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

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2017 Through September 30, 2017

Medicaid Program
Department of Health

Report 2017-S-23 August 2018

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 April 1, 2017 through September 30, 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 September 30, 2017, eMedNY processed over 193 million claims, resulting in payments to providers of more than $31 billion. The claims are processed and paid in weekly cycles, which averaged over 7.4 million claims and $1.2 billion in payments to providers.

Key Findings

The audit identified approximately $10.2 million in improper Medicaid payments, as follows:

- $3.7 million in overpayments for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $3.1 million in overpayments for claims involving Medicare coverage that eMedNY incorrectly processed;
- $1.3 million in overpayments for improper newborn birth claims;
- $783,016 in improper fee-for-service claims for Medicaid recipients who were enrolled in a managed care plan;
- $684,457 in overpayments for Comprehensive Psychiatric Emergency Program claims that were billed in excess of permitted limits;
- $465,257 in improper episodic payments to home health care providers; and
- $172,052 in other overpayments for inpatient, clinic, practitioner, and referred ambulatory claims.

By the end of the audit fieldwork, about $4.5 million of the overpayments were 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 42 of 51 providers we identified. Prior to being terminated from the Medicaid program, eMedNY paid five of the providers a total of $292,681 from the date they were charged with a crime to their termination date. The Department should assess whether these payments should be recovered.

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 April 1, 2016 Through September 30, 2016 (2016-S-12)

Department of Health: Medicaid Claims Processing Activity October 1, 2016 Through March 31, 2017 (2016-S-66)

State of New York
Office of the State Comptroller

Division of State Government Accountability

August 3, 2018

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 April 1, 2017 Through September 30, 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

Table of Contents

State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.ny.gov
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

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 State fiscal 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 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 September 30, 2017, eMedNY processed over 193 million claims, resulting in payments to providers of more than $31 billion. The claims are processed and paid in weekly cycles, which averaged over 7.4 million claims and $1.2 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.

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

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

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 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 $10.2 million in improper payments pertaining to: claims that were billed with incorrect information related to other insurance that recipients had, such as Medicaid claims involving Medicare coverage; incorrect newborn birth claims; inappropriate fee-for-service payments when the recipient had managed care; claims for the Comprehensive Psychiatric Emergency Program; improper episodic home health care payments; and other improper claims.

At the time the audit fieldwork concluded, about $4.5 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $5.7 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 42 of the providers we identified from the Medicaid program, but the status of six other providers was still under review at the time our fieldwork was completed. Prior to program termination, Medicaid paid 5 of the 42 providers a total of $292,681 from the date they were charged with a crime to their termination date. Department officials should determine the appropriateness of these payments.

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 recipient has other insurance coverage, the other insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the recipient's normal financial obligation, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer. However, Medicaid should not pay a claim when that claim was rejected or disallowed by Medicare based on the service not being medically necessary.

Errors in the amounts claimed for coinsurance, copayments, or deductibles and/or in the designation of the primary payer result in improper Medicaid payments. We identified such errors on 116 claims that resulted in overpayments totaling about $3.7 million. Providers adjusted 87 claims (75 percent), resulting in Medicaid savings of about $3 million.

Designation of Primary Payer

We identified overpayments totaling $2,952,150 on 77 claims in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. Typically, primary payers pay more than secondary payers do. 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 billed as the primary payer. At the time our audit fieldwork concluded, providers had adjusted 58 claims, saving Medicaid $2,480,353. However, the remaining 19 claims that were overpaid by an estimated $471,797 still needed to be adjusted.

Improper Payment of Claims Determined to Be Not Medically Necessary

The Department has issued a general policy covering all providers, directing that when Medicare determines a claimed service is not medically necessary, Medicaid should not pay for the service. We identified 33 claims that were overpaid by $666,570 because the service provided did not meet Medicare's level of medical necessity. In each instance, the provider-supplied information (e.g., explanation of medical benefits, denial letters) showed the claims did not meet Medicare's level of medical necessity. For example, one Medicare denial letter stated that a hospital admission was denied because the patient did not have a medical condition that would necessitate a hospital stay. At the end of our fieldwork, providers had adjusted 23 claims, saving Medicaid $395,452. However, overpayments for the remaining ten claims, totaling $271,118, still needed to be recovered.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $74,342 on six claims that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and they adjusted all of the claims, saving Medicaid $74,342.

