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

Division of State Government Accountability

Oversight of the Early Intervention Program's State Fiscal Agent

Department of Health

Report 2015-S-22 March 2016

Executive Summary

Purpose

To determine whether the Department of Health provided effective oversight of State Fiscal Agent contracts to ensure contractor compliance with contract deliverables, including timely processing of provider claims for Early Intervention services provided. The audit covered the period April 1, 2013 through December 10, 2015.

Background

In New York State, the Department of Health (Department) is the lead agency responsible for the Early Intervention Program (Program). The mission of the Program is to identify and evaluate as early as possible those infants and toddlers from birth to three years of age whose healthy development is compromised and provide for appropriate intervention to improve child and family development. Early Intervention (EI) services, such as physical therapy and speech-language pathology services, are provided at no cost to an eligible child's family, and are funded first through third-party payers, including commercial insurance and Medicaid. The State and counties share the remaining costs. The Program serves more than 60,000 children annually, at a cost of about $556 million. Legislation effective April 1, 2013 required the Department to begin using a State Fiscal Agent (SFA) to administer EI claims and payments. The Department engaged an interim SFA, followed by a five-year, $42.8 million contract with the current SFA, Public Consulting Group (PCG). In total, the Department has paid $19.1 million since April 1, 2013 for SFA services.

Key Findings

- The Department generally provides effective oversight of the SFA that helps ensure EI claims are paid timely and the SFA fulfills contract deliverables related to customer service and data and reporting.
- Despite improvement in the SFA's timeliness of EI claim payments, as of September 2015, there were 169,615 unpaid claims totaling $10.9 million that were submitted from July 1, 2013 through June 30, 2015. These claims required further actions by the SFA, insurers, or providers to resolve.
- Of the 169,615 unpaid claims, more than 18,000 claims (totaling nearly $1.4 million) had been outstanding for more than 17 months.

Key Recommendations

- Take prompt action to resolve the 169,615 unpaid claims by working with PCG, providers, and third-party payers. Continue to address any remaining barriers to timely payment of EI claims.
- Work with PCG to gather input on potential enhancements to online training and customer service to better meet stakeholder needs.

Other Related Audits/Reports of Interest

Department of Health: Appropriateness of Medicaid Eligibility Determined by the New York State of Health System (2014-S-4)
Office for the Aging/Department of Health: Social Adult Day Services (2014-S-31)

State of New York
Office of the State Comptroller

Division of State Government Accountability

March 24, 2016

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
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. By so doing, it provides 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 Department of Health's *Oversight of the Early Intervention Program's State Fiscal Agent.* The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

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

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

In New York State, the Department of Health (Department) is the lead State agency responsible for the Early Intervention Program (Program). The Program was established in 1993 under Article 25 of the Public Health Law, and is part of the national Early Intervention Program created in 1986 under the federal Individuals with Disabilities Act. The Program's mission is to identify and evaluate as early as possible those infants and toddlers from birth to three years of age whose healthy development is compromised and provide for appropriate intervention to improve child and family development. In some circumstances, children can remain in the Program beyond age three. The Department's Bureau of Early Intervention administers and monitors the Program, which provides services to more than 60,000 children with disabilities annually, at a cost of about $556 million. Other entities with a role in the Program include the Department of Financial Services, which supervises commercial insurance companies' compliance with State Insurance Law, and the Early Intervention Coordinating Council (Council), a Governor-appointed, 27-member advisory council that includes parents, EI providers, and others and serves to advise, assist, and offer recommended actions to the Department.

EI services, such as physical therapy and speech-language pathology services, are provided by about 600-700 agencies and individuals at no cost to an eligible child's family, and are funded first through third-party payers, including commercial insurers and Medicaid. The remaining costs are shared by the State (49 percent) and municipalities (51 percent) and paid from an escrow account. Of the children served, about 55 percent are covered by Medicaid, including 4 percent who have both Medicaid and other insurance; 23 percent have commercial insurance; and the remaining 22 percent are not insured. The State and municipalities cover about 50 percent of annual EI claims through payments from the escrow account.

