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

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2015 Through March 31, 2016

Medicaid Program
Department of Health

Report 2015-S-74 November 2016

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, 2015 through March 31, 2016.

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, 2016, eMedNY processed about 200 million claims, resulting in payments to providers of about $29 billion. The claims are processed and paid in weekly cycles, which averaged over 7.7 million claims and $1 billion in payments to providers.

Key Findings

The audit identified approximately $6.8 million in inappropriate Medicaid payments, as follows:

- $3,521,562 in overpayments for fee-for-service claims for recipients whose services were covered by managed care;
- $1,342,307 in overpayments for claims billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $937,424 in overpayments for newborn claims that were submitted with incorrect birth weights;
- $389,813 in improper payments for inpatient, clinic, durable medical equipment, transportation, and eye care services;
- $333,504 in improper payments identified by the Centers for Medicare & Medicaid Services that the Department did not recover from providers;
- $260,330 in overpayments for inpatient claims that were billed at a higher level of care than what was actually provided; and
- $50,767 in improper payments for duplicate billings.

By the end of the audit fieldwork, about $2.4 million of the overpayments were recovered.

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 14 of the providers we identified, but the status of one provider was still under review at the time our fieldwork was completed.

Key Recommendations

- We made nine 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, 2015 Through September 30, 2015 (2015-S-16)

Department of Health: Medicaid Claims Processing Activity October 1, 2014 Through March 31, 2015 (2014-S-53)

State of New York
Office of the State Comptroller

Division of State Government Accountability

November 30, 2016

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, 2015 Through March 31, 2016*. 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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State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.state.ny.us
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. In State Fiscal Year 2015-16, the federal government funded about 53.2 percent of New York's Medicaid claim costs; the State funded about 30.6 percent; and the localities (the City of New York and counties) funded the remaining 16.2 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, 2016, eMedNY processed about 200 million claims, resulting in payments to providers of about $29 billion. The claims are processed and paid in weekly cycles, which averaged over 7.7 million claims and $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 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, 2016, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers.

In addition, we identified the need for improvements in the processing of certain types of claims. We found about $6.8 million in improper payments pertaining to: fee-for-service claims for recipients who were covered by a managed care plan; claims with incorrect information pertaining to other insurance recipients had; claims with incorrect newborn birth weights; improper inpatient, clinic, and other claims; overpayments identified by the Centers for Medicare & Medicaid Services (CMS) that the Department did not recover from providers; hospital claims that were billed at a higher level of care than what was actually provided; and claims for duplicate services.

At the time the audit fieldwork concluded, about $2.4 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments (totaling about $4.4 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 14 of the providers we identified, but the status of one provider was still under review at the time our fieldwork was completed.

Improper Fee-for-Service Claims for Services Covered by Managed Care

In general, the Department uses two methods to pay Medicaid providers: the fee-for-service method and the managed care plan method. Under the fee-for-service method, Medicaid pays health care providers directly for Medicaid-eligible services rendered to Medicaid recipients. Under the managed care plan method, Medicaid pays each managed care plan (Plan) a monthly premium for each Medicaid recipient enrolled in the Plan, and the Plan arranges for the provision of services its members require. Plans typically have networks of participating health care providers that they reimburse directly for services provided to their enrollees. Generally, the costs of all services that Plan enrollees require are covered by the Medicaid monthly premiums. However, certain services are specifically excluded from managed care coverage and Medicaid reimburses those services on a fee-for-service basis.

The Department uses eMedNY to make Medicaid payments to participating health care providers and managed care plans. For payment control purposes, claims processed by eMedNY are subject to various automated system edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement. For example, an edit exists to deny fee-for-service claims for services that are covered by a recipient's Plan. Maintaining an accurate record of the services that are covered by or not covered by (i.e., carved out of) a particular Plan is essential to ensure

claims are processed and paid correctly.

Our audit identified $3,521,562 in overpayments for 14,983 fee-for-service clinic claims that were inappropriately processed between January 1, 2012 and December 31, 2015. The claims were processed on behalf of 3,504 recipients who were enrolled in a particular Plan on the dates of service. We determined the clinic services were covered by the Plan and, therefore, the fee-for-service claims should not have been paid. According to Department officials, a data entry error in eMedNY allowed all clinic services for enrollees of this Plan to be processed as fee-for-service. After we alerted Department officials to the issue, they immediately updated eMedNY to prevent future inappropriate payments. However, at the conclusion of our audit fieldwork, the Department had still not corrected the inappropriate claims we identified, which would save Medicaid more than $3.5 million. (Note: A provider who was contacted by auditors during the audit voided one of the inappropriate claims, saving Medicaid $5,400.)