Recommendations

1. Review the $742,915 ($471,797 + $271,118) in overpayments and recover, as appropriate.

2. Routinely review high-risk claims with Medicare involvement that indicate no Medicare payment to determine if services were not medically necessary and, therefore, not reimbursable.

Incorrect eMedNY Claim Adjustment Reason Code Mapping

In December 2009, the Department implemented the Medicare/Medicaid claim crossover system. Under this system, providers submit medical claims for dual-enrolled individuals to Medicare. After Medicare processes the claims, they are electronically transferred to eMedNY for payment of Medicare deductibles, coinsurance, and copayments. However, in certain circumstances, providers are allowed to avoid this system and self-report to eMedNY the deductible, coinsurance, and copayment amounts that Medicaid should pay (referred to as "direct bill").

Medicare and other insurance providers use universal Claim Adjustment Reason Codes (CARCs) to inform medical providers why a claim was denied or paid differently than it was originally billed. Group codes, which further describe adjustment amounts, are used as well. CARC information and group codes are reported to eMedNY through the Medicare/Medicaid claim crossover system. Additionally, when providers direct bill Medicaid for recipients' remaining financial obligation (e.g., deductible, coinsurance), they are required to report CARCs as well as group codes on their claims. The CARCs and group codes are essential for Medicaid to determine whether a billed service should be paid as well as the correct payment amount. eMedNY interprets and "maps" a claim's CARC and group codes to take certain actions (e.g., to pay or to not pay).

Generally, Medicaid should not pay claims that Medicare has denied. Medicaid's provider manual specifically states that Medicaid will not pay for claims Medicare deems not medically necessary. However, eMedNY made overpayments totaling $3,133,608 for 44,329 claims that Medicare denied. We identified three CARC codes (B22, 151, 50) that were incorrectly mapped within eMedNY.

CARC B22 and 151

A CARC code of B22 means the payment was adjusted based on the diagnosis, and a CARC code of 151 means that the payment was adjusted because the payer deemed that the information provided did not support the frequency of services. For claims processed by eMedNY for the period January 1, 2013 to October 14, 2017, we identified 44,265 claims with overpayments of $2,446,139 involving a CARC code of either B22 or 151. In nearly all the instances, the CARC information was directly reported to eMedNY through the Medicare/Medicaid claim crossover system. Medicare determined the providers' claims to be ineligible for reimbursement, but since eMedNY was inappropriately mapped, these claims were allowed to be paid anyway. We notified Department officials of the incorrect mapping, and they corrected the eMedNY system in October 2017. During the course of our audit, officials stated that they are evaluating ways to recover these overpayments.

CARC 50

A CARC code of 50 means the payment was denied because the service was deemed not medically necessary. For the period January 1, 2017 to December 31, 2017, we identified 64 claims, totaling $687,469, that eMedNY allowed to be paid even though the providers reported a CARC 50 denial on their direct bill claim submission to eMedNY. These payments were allowed because of the existing inappropriate mapping for this CARC code. We notified Department officials of the incorrect mapping, and reminded them of its policy that Medicaid will not pay for claims deemed by Medicare to be not medically necessary. Despite the policy, Department officials disagree with changing eMedNY's mapping for CARC 50 because they believe providers may not be reporting it correctly. We determined that one provider accounted for 48 of the 64 claims (75 percent), which represented $469,164 of the $687,469 in overpayments. To address the Department's concern over the accuracy of the reported CARC information, we contacted the one provider and requested supporting documentation for 20 claims to verify that the reported CARC code was properly reported. The provider supplied us with Medicare denial letters to support that 16 of the

claims were denied by Medicare for medical necessity. For example, one Medicare denial letter stated that a hospital admission claim was denied payment because the patient did not meet medical criteria for inpatient admission. For the remaining four claims, the provider supplied us with Medicare's explanation of benefits, which showed the provider received payment after our fieldwork had ended. This information was shared with Department officials to assist them in evaluating the appropriate mapping for CARC 50.

Recommendations

3. Review the $3,133,608 in overpayments and make recoveries, as appropriate.

4. Evaluate eMedNY's current claims processing rules to ensure the Department's existing policy in regard to reimbursement of CARC 50 claims is followed.

