbursement. The claim was overpaid by $178.

Recommendation

11. Review the unresolved overpayments totaling $49,695 ($49,517 + $178) and make recoveries, as appropriate.

Status of Providers Who Abuse the Program

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 24 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. In addition, we identified four providers who were involved in a civil settlement. Of the 28 providers, 25 had an active status in the Medicaid program. Three providers had an inactive status (i.e., two or more years of no claims activity and, therefore, they would be required to seek reinstatement from Medicaid to submit new claims). We advised Department officials of all 28 providers and the Department terminated 22 of them

from the Medicaid program and determined there was no basis to exclude the four providers involved in a civil settlement. The Department still needed to resolve the program status of the remaining two providers.

Recommendation

12. Determine the status of the remaining two providers relating to their future participation in the Medicaid program.

Audit Scope, Objectives, and Methodology

We audited selected Medicaid claims processed by the Department 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 scope of our audit was from October 1, 2016 through March 31, 2017. Additionally, claims and transactions outside of the audit scope period were examined in instances where we observed a pattern of problems and high risk of overpayment. The expanded audit periods are noted in the applicable sections of this report.

To accomplish our audit objectives and evaluate the relevant internal controls, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments, and tested the operation of certain system controls. We interviewed officials from the Department, CSRA (the Department's Medicaid fiscal agent), and the Office of the Medicaid Inspector General. We 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. Our audit steps reflect a risk-based approach, taking into consideration the time constraints of the weekly cycle and the materiality of payments.

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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials generally agreed with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to certain Department comments is included in the report's State Comptroller's Comment.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews, and evaluations of New York State and New York City taxpayer-financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

November 20, 2017

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
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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 2016-S-66 entitled, "Medicaid Claims Processing Activity October 1, 2016 through March 31, 2017."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2016-S-66 entitled,
Medicaid Claims Processing Activity
October 1, 2016 Through March 31, 2017

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-66 entitled, "Medicaid Claims Processing Activity October 1, 2016 Through March 31, 2017."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1

Review the remaining approximate $240,000 in identified overpayments and make recoveries, as appropriate.

Response #1

The two remaining claims in question from this audit are Third Party Liability (TPL) claims that are both billed to Medicare. Once the Medicare benefit is exhausted, the claims are billed to Medicaid. The claims, as submitted by the respective providers, did not reflect the Medicare payments. After review of these claims by the Island Peer Review Organization (IPRO), the Department, and the eMedNY claims processing team at CSRA (the Department's Medicaid fiscal agent), it was determined that Third Party Payer factors are preventing IPRO from successfully adjusting these claims through IPRO's electronic reconciliation process. The Department has directed IPRO to send letters to both providers requesting that the claims be resubmitted to include the Medicare TPL payment information. Once the revised claims with this information are processed by eMedNY, and IPRO has the revised the Medicaid payment amount, decisions will be made regarding whether there are Medicaid payments that should be recouped.

Recommendation #2

Review the remaining $2.8 million in identified overpayments and make recoveries, as appropriate.

Response #2

OMIG's Recovery Audit Contractor (RAC) has reviewed the identified overpayments, and is in the process of pursuing recovery of any payment determined to be inappropriate.

Recommendation #3

Design and implement eMedNY system changes to prevent multiple CPEP payments for individual episodes of care, and to prevent CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Response #3

The Office of Mental Health (OMH) is aware of the issue and has been working internally to review, and consider updating, regulations, billing practices, and provider guidance surrounding the Comprehensive Psychiatric Emergency Program (CPEP). OMH has been working with the Department and its policy area, to update the eMedNY system to prevent this issue from happening in the future.

Recommendation #4

Review the remaining overpayments totaling $571,329 ($372,466 + $198,863) and make recoveries, as appropriate.

Response #4

OMIG's RAC has recovered $383,847, and will continue to pursue recovery of any payment determined to be inappropriate.

Recommendation #5

Retroactively process the managed care enrollment for the remaining newborn we identified.