Historically, EI providers submitted claims and received payment in full directly from the counties. The counties, in turn, were responsible for seeking reimbursement from Medicaid and commercial insurers before seeking reimbursement from the State. However, as a result of Public Health Law reforms effective April 1, 2013 that were intended to provide fiscal and mandate relief for local governments, the Department was authorized to identify and begin using a State Fiscal Agent (SFA) to provide overall fiscal management and payment of EI claims. Under the SFA process, EI providers bill commercial insurers and Medicaid through the SFA. The SFA then verifies basic claim information and sends claims to the first payer, which is usually private or self-funded insurance, and then on to any subsequent payers, which may include Medicaid and the escrow account. Commercial insurers and Medicaid send payment to the provider and then send remittance advices to the SFA with claim information that the SFA needs to fully process the claim for payment.

In January 2013, the Department issued a Request for Proposals to procure an SFA, specifying the need for the SFA to be fully operational by April 1, 2013. In mid-April, the Department executed a single source contract with an interim SFA, James McGuinness and Associates (McGuinness), a Schenectady, New York-based corporation, to process EI claims until it could procure a permanent SFA. During McGuinness' time as SFA, it paid about 3.6 million EI claims totaling $276.4 million

that were submitted from April 1 through September 30, 2013.

The Department opened bids for a permanent SFA on March 12, 2013 and announced its selection of Public Consulting Group (PCG), the only vendor that responded to the Request for Proposals. The five-year, $42.8 million contract with PCG runs from April 1, 2013 through March 31, 2018, although PCG didn't take over as SFA until October 1, 2013. For the period April 1, 2013 through July 31, 2015, the Department paid $19.1 million for SFA services, including about $550,000 to McGuinness during the six-month period from April 1 through September 30, 2013 and $18.6 million to PCG from April 1, 2013 through July 31, 2015.

The Department's contract with PCG includes four main deliverables, plus a fifth deliverable for turnover services related to transition at the end of the contract. The deliverables, and their maximum allowable percent of contract cost, are as follows:

1. Claiming and adjudication - maximum of 60 percent;

2. Customer service, including operating a call center – maximum of 30 percent;

3. Project planning and operations management, including risk management, quality improvement, performance management, and training – maximum of 40 percent;

4. Data and reporting, including development of a data warehouse and data management as well as reporting – maximum of 30 percent; and

5. Turnover, to be paid only in year five of the contract – maximum of 5 percent.

The contract also includes Service Level Agreements that detail performance specifications and penalties for non-compliance. PCG submits a monthly invoice to the Department for one-twelfth of the annual rate for each contract deliverable, along with reports for each of the four main deliverables that describe in detail its work activities for that month and progress toward benchmarks. Pursuant to the contract, the Department's monthly payments to PCG are based on its assessment of the activities PCG reports for each deliverable, and they may not always equal one-twelfth of the prorated monthly amount. PCG also regularly submits performance reports to the Department. For example, the Executive Summary reports information about payment processing, including time to fully adjudicate claims, total payments, and payments by payer type. Medicaid Denial Reports indicate reasons for claim denials, including percent by provider, and comparisons to prior months. PCG reports quarterly to the Council about SFA progress, including billing and claiming statistics as well as call center trends and current concerns.

Audit Findings and Recommendations

The Department generally provides effective oversight of the SFA that helps ensure EI claims are paid timely and the SFA fulfills contract deliverables related to customer service and the Department's data and reporting needs. EI claims are paid more quickly now than at the onset of the SFA, and the Department is working to resolve older unpaid claims. However, it should continue to pursue solutions that allow both the Department and the SFA to have necessary information to address unpaid claims. As of September 2015, there were 169,615 unpaid claims totaling $10.9 million that had been submitted during the two years ended June 30, 2015. The Department should also consider the potential for improvements in customer service that will enhance its responsiveness to stakeholder concerns.