Incorrect Newborn Birth Claims Involving Managed Care

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 and payment of covered health care services. 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. The low birth weight payments are intended to cover the higher cost of care these newborns require. In addition to the supplemental payment to the Plans, there is also a fee-for-service Graduate Medical Education (GME) claim (hospitals receive fee-for-service GME payments for care provided to recipients enrolled in Plans to cover the costs of training residents).

Medicaid overpaid $1,266,580 for 11 Supplemental Low Birth Weight Newborn Capitation claims and one fee-for-service hospital claim that covered the same period as the Supplemental Low Birth Weight Newborn Capitation claim. These overpayments generally occurred because hospitals reported inaccurate birth information (e.g., birth weight) to the Plans, or the cost of the newborn's birth was previously reimbursed under another claim. For example, in one instance, a Plan submitted a claim for a low birth weight payment and erroneously reported a birth weight of 428 grams instead of 2,855 grams. After reviewing the fee-for-service hospital GME claim, we noted the short length of stay was not indicative of a premature low birth weight newborn, and further found that the hospital reported a birth weight of 2,855 grams on the newborn's inpatient GME claim. We contacted the Plan about the discrepancy and the Plan corrected its claim. Medicaid originally paid the Plan $108,385 for its claim. However, based on the correct weight (2,855 grams), Medicaid paid the Plan only $4,399, saving Medicaid $103,986. At the time our fieldwork ended, 11 of the 12 claims were corrected for a cost savings of $1,158,188. However, one claim with an estimated cost savings of $108,392 still needed to be recovered.

Recommendation

5. Review the one claim that overpaid $108,392 and make recoveries, as appropriate.

Improper Fee-for-Service Payments Covered by Managed Care

We identified 55 fee-for-service claims totaling $783,016 that were paid even though the member was enrolled in a Plan, which should have paid for the service. The claims were paid either because the members were not enrolled into managed care timely, or the members were disenrolled from managed care using an end date other than the last day of the month. As a result of our review, 16 of the 55 claims were adjusted, saving Medicaid $355,016. However, 39 claims still have to be adjusted for an estimated cost savings of $428,000.

Retroactive Enrollment

We found that Medicaid overpaid $425,524 for 26 fee-for-service claims to five hospitals for service dates ranging from May 30, 2015 to May 15, 2017. In each case, Medicaid made a fee-for-service payment to a hospital and a capitation payment to a Plan. The inappropriate payments occurred primarily because Medicaid eligibility files were not updated with managed care enrollment information in a timely manner. As a result, eMedNY system edits did not deny the improper fee-for-service payments. At the time our audit fieldwork concluded, the hospitals had adjusted 16 claims, saving Medicaid $355,016. However, the remaining ten claims, totaling $70,508, were still in the process of being corrected.

Disenrollment Before the End of the Month

Since Plans are reimbursed a monthly premium, the expectation is that the member should be enrolled for a full month. However, under certain circumstances (e.g., incarceration, death), it is appropriate to end a member's managed care coverage before the end of the month. Outside of these circumstances, when a member is disenrolled from managed care before the end of the month, a situation arises that allows fee-for-service claims to be paid inappropriately from the date of disenrollment until the end of the month.

We identified $357,492 for 29 hospital fee-for-service claims that were inappropriately paid because members were disenrolled from a Plan before the end of the month. For example, a member was disenrolled from managed care effective December 2, 2016, with the Plan receiving a monthly premium payment for December 2016. The member then went into the hospital on December 21, 2016, and the hospital was paid about $75,000 under fee-for-service. eMedNY paid this claim because the service date was after the managed care disenrollment date of December 2, 2016. If the member had been disenrolled at the end of the month (December 31, 2016), eMedNY would have rejected the claim and notified the hospital that it should have billed the Plan.

Recommendation

6. Review the $428,000 ($70,508 + $357,492) 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 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.

For the period January 1, 2012 through September 30, 2017, we identified 645 CPEP claims for which Medicaid paid $684,457 in excess of the permitted limits:

- $623,572 for 586 claims that contained multiple CPEP days of service per episode of care on a single claim.
- $56,419 for 53 claims where the provider billed multiple days of service per episode of care on different claims.
- $4,466 for six CPEP claims on the same date of service as a psychiatric hospital stay.