Recommendation

1. Review the $3,516,162 in improper fee-for-service claim payments we identified and recover overpayments as appropriate.

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 patient'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 71 claims that resulted in overpayments totaling $1,342,307.

Coinsurance, Copayments, and Deductibles

We identified overpayments totaling $687,584 on 29 claims (for which Medicaid originally paid $746,277) that resulted from excessive charges for coinsurance, copayments, and deductibles for recipients covered by other insurance. We contacted the providers and, as a result of our inquiries, they adjusted 21 of the 29 claims, saving Medicaid $128,838. In addition, one claim was partially adjusted by a provider, saving Medicaid $419,438. However, we still question the remaining $83,052 of the $130,225 paid on the adjusted claim. Also, three providers still needed to adjust seven claims that were overpaid an estimated $56,256.

Designation of Primary Payer

We identified eight claims (totaling $976,809 in payments) 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 when the services were provided and, therefore, Medicaid was incorrectly designated as the primary payer. At the time our audit fieldwork concluded, the providers adjusted seven of the claims, saving Medicaid $630,516. One provider, however, still needed to adjust one claim that was overpaid by an estimated $6,043.

Paper Claims With Other Insurance

Professional service providers (e.g., physicians) can submit their claims to Medicaid using electronic or paper formats. When submitting a paper claim, providers are required to use claim forms prescribed by the Department. The eMedNY system captures the data on these forms via an automated imaging process. The completeness and accuracy of the data are essential for Medicaid to make a proper payment.

Providers that use a paper form to bill Medicaid must indicate whether any other insurance made a payment on the claim. The eMedNY system processes Medicaid claims differently depending on what type of insurance (e.g., Medicare, Medicare managed care, commercial insurance) was the primary payer on the claim. For example, when a Medicaid recipient also has commercial insurance, Medicaid will generally pay the lesser of the patient's normal financial obligation (i.e., deductible and/or coinsurance) or the standard Medicaid fee for the procedure less the primary insurance payment. If, however, a Medicaid recipient is also covered by a Medicare managed care plan, Medicaid will pay the patient's entire financial obligation.

Currently, there is no way for providers to indicate on a paper claim that a recipient's primary insurance is a Medicare managed care plan (note: providers can designate "Medicare" but not specifically a "Medicare managed care plan"). As a result, paper claims for these recipients may not be processed correctly and Medicaid could pay something other than the patient's financial obligation, which can lead to overpayments. We identified potential Medicaid overpayments of $18,164 for 34 vision care claims (for which Medicaid originally paid $26,483) that were billed on paper forms.

For example, we contacted a provider and obtained the explanation of benefits (EOB) documentation to support a claim for a Medicaid recipient who received a prosthetic eye and who was also enrolled in a Medicare managed care plan. While the provider could not indicate on the paper claim form that the recipient's primary insurance was a Medicare managed care plan, we confirmed the provider accurately reported the primary insurance payment amount of $866 on the paper form. We determined Medicaid inaccurately paid the provider $1,134 (i.e., the standard Medicaid fee of $2,000 for the prosthetic eye less the primary insurance payment of $866). According to the EOB, the coinsurance was $221. Because the recipient was in a Medicare managed care plan, Medicaid should have only paid the patient's financial obligation of $221. This resulted in a Medicaid overpayment of $913 for the service ($1,134 - $221).

A Department official advised us that the provider billed this claim correctly based on the existing eMedNY billing guidelines, when applied to paper claims. However, because providers currently cannot report on paper claims that a Medicare managed care plan is the primary insurance, the Department must determine how providers can properly bill Medicaid on such claims so that future overpayments are prevented.

Recommendations

2. Review and recover the unresolved overpayments totaling $163,515 ($83,052 + $56,256 + $6,043 + $18,164).

3. Determine how providers who submit paper claim forms can accurately bill Medicaid for patient responsibility amounts when recipients also have Medicare managed care coverage; take any necessary corrective actions, including updating the eMedNY billing guidelines accordingly; and formally notify providers of the changes.

