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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

July 21, 2009

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Claims Processing Activity
April 1, 2008 through September 30, 2008
Report 2008-S-70

Dear Dr. Daines:

According 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 audited selected Medicaid claims processed by the Department of Health during the period April 1, 2008 through September 30, 2008.

A. 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 generates payments to reimburse the providers for their claims. During the six month period ended September 30, 2008, eMedNY processed 143 million claims resulting in $21 billion paid to providers. The claims are processed and reimbursed in weekly cycles which average 5.5 million claims and $824 million of payments.

The Office of the State Comptroller (OSC) performs audit steps during each weekly cycle of eMedNY processing to determine that eMedNY reasonably assures accurate Medicaid claims processing resulting in correct reimbursement payments to authorized providers. For example, the audit steps verify that Medicaid payments are supported by approved claims, provider reimbursement rates are correctly inputted, changes to system edits are approved, and payments fall within acceptable ranges for various categories of claims.

As audit exceptions are identified during the weekly cycle, OSC auditors work with Department staff to resolve them in a timely manner so that 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 an expanded OSC performance audit.

Our audit tests assumed the validity of the underlying claims (i.e. that the provider was qualified to provide the services, the services were necessary and the service charges were appropriate). The audit objective was solely to examine the accuracy of the Department's payment process and that the claims were correctly processed and paid based upon the information submitted by the provider. We do, however, examine and assess the validity of claims as part of OSC performance audits of provider operations and the Department's overall administration of the Medicaid program.

B. Audit Scope, Objective and Methodology

During the period April 1, 2008 through September 30, 2008, we audited selected Medicaid claims processed by the Department. The objective of our performance audit was to determine whether the Department's eMedNY system reasonably assured that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider payments.

To accomplish our audit objective, we performed various analyses of claims from Medicaid payment files and verified the accuracy of certain payments. We interviewed Department officials and officials from Computer Sciences Corporation (the Department's Medicaid fiscal agent). We also reviewed applicable sections of federal and State laws and regulations, examined the Department's relevant 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. Our audit steps were designed to reasonably assure that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider 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 management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

Based on the results of our review of the weekly cycles of Medicaid payments made during the six months ended September 30, 2008, we concluded that eMedNY reasonably assured that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider payments. When audit exceptions were identified during the weekly audits, these were communicated with Department officials who initiated appropriate actions to address them. We also identified seven reportable conditions. Five of these resulted in net overpayments of about $335,000. The seven reportable conditions we identified include:

- Improvements needed in security controls over Medicaid checks stored by the Department's fiscal agent, Computer Sciences Corporation;
- $115,522 in net overpayments resulting from 30 invalid neonatal inpatient claims;
- $107,619 in overpayments resulting from 1,237 upcoded orthodontic claims submitted by an orthodontist. This orthodontist also employed other practitioners to perform orthodontic procedures. However, one of the two practitioners was not enrolled in Medicaid, and another was credentialed as a dentist (not an orthodontist);
- $96,808 in overpayments resulting from 113 duplicate transportation claims;
- $11,267 in overpayments resulting from 575 eye care claims submitted by an optometrist, which involved both invalid transportation fees and claims that lacked supporting documentation;
- $3,889 in overpayments on one claim resulting from inaccurate reporting of coinsurance; and
- Three providers who had abused the Medicaid program had not been terminated from the eMedNY system.

Detailed results of our audit were provided to Department officials during the conduct of our audit fieldwork. As a result of our audit, we made 15 recommendations to the Department to recover Medicaid payments and improve the controls over payments.

Recommendation

Implement the specific recommendations for strengthening Department claims processing activities that were provided to Department officials during the audit.

We provided a draft copy of this report to Department officials for their review and formal comment. We consider the Department's comments in preparing this report and have included them as Appendix A. Department officials agree with and will implement our specific recommendations for strengthening claims processing activities.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 therefor.

Major contributors to the report include Steve Sossei, Sheila Emminger, Andrea Inman, Christopher Morris, Earl Vincent, Amanda Strait, Tracy Samuel, Lisa Rooney, Kate Merrill, Daniel Zimmerman, Martin Patterson, and Brenda Maynard.

We wish to thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Brian E. Mason
Audit Manager

cc: Stephen Abbott, Department of Health
Steven Sossei, Office of the State Comptroller
Thomas Lukacs, Division of the Budget

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

June 11, 2009

Mr. Brian E. Mason, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2008-S-70 on "Medicaid Claims Processing Activity April 1, 2008 through September 30, 2008".

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Deborah Bachrach

APPENDIX A

Nicholas Meister
Steve Abbott
Irene Myron
Ron Farrell
Gail Kerker

Department of Health's Comments on the Office of the State Comptroller's Draft Audit Report 2008-S-70 on "Medicaid Claims Processing Activity April 1, 2008 through September 30, 2008"

The following are the Department of Health's comments in response to the Office of the State Comptroller's (OSC) draft audit report 2008-S-70 on "Medicaid Claims Processing Activity April 1, 2008 through September 30, 2008."

OSC Recommendation:

Implement the specific recommendations for strengthening Department claims processing activities that were provided to Department officials during the audit.

Department Response:

The Department agrees and will implement the specific recommendations for strengthening its claims processing activities that were provided by OSC. It will additionally collaborate with the Office of the Medicaid Inspector General in reviewing overpayments identified by OSC and pursuing appropriate recoveries where warranted.