The overpayments occurred because the eMedNY 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 a duplicate. The Department is working on a project to prevent these types of overpayments. However, the Department has not established a completion date for this project. Therefore, overpayments will continue to occur until the Department can strengthen claims processing controls.

Recommendations

7. Review the $684,457 in overpayments and make recoveries, as appropriate.

8. Ensure the planned eMedNY system change prevents multiple CPEP payments for an individual episode of care, and prevents CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Improper Episodic Payments for Home Care

Certified Home Health Agency (CHHA) providers receive payments under the Episodic Payment System (EPS) to provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care in the home. The payment is based on a price for 60-day episodes of care. CHHAs can be paid for a full episode (when the episode of care is 60 days) or for a partial episode (when the episode of care is less than 60 days). Payments for a partial episode may be pro-rated based on the number of days of care (full payments may occur in certain circumstances, such as when the patient is transferred to a hospital or hospice, or in cases of death). We found Medicaid overpaid $465,257 in episodic home health care payments.

Managed Long Term Care

According to the EPS billing guidelines, a CHHA should receive a partial pro-rated episodic payment when a recipient is discharged to a managed long term care (MLTC) plan. All MLTC plans provide Medicaid home care and other community services. Therefore, a Medicaid capitation payment to a MLTC plan and a full episodic payment to a CHHA for the same recipient and overlapping service dates are duplicative. For claims processed by eMedNY for the period April 1, 2017 to October 31, 2017, 29 CHHAs received Medicaid overpayments totaling $229,174 (115 claims) for recipients discharged from a CHHA to a MLTC plan. In each instance, the CHHAs submitted a claim with an incorrect discharge code (that did not indicate the patient was discharged to a MLTC plan), causing a full episodic payment instead of the appropriate partial pro-rated episodic payment.

Multiple Episodic Payments Within 60 Days

We also identified $236,083 in overpayments, for 134 claims processed during the period April 1, 2017 through October 31, 2017, to CHHAs that improperly received a full payment for patients readmitted within 60 days of their original episode start date.

- Many of the overpayments we identified occurred when a Medicaid recipient had multiple episodes with the same provider. In these scenarios, the CHHA should have submitted an adjustment claim to include all services within 60 days of the first episode start date and a second claim for a partial pro-rated payment. These improper claims (104 claims) resulted in Medicaid overpayments of $171,047 to 22 CHHAs.
- 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 14 CHHAs $65,036 (30 claims) for services provided to recipients admitted to a different CHHA within 60 days of their first episode.

Recommendation

9. Review the $465,257 ($229,174 + $171,047 + $65,036) in improper payments made to CHHAs that we identified and recover overpayments, as appropriate.

Improper Payments for Inpatient, Clinic, Practitioner, and Referred Ambulatory Claims

We identified $172,052 in overpayments resulting from errors in billing related to inpatient, clinic, practitioner, and referred ambulatory claims. At the time our audit fieldwork concluded, $19,489 of the overpayments had been recovered. However, actions are still required to address the balance of the overpayments totaling $152,563.

The overpayments occurred under the following scenarios:

- Three hospitals submitted claims with incorrect birth weights, resulting in Medicaid overpayments of $102,578. For example, one hospital billed a claim for a newborn with a birth weight of 390 grams. However, our review of related birth records determined the infant weighed 3,100 grams. The hospital had not adjusted its claim at the end of fieldwork. Medicaid will save $91,829 once this claim is adjusted.
- A clinic incorrectly reported the price of chemotherapy drugs it obtained free from a manufacturer on seven claims. Medicaid incorrectly paid $47,244 for these claims. At the time our fieldwork ended, the provider had not corrected the claims, and the $47,244 still needed to be recovered.
- Providers incorrectly coded three claims, resulting in Medicaid overpayments of $8,546. Upon our inquiry, the providers corrected two of the three claims, resulting in a Medicaid cost savings of $5,148. The third claim was submitted by a clinic for a patient's dialysis at its facility. We determined the dialysis was actually performed in the patient's home. The clinic's incorrect coding of the service location resulted in Medicaid overpaying $3,398. At the end of our audit fieldwork, the provider had not corrected the claim, and $3,398 still needed to be recovered.
- Two providers failed to use the correct modifier for drugs administered at a clinic. As a result, the two claims were overpaid by $5,835. One provider corrected its claim for a cost savings of $3,350. At the time our fieldwork ended, the other provider had not corrected its claim that was overpaid by $2,485, and this amount should be recovered from the provider.
- Medicaid providers are required to maintain all records for a period of six years and to have them readily accessible for audit purposes. We requested records for two claims from two different providers who did not respond to our record request. The unsupported payments related to a practitioner who received a payment of $3,857 and a hospital that was paid $234 for a referred ambulatory service. By the end of our audit fieldwork, the providers had not yet corrected any of the claims, which would save Medicaid $4,091.
- We found two claims that duplicated the charges already submitted. In both instances, the providers corrected the issue, saving Medicaid $2,551.