Incorrect Birth Weights

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 newborn services. Under managed care, Medicaid pays Plans a fixed monthly capitation payment for each newborn enrolled in a Plan, and the Plan is responsible for the provision 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 has a low birth weight, Medicaid pays Plans a one-time Supplemental Low Birth Weight Newborn Capitation Payment (or “kick” payment) for each enrolled newborn weighing less than 1,200 grams (or approximately 2.64 pounds) at birth. The low birth weight kick payments are intended to cover the higher cost of care these newborns require.

Medicaid also makes separate fee-for-service Graduate Medical Education (GME) payments to hospitals for care provided to recipients (including newborns) enrolled in Plans to cover the costs of training residents.

Medicaid reimbursement of inpatient services for newborns is highly dependent on the birth weight. Low birth weights often increase payment amounts. We determined Medicaid overpaid $937,424 for 12 incorrect claims that contained low birth weights. The overpayments generally occurred because hospitals reported inaccurate birth weight information to the Plans and Medicaid on their claims. We contacted the providers and, as a result of our inquiries, they corrected seven of the 12 claims, saving Medicaid $615,261. However, by the end of our audit fieldwork, four providers had not corrected the five remaining claims totaling overpayments of $322,163.

Low Birth Weight Kick Payments

Medicaid overpaid five Plans $535,939 for six low birth weight kick claims that contained inaccurate birth weights. We found that the hospitals did not accurately report birth weights to the Plans on these claims. In turn, the Plans reported the incorrect information to Medicaid, causing the overpayments. In addition, the errors in the reported birth weights caused overpayments of $11,736 for GME payments on two additional claims.

For example, one hospital submitted a claim for a newborn with a birth weight of 1,174 grams (or approximately 2.6 pounds) to a Plan. Consequently, the Plan billed Medicaid for a low birth weight kick claim and Medicaid paid $99,480 for this claim. However, according to the inpatient claim, the newborn's hospital stay was only two days, which is unusually short for a newborn with a birth weight of 1,174 grams. At our request, the hospital reviewed the birth weight and determined it was actually 2,590 grams (or approximately 5.7 pounds). As a result, the Plan was not eligible for the $99,480 low birth weight kick payment. In addition, the change in birth weight would result in a decrease of $11,196 in the hospital's subsequent GME payment. By the end of our audit fieldwork, the Plan and the hospital had not corrected either claim, which would save Medicaid $110,676 ($99,480 + $11,196).

At the conclusion of our audit fieldwork, as a result of our inquiries, the Plans adjusted two kick claims, saving Medicaid $224,972. Additionally, one hospital adjusted a GME claim saving Medicaid $540. However, the Plans still needed to adjust four low birth weight kick claims that were overpaid an estimated $310,967, and one hospital needed to adjust a GME claim with an estimated overpayment of $11,196.

Hospital Fee-for-Service Payments

We found that Medicaid overpaid $288,814 for three duplicate fee-for-service newborn claims. In two of the three cases, Medicaid made a fee-for-service payment to a hospital and a capitation payment to a Plan. The overpayments occurred because the newborns were retroactively enrolled into a managed care plan, making the fee-for-service payments inappropriate. The hospitals corrected the two claims, saving Medicaid $195,611. In the third case, Medicaid made a fee-for-service payment to a hospital as well as a low birth weight kick payment to a Plan. Upon our inquiry, the Department determined the Plan was not entitled to the kick payment because the Plan never paid for the inpatient stay. The Department corrected the claim, saving Medicaid $93,204.

We also identified a claim for a newborn with a reported birth weight of 150 grams (less than one pound) who was discharged in one day. We contacted the provider and, as a result of our inquiry, the provider corrected the birth weight on the claim, saving Medicaid $100,935.

Recommendation

4. Review the five unresolved overpayments totaling $322,163 ($310,967 + $11,196) and recover as appropriate.

Improper Payments for Inpatient, Clinic, DME, and Other Claims

We identified $389,813 in overpayments that resulted from excessive charges on inpatient, clinic, durable medical equipment (DME), transportation, and eye care claims. At the time our audit fieldwork concluded, $329,497 of the overpayments had been recovered. However, actions were still required to address the balance of the overpayments totaling $60,316.