Timeliness of Early Intervention Claims Processing and Payment

The Department has generally been effective at working with the SFA to improve the timeliness of EI claims processing and payment. Initially, the transition to the new SFA resulted in confusion and increased the number of unsettled claims. Consequently, in mid-August 2013, the Department announced that it would issue "safety net" payments to EI providers in response to provider concerns about unpaid EI claims that had been submitted to insurance companies. The Department cited commercial insurers' lack of compliance with EI reforms as contributing to the delays, specifically insurers' failure to provide necessary claim information to the SFA, as well as payments that were incorrectly issued to families instead of providers. The one-time payments were intended to ensure continued availability of services during the transition to using the new SFA.

In total, the Department issued $6.8 million in safety net payments to 172 providers in August and September 2013. The payments, which ranged from less than $1,000 to as high as $950,610 (per provider), represented 75 percent of the dollar value of claims submitted between April 1 and July 29, 2013, for which no known payment or denial had been made. In turn, under the terms of an EI Program Provider Agreement Amendment, providers agreed to assign to the Department 25 percent of each payment they received after October 1, 2013 until the payment was fully recovered and to pay the Department any remaining amount of the safety net payment that had not yet been recovered as of July 31, 2014.

For the period April 1, 2013 through August 31, 2015, providers submitted about 18.4 million EI claims to the SFA, totaling $1.4 billion. The Department works in conjunction with PCG to obtain information about claims processing and to monitor claim status and payment timeliness. Also, the Department has worked with the Department of Financial Services and stakeholders to help resolve payment concerns. For the period April 1, 2013 through July 31, 2015, the Department paid PCG $7.9 million for claiming and adjudication services.

Unpaid claims

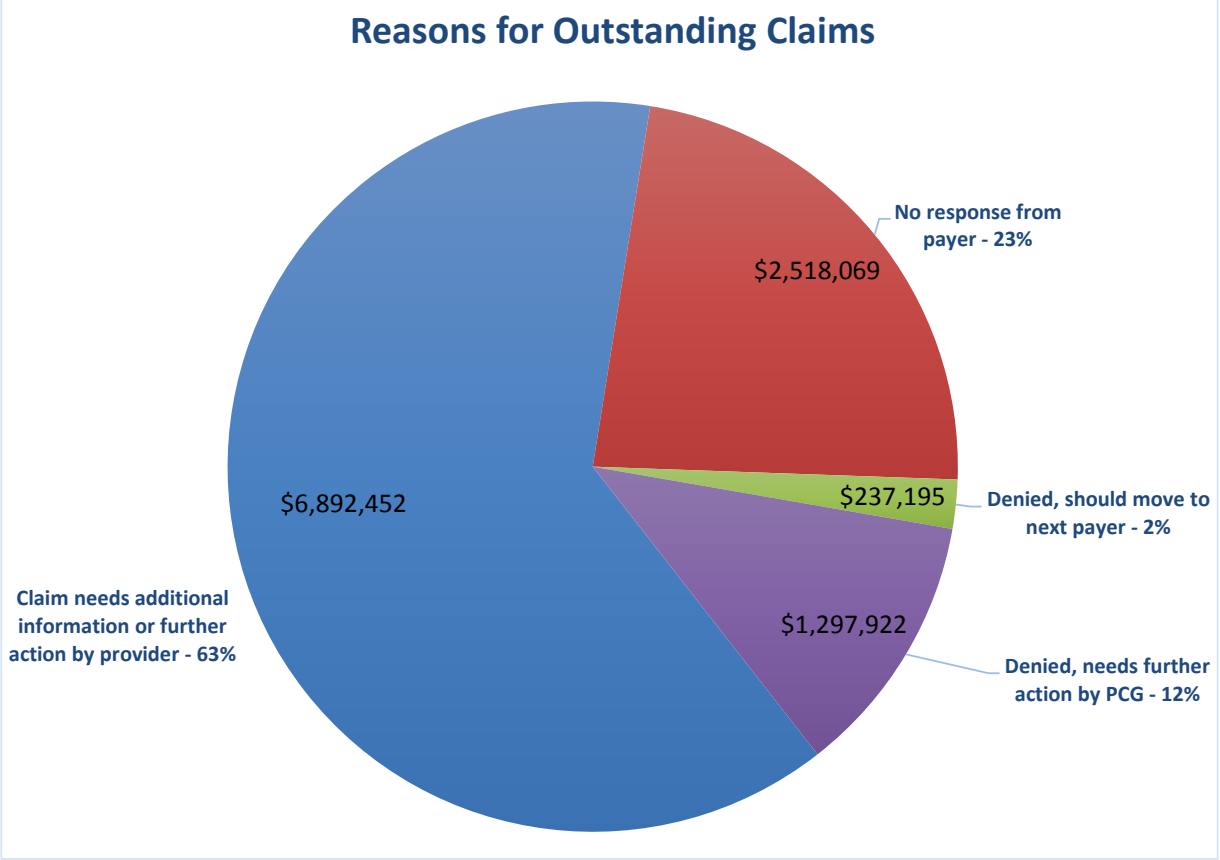
Although the timeliness of claim processing and payment improved considerably since 2013, processing of about $10.9 million in unpaid EI claims remained incomplete as of September 17, 2015. Most of the unpaid claims required actions from insurers; however, 31,127 claims (12 percent) primarily required SFA action to fully resolve.