- We concluded that Medicaid overpaid $1,207 for a claim to a hospital for a live birth that should not have been paid. The $1,207 should be recovered from the provider.

Recommendation

10. Review the $152,563 in overpayments 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 49 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 two providers who were involved in a civil settlement. Of the 51 providers, 49 had an active status in the Medicaid program. The remaining two providers had an inactive status (i.e., two or more years of no claims activity and, therefore, would be required to seek reinstatement from Medicaid to submit new claims). We advised Department officials of the 51 providers and the Department terminated 42 of them from the Medicaid program. Prior to being terminated from the Medicaid program, eMedNY paid 5 of the 42 providers a total of $292,681 from the date they were charged with a crime to their termination date. Also, the Department determined that three of the providers should not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the six remaining providers.

Recommendations

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

12. Determine the appropriateness of the $292,681 received by the five terminated providers and recover improper payments, as warranted.

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 April 1, 2017 through September 30, 2017. In some instances, we observed a pattern of problems and high risk of overpayment and, therefore, examined claims and transactions outside of the audit scope period. For those instances where our findings include claims and transactions prior to April 1, 2017 or subsequent to September 30, 2017, we have noted the period covered as part of our discussion of the findings in the body of this report.

To accomplish our audit objectives and assess 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 concurred 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

Andrea Inman, Audit Director
Warren Fitzgerald, Audit Manager
Paul Alois, Audit Supervisor
Christi Martin, Examiner-in-Charge
Kate Merrill, Examiner-in-Charge
Daniel Rossi, Examiner-in-Charge
Rebecca Tuczynski, Examiner-in-Charge
Suzanne Loudis, Supervising Medical Care Representative
Dawn Daubney, Medical Care Representative
Roman Karpishka, Research Specialist
Eric Spence, Research Specialist
Benjamin Babendreier, Senior Examiner
Karen Ellis, Senior Examiner
Kim Geary, Senior Examiner
Tracy Glover, Senior Examiner
Rachelle Goodine, Senior Examiner
Jacqueline Keeys-Holston, Senior Examiner
Suzette Millard, Senior Examiner
Natesha Salmon, Senior Examiner
Mary McCoy, Supervising Editor

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.ny.gov

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.ny.gov

Ken Shulman, Assistant Comptroller
518-473-0324, kshulman@osc.ny.gov

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

July 3, 2018

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 2017-S-23 entitled, "Medicaid Claims Processing Activity April 1, 2017 through September 30, 2017."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
Erin Ives
Brian Kiernan
Timothy Brown
Elizabeth Misa
Daniel Duffy
Geza Hrazdina
Jeffrey Hammond
Jill Montag
James Dematteo
James Cataldo
Diane Christensen
Lori Conway
OHIP Audit SM

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

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2017-S-23 entitled,
Medicaid Claims Processing Activity
April 1, 2017 Through September 30, 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 2017-S-23 entitled, "Medicaid Claims Processing Activity April 1, 2017 Through September 30, 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 $742,915 ($471,797 + $271,118) in overpayments and recover, as appropriate.

Response #1

OMIG's contractor will review the identified claims, and pursue recovery of any determined to be inappropriate.

Recommendation #2

Routinely review high-risk claims with Medicare involvement that indicate no Medicare payment to determine if services were not medically necessary and, therefore, not reimbursable.

Response #2

The Department and OMIG will explore options regarding the review of claims with Medicare/Medicare Managed Care as primary for medical necessity.

Recommendation #3

Review the $3,133,608 in overpayments and make recoveries, as appropriate.

Response #3

OMIG in conjunction with the Department, will review the identified overpayments, and determine an appropriate course of action.