The overpayments occurred under the following scenarios:

- Six providers were overpaid $292,609 because they submitted inaccurate information on 18 claims for inpatient, clinic, DME, and transportation services. For example, one provider billed an inpatient claim that indicated the patient was discharged home, even though the patient had actually been transferred to another inpatient facility. At our request, the provider reviewed and subsequently adjusted the discharge code on the claim (to indicate the transfer), which lowered the payment and saved Medicaid $106,794. Of the remaining 17 claims, seven have been adjusted, saving Medicaid $166,698; however, two providers still needed to adjust ten claims, which would save Medicaid $19,117.
- One provider inappropriately billed $56,005 on seven clinic claims for physician-administered drugs, even though the patient was enrolled in a free drug assistance program. At our request, the provider reviewed and subsequently adjusted all seven claims, saving Medicaid $56,005.
- Five providers billed $26,331 on eight claims for services that were not supported by patient records. For example, two providers billed $25,645 on five DME claims for insulin pumps that were not ordered by an endocrinologist, as required by Medicaid. By the end of our audit fieldwork, the providers had not yet corrected any of the eight claims, which would save Medicaid $26,331.
- Three providers billed $83,471 for nine items (eight speech generating devices and one eye care item) at higher rates than allowed by Medicaid policy. By the end of our fieldwork, the providers had not yet corrected these claims, which would save Medicaid $14,618.
- One provider was paid $250 for a vision care service that should have been covered by the recipient's managed care plan. The claim was paid because the Department's eligibility data for this recipient contained conflicting information. The Department corrected the recipient's eligibility records, but by the end of our fieldwork, the claim had not been corrected, which would save Medicaid $250.

Recommendation

5. Review and recover the 28 unresolved overpayments totaling $60,316 ($19,117 + $26,331 + $14,618 + $250).

Payment Error Rate Measurement Overpayments

In accordance with the Improper Payments Information Act of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act), the CMS conducted a Payment Error Rate

Measurement (PERM) review of the New York State Medicaid program for the fiscal years 2011 and 2014. The purpose of the federal PERM review is to identify improper Medicaid payments.

CMS' PERM review identified $333,504 in improper payments pertaining to: duplicate billings; non-covered services and recipients; fee-for-service claims covered by managed care; claims with incorrect information pertaining to other insurance; and errors caused by eMedNY system logic. The Department complied with federal regulations by returning the $169,254 federal share of the overpayments to CMS. The Department funded the repayment using State Medicaid funds. However, the Department did not attempt to recover the identified overpayments from the Medicaid providers, as required by federal law and CMS regulations. Department officials said they originally viewed the PERM review as a tool to enhance eMedNY controls, correct Medicaid policies, and educate providers on the proper claims submission processes.

As a result of our audit, Department officials are reviewing their decision and will determine whether the funds should be recovered. As of the end of the audit fieldwork, the Department had not yet recovered the $333,504 in overpayments.

Recommendation

6. Review and recover the unresolved overpayments from the 2011 and 2014 PERM reviews totaling $333,504.

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 identified overpayments totaling $260,330 to two hospitals that billed for higher (and more costly) levels of care than what was actually provided to patients. For example, Medicaid paid a hospital $389,121 for 577 days of acute psychiatric care. We reviewed the hospital's medical records and determined that only 495 of the days should have been billed as acute care. The hospital corrected the acute portion of the claim, which resulted in a savings of $57,255. Medicaid paid another hospital $575,490 for 664 days of acute psychiatric care. Upon review, the hospital determined 287 days were incorrectly billed as acute care and should have been billed at a lower ALC rate. The hospital adjusted the claim, which resulted in a savings of $203,075.

Recommendation

7. Formally advise the two hospitals to accurately report alternate levels of patient care when billing Medicaid.

Duplicate Billings

Medicaid overpaid five providers a total of $50,767 on six claims (which originally paid $56,211) because the providers billed for certain services more than once. The duplicate payments occurred under different scenarios, as follows:

- One provider billed for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same patient encounter, even though the CPEP evaluation is allowed only once per encounter. This resulted in an overpayment of $4,258.
- One provider billed for multiple days of ventilation management on an outpatient claim, even though only one date should have been billed. As a result, Medicaid overpaid the provider $3,168.
- Two providers billed for more dentures than were actually provided. The two claims resulted in overpayments of $8,026.
- One provider billed Medicaid for two DME claims for a recipient who was also receiving services from a child care provider. According to the Medicaid policy, DME is included in the child care facility's Medicaid reimbursement rate and, therefore, should not be billed to Medicaid separately. The two claims resulted in overpayments of $35,315.