Based on PCG information, as of September 17, 2015, there were 169,615 unpaid EI claims (totaling about $10.9 million) that were submitted between July 1, 2013 and June 30, 2015. The following table depicts the breakdown of unpaid claims by submission date ranges. Of the total unpaid claims, 65,500 (about 39 percent) were submitted between 8.6 and 26.9 months prior to September 17, 2015. The remaining 104,115 claims (61 percent) were submitted between 2.6 and 8.6 months prior to the report date.

Date Range of Submissions (Duration of Incomplete Processing as of September 17, 2015)	Number of Unpaid Claims	Percent of Unpaid Claims	Value of Unpaid Claims	Percent of Unpaid Claim Value
7/1/13 - 3/31/14 (17.8 – 26.9 months)	18,490	11%	$1,381,882	13%
4/1/14 - 12/31/14 (8.6 – 17.8 months)	47,010	28%	$3,644,032	33%
1/1/15 - 6/30/15 (2.6 – 8.6 months)	104,115	61%	$5,901,724	54%
Totals	**169,615**	**100%**	**$10,927,638**	**100%**

Commercial insurance claims, totaling about $6.3 million, accounted for 77,829 (46 percent of the unpaid claims) while Medicaid claims, totaling about $4.6 million, accounted for the remaining 91,786 (or 54 percent) of the unpaid claims. Of the claims in the 2.6-8.6 month range, 69 percent were Medicaid claims, and the remaining 31 percent were commercial insurance. In contrast, of the older claims, 70 percent were commercial insurance claims and 30 percent were Medicaid. Moreover, 18,490 claims (totaling about $1.4 million) had been outstanding for more than 17 months at the time of our review.

According to PCG data, the unpaid claims were outstanding for several reasons, primarily because additional information from and/or further action by the providers was required. The following pie chart illustrates the reasons why claims processing had not been completed.