Response #5

The Department has reviewed the enrollment history on the remaining newborn identified in this audit. Its review has determined that the newborn was retroactively enrolled into Fidelis on August 16, 2016 back to month of birth, prior to the opening conference on this audit. The newborn's enrollment was deleted on February 1, 2017, for a reason unknown to the Department. The Department is in the process of researching the reason for the deletion of the enrollment before it can take further action.

Recommendation #6

Review the remaining $717,266 ($287,449 + $429,817) in identified overpayments and make recoveries, as appropriate.

Response #6

As part of its routine audit efforts, OMIG will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #7

Review the remaining $615,244 in identified overpayments and make recoveries, as appropriate.

Response #7

OMIG has recovered $416,717, and will continue to pursue recovery of any payment determined to be inappropriate.

Recommendation #8

Formally advise the hospitals in question to report accurate birth weight information on their claims.

Response #8

CSRA notified the Department in a transmittal dated September 20, 2017 that the specific providers identified in this audit were educated in the various proper billing procedures identified in the audit findings.

The Department has also issued a Medicaid Update article that can be found at:
http://www.health.ny.gov/health_care/medicaid/program/update/2015/sept15_mu.pdf.

This update reminds all providers on the proper reporting of the birth weight of newborns on inpatient claims billed to Medicaid Fee-for-Service, as well as Medicaid managed care plans. The article above includes a link to the billing guidelines in the provider manual.

Recommendation #9

Review the $705,466 in improper payments made to the CHHAs and recover overpayments, as appropriate.

Response #9

OMIG extracted its own data, performed analysis, and is pursuing recovery of any payment determined to be inappropriate.

Recommendation #10

Review the unresolved overpayments on the 657 claims totaling $404,227 and make recoveries, as appropriate.

Response #10

The Department has corrected the weighting error on the Procedure Based Weight file for the two dental anesthesia procedure codes (D9223 and D9243) for Ambulatory Patient Groups (APGs) for the period January 1, 2016 through June 30, 2016.

In the preliminary report provided by OSC, OSC identified errors in the Service Intensity Weight file for two dental anesthesia codes for APGs institutional claims for the period January 1, 2016 through June 30, 2016. This file identified 657 claims totaling $404,227 for this period. The Department stated in the preliminary response that the weighting for these claims would be adjusted retroactively to January 1, 2016.

The Department previously adjusted the APG Grouper on July 2016 for prospectively paid claims. No retroactive adjustments were made for claims submitted between January 2016 and June 2016. A subsequent APG change was made in January 2017, to price claims correctly for the period January 2016 through June 2016. However, previously paid claims for this period were not retroactively adjusted. The Department has requested that CSRA reprocess the previously paid claims for this six-month period to recoup any potential overpayments made to providers. Once these claims have been reprocessed, providers will likely review the medical records and readjust some of these claims by reporting the actual total units of anesthesia provided, resulting in a decrease in the projected savings identified by OSC.

* Comment 1

Recommendation #11

Review the unresolved overpayments totaling $49,695 ($49,517 + $178) and make recoveries, as appropriate.

Response #11

OMIG will review the unresolved overpayments and recover any payment determined to be inappropriate.

Recommendation #12

Determine the status of the remaining two providers relating to their future participation in the Medicaid program.

Response #12

OMIG is currently reviewing the remaining two providers.

* See State Comptroller's Comment, page 23.

State Comptroller's Comment

1. We are pleased the Department corrected the errors on its Procedure Based Weight file. However, the Department surmises that, as a consequence of the needed corrections, providers will resubmit some of their previously paid claims based on their re-examininations of the medical records and change the actual units of anesthesia supplied on those adjusted claims. The Department states this will result in a decrease in the savings we identified. We note that the Department did not provide any basis or reason why the affected providers would change the units of anesthesia they originally reported based on a re-review of their medical records (the providers' medical records should have supported their originally submitted Medicaid claims). Furthermore, the Department should be suspicious of any claims that are, in fact, readjusted and submitted to Medicaid with higher units of anesthesia. Therefore, we believe the $404,227 we identified is accurate.