We contacted the providers and, as a result of our inquiries, three providers corrected three of the claims, saving Medicaid $13,212. By the end of our audit fieldwork, one provider had not corrected one of the overpaid denture claims and a second provider had not corrected the two DME claims, which would save Medicaid a total of $37,555.

Recommendation

8. Review and recover the unresolved overpayments totaling $37,555.

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 15 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 three providers who were involved in civil settlements. Of the 18 providers, 16 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, they would be required to seek reinstatement from Medicaid to

submit new claims). We advised Department officials of the 18 providers and the Department terminated 14 of them from the Medicaid program. The Department determined three of the 18 providers should not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the remaining provider.

Recommendation

9. Determine the status of the remaining provider regarding its future participation in the Medicaid program.

Audit Scope 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, 2015 through March 31, 2016. 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.

To accomplish our audit objectives and to determine whether internal controls were adequate and functioning as intended, 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, Computer Sciences Corporation (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 it. 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 rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

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
Christopher Morris, Audit Supervisor
Andrea LaBarge, Examiner-in-Charge
Daniel Rossi, Examiner-in-Charge
Rebecca Tuczynski, Examiner-in-Charge
Earl Vincent, Examiner-in-Charge
Judith McEleney, Supervising Medical Care Representative
Suzanne Loudis, Medical Care Representative
Roman Karpishka, Research Specialist
Eric Spence, Research Specialist
Benjamin Babendreier, Senior Examiner
Lauren Bizzarro, Senior Examiner
Christian Butler, Senior Examiner
Jacqueline Keeys-Holston, Senior Examiner
Suzette Millard, Senior Examiner
Natesha Salmon, Senior Examiner

Division of State Government Accountability

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

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

Brian Mason, Assistant Comptroller
518-473-0334, bmason@osc.state.ny.us

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 1, 2016

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2015-S-74 entitled, "Medicaid Claims Processing Activity October 1, 2015 through March 30, 2016."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Michael J. Nazarko
Jason A. Helgerson
Dennis Rosen
James Dematteo
James Cataldo
Brian Kiernan
JoAnn Veith
Elizabeth Misa
Ralph Bielefeldt
Geza Hrazdina
Jeffrey Hammond
Jill Montag
Diane Christensen
Lori Conway
OHIP Audit SM

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-74 entitled,
Medicaid Claims Processing Activity
October 1, 2015 Through March 31, 2016

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2015-S-74 entitled, "Claims Processing Activity 10-1-2015 to 3-31-2016."

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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1

Review the $3,516,162 in improper fee-for-service claim payments we identified and recover overpayments as appropriate.

Response #1

OMIG has performed analysis on the improper fee-for-service claims, and will pursue recovery of any inappropriate payments.

Recommendation #2

Review and recover the unresolved overpayments totaling $163,515 ($83,052 + $56,256 + $6,043 + $18,164).

Response #2

OMIG's Recovery Audit Contractor has reviewed the unresolved overpayments, and is in the process of making recoveries, where appropriate.

Recommendation #3

Determine how providers who submit paper claim forms can accurately bill Medicaid for patient responsibility amounts when recipients also have Medicare managed care coverage; take any necessary corrective actions, including updating the eMedNY billing guidelines accordingly; and formally notify providers of the changes.

Response #3

The Department is working to determine the best method for updating eMedNY billing guidelines to inform providers how to accurately bill Medicaid for Medicare managed care patient responsibility amounts using paper forms. The Department anticipates establishing and publishing billing guidelines by February 2017.

Recommendation #4

Review the five unresolved overpayments totaling $322,163 ($310,967 + $11,196) and recover as appropriate.

Response #4

OMIG performed analysis on the five unresolved overpayments:

1 claim has been voided for $99,480.
1 claim is under review.
3 claims are in the current OMIG Low Birth Weight Audit, to be recovered.

Recommendation #5

Review and recover the 30 unresolved overpayments totaling $70,573 ($19,117 + $36,588 + $14,618 + $250).

Response #5

External Ambulatory Infusion Pumps (E0784) used for the administration of insulin are covered for Diabetes Mellitus as medically necessary when ordered by an endocrinologist and when specific clinical criteria are met. This item is approved by the Dispensing Validation System, which requires the provider to maintain all supporting documentation. In two instances, the pumps were ordered by appropriate staff in the endocrinologist's office. The referring providers were Physician Assistants who were affiliated with endocrinologists, meeting the intent of the policy. The provider, Shelbourne Pharmacists, was placed on pre-payment review to monitor all future insulin pumps claims. The Department also clarified the ordering provider policy by issuing an eMedNY Provider Communication on September 15, 2016.

* Comment 1

Although the providers identified in this audit billed more than the allowable fee for speech generating devices, claims payment was made at the Medicaid Reimbursement Amount (MRA) so no overpayment was made. In these cases, it would not be appropriate to apply the "cost plus 50%" policy as this policy only applies when the item does not have an MRA. As speech generating devices have an MRA, they are not subject to this calculation and were appropriately paid at the MRA.

* Comment 2

OMIG will review the remaining unresolved overpayments, and recover any inappropriate payments.

*See State Comptroller's Comments, page 23.

Recommendation #6

Review and recover the unresolved overpayments from the 2011 and 2014 PERM reviews totaling $333,504.

Response #6

The Centers for Medicare and Medicaid Services (CMS) identified a total of $333,504 ($202,169 + $131,335) in overpayments for review years 2011 and 2014, respectively.

The Department's current protocol is to adjust the CMS-64 by the amount of the Federal Share of the overpayment amount. The Department has viewed the Payment Error Recovery Measurement (PERM) review as a tool to help educate providers on the proper claims submission process so that medical record and systems errors are submitted correctly. The Department concluded that the recovery of the full overpayment from providers would cause financial hardship. For 2011, the Department repaid the Federal Share by adjusting the CMS-64 in the amount of $169,254.

* Comment 3

The Department's policy is to continue to review the PERM overpayments recovery protocol and will amend it to include additional edits as needed to reduce potential errors. If deemed appropriate, actions will be taken to recover the overpayments to further strengthen the PERM process.

Recommendation #7

Formally advise the two hospitals to accurately report alternate levels of patient care when billing Medicaid.

Response #7

Computer Sciences Corporation (CSC) Provider Services formally advised the two hospitals identified in this audit on how to accurately report alternate levels of patient care.

Recommendation #8

Review and recover the unresolved overpayments totaling $37,555.

Response #8

The Department notified OSC in the Preliminary report that the dental office identified in this audit was contacted regarding the overpayment of dentures in the amount of $2,240. The dental office refunded this amount in a check to CSC on January 5, 2016.

During the prior approval process, the Department's Bureau of Medical Review (BMR) staff made an error when checking the member's eligibility. As a principal provider was indicated, that principal provider is responsible for paying the Medicaid vendor for the equipment. BMR staff approved the equipment request and the vendor was paid in error under Fee-for-Service (FFS). BME staff will be reminded to check for a principal provider during a prior approval review and inactivate the request in eMedNY (to prevent FFS payment) and remind the vendor to seek payment from the principal care provider.

OMIG will review the remaining unresolved overpayments of $35,315 and recover where appropriate.

Recommendation #9

Determine the status of the remaining provider regarding its future participation in the Medicaid program.

Response #9

OMIG has excluded the remaining provider.

State Comptroller's Comments

1. Based on the Department's response, we concur that two claims for External Ambulatory Infusion Pumps ordered by physician assistants were appropriate. Consequently, we amended page 12 of our report to reduce the overpayments pertaining to the DME claims by $10,257 (from $36,588 to $26,331). In addition, we encourage the Department to review the propriety of the remaining five claims for External Ambulatory Infusion Pumps identified in our report.
2. We determined Medicaid overpaid three claims because the provider was reimbursed in excess of "cost plus 50 percent" for the item. Each claim was for a speech generating device accessory that did not have a Medicaid Reimbursement Amount on file, and consequently, the claims were subject to the "cost plus 50 percent" limit. Therefore, we maintain that the claims in question were overpaid.
3. If Department officials determine that recovering the full amounts of overpayments from certain providers, as identified by the PERM review, would cause financial hardships, then officials should explore other recovery and repayment options, such as a payback schedule, to avoid causing providers undue financial harm.