The results of our analysis are detailed as follows:

- For 90,752 claims totaling $6,892,452 (or 63 percent of the unpaid amount), additional information or action by the provider was needed to enable PCG to send them to the next payer. For example, the provider may need to correct a name, date, or identification number because the initial claim data did not match insurance or Medicaid data on file.
- For 45,038 claims totaling $2,518,069 (or 23 percent of the unpaid amount), the first payer had not sent an Explanation of Benefits or remittance to the SFA, which prevents the SFA from knowing how much to pay the provider.
- For 31,127 claims totaling $1,279,922 (or 12 percent of the unpaid amount), claims were denied and the SFA needed to take further action, such as ensuring the claim was not a duplicate of another claim.
- For 2,698 claims totaling $237,195 (2 percent of the unpaid amount), the SFA is awaiting Explanation of Benefits or remittance information from a second payer, following the first payer's denial of the claim.

Department officials cited the lack of response to claims by private third-party payers as a major barrier to fully resolving these claims. Officials further pointed to the role of self-funded plans that are not subject to State Insurance Law in the volume of outstanding claims, and they also emphasized their efforts to address Medicaid denials that result from coding problems related to the authorized provider on file but still relate to otherwise valid claims.

SFA Submissions to First Payers

As noted previously, the timeliness of the SFA's submissions of EI claims to the first payer improved considerably since the SFA process began. Providers of EI services submit claims for payment through the New York Early Intervention System, the Department's claiming system. A small number of claims are submitted by municipalities through the legacy KIDS system, which will be phased out. The Department extracts the claims from the system and sends them to PCG weekly. PCG then begins the payment process by sending the claims to the first payer (commercial insurance, Medicaid, or escrow for claims to be paid in full by the State and county). The Department, provider, and municipalities can all monitor the status of claims through PCG's payment processing system, EIbilling.com.

The Service Level Agreement with PCG for claiming and adjudication includes a requirement for PCG to send a minimum of 98 percent of all "clean" EI claims (i.e., those without errors), for the month, to the first payer within one business day of receipt. An additional provision allows the Department to impose a penalty for failure to meet this requirement. We analyzed EI claims data from three non-consecutive months to determine when the relevant SFA sent claims to the first payer. Our sample consisted of 1.8 million claims totaling $133.6 million, and included one month (June 2013) when the interim SFA, McGuinness, processed claims and two months (May 2014 and April 2015) when PCG processed claims.

Our analysis indicated that the percent of claims the SFA sent to the first payer within one day improved over time. In June 2013, McGuinness sent 55 percent of the claims submitted that month to the first payer within one day. In May 2014, PCG processed 95 percent of the claims within one day; however, we were unable to determine how many of these were clean, and the Department did not impose a penalty, citing PCG's overall good performance. Data from April 2015 indicated that PCG sent 99 percent of the claims submitted that month within one day.

Timeliness of Payments

Initially, the transition to the SFA decreased the timeliness of payments to EI providers. However, since the changes took effect in 2013, the Department has worked with PCG (the current SFA) to reduce average payment time and to address barriers impeding effective claims processing and payment.

There are various criteria governing when claims must be paid. For example, State Insurance Law Section 3224-a requires commercial insurers to respond to (either pay in full or in part, or deny) clean claims within 30 days of receipt of electronic claims or within 45 days for claims submitted by other means, such as paper claims. Insurers that are not subject to State Insurance Law (unregulated insurance companies) are not required to respond within any specific time frame. Medicaid must pay clean claims within 90 days. Our analysis of timeliness focused on whether the Department, through the SFA, took steps to improve payment time overall.

There were significant delays in EI provider payments for several months immediately after the SFA took effect; however, the Department has made progress in addressing the issues causing

the delays. According to Department officials, initial delays in payments were due to startup problems, primarily regarding commercial insurance remittance forms. Many insurers were not sending the required information about the results of the claim adjudication process to the SFA, or were not responding to claims at all. Another problem affecting provider payments involved Medicaid error codes. For example, Code 35 billing errors occurred when there were changes in billing providers, and municipalities' records had not been updated for such changes. Further, Code 22 errors occurred when a claim for a child with commercial insurance was billed first to Medicaid rather than to the insurer, as required