Recommendation #4

Evaluate eMedNY's current claims processing rules to ensure the Department's existing policy in regard to reimbursement of CARC 50 claims is followed.

Response #4

The Department will continue to evaluate current eMedNY claims processing rules to determine the appropriateness of claim reimbursement for Claims Adjustment Reason Code (CARC) 50. However, it should be noted that, contrary to the audit report, some Medicare claim denials that have a CARC 50 code relate to services that, in fact, are medically necessary and therefore may be eligible for Medicaid reimbursement.

* Comment 1

Recommendation #5

Review the one claim that overpaid $108,392 and make recoveries, as appropriate.

Response #5

OMIG will review the identified claim, and pursue recovery if determined to be inappropriate.

Recommendation #6

Review the $428,000 ($70,508 + $357,492) in overpayments and make recoveries, as appropriate.

Response #6

OMIG will review the identified claims, and pursue recovery of any determined to be inappropriate.

Recommendation #7

Review the $684,457 in overpayments and make recoveries, as appropriate.

Response #7

OMIG's contractor will review the identified claims, and pursue recovery of any determined to be inappropriate.

Recommendation #8

Ensure the planned eMedNY system change prevents multiple CPEP payments for an individual episode of care, and prevents CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

*See State Comptroller's Comment, Page 24.

Response #8

The Office of Mental Health (OMH) is currently in the process of reviewing and updating the regulations and billing practices for the Comprehensive Psychiatric Emergency Program (CPEP) with assistance from CPEP providers. One of the goals of these revisions is to clarify that one claim may be submitted per emergency visit, rather than per calendar day.

Additionally, 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. Evolution Project #6036 (EP6036) addresses this recommendation and is currently underway. A Functional Requirements Documentation (FRD) meeting was held on June 21, 2018, and CSRA will transmit the FRD for formal approval. Once approved, a project plan will be developed and an implementation date will be determined.

Recommendation #9

Review the $465,257 ($229,174 + $171,047 + $65,036) in improper payments made to CHHAs that we identified and recover overpayments, as appropriate.

Response #9

OMIG will extract its own data, perform analysis, and pursue recovery of any payment to the Certified Home Health Agencies (CHHAs) determined to be inappropriate.

Recommendation #10

Review the $152,563 in overpayments and make recoveries, as appropriate.

Response #10

OMIG will review the overpayments, and pursue recovery of any payment determined to be inappropriate.

Recommendation #11

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

Response #11

Of the remaining six providers, OMIG has determined the following:
Three providers have been excluded.
Three providers are still under review.

Recommendation #12

Determine the appropriateness of the $292,681 received by the five terminated providers and recover improper payments, as warranted.

Response #12

OMIG's analysis of the OSC data determined the payments were appropriately paid by Medicaid. The dates of service were prior to the effective date of the exclusion from the Medicaid program, and the payments were not adjudicated until after the date of exclusion.

State Comptroller's Comment

1. The Department's statement that some claims having a Medicare denial code of CARC 50 are for medically necessary services is misleading. A CARC 50 code indicates Medicare denied the payment because the service was deemed not medically necessary. Department policy specifically states that Medicaid will not pay for claims that Medicare deems not medically necessary. Medicaid does not pay claims with a Medicare denial code of CARC 50 when claims are processed via the Department's automated Medicare/Medicaid claim crossover system. The claims identified in our report did not cross over from Medicare via the Department's automated crossover system. Instead, the providers reported a CARC 50 code on their claims and billed the claims in question directly to eMedNY. However, because of the current mapping rules, the claims were allowed to pay, contrary to existing policy. The Department should apply its policy consistently to both claims submitted via the crossover system and directly billed.

   As noted on page 9 of our report, Department officials believe the providers who directly billed Medicaid may not have reported CARC 50 codes on their Medicaid claims correctly. As stated on pages 9 and 10, one provider accounted for $469,164 of the $687,469 in overpayments. The provider supplied us with supporting documentation for 20 claims, showing Medicare denied 16 of the claims for medical necessity, and for four claims, Medicare's explanation of benefits showed the provider subsequently received payment from Medicare after our fieldwork ended. This illustrates that a process exists for providers to appeal Medicare's decision of medical necessity and properly receive payment from Medicaid once the medical necessity has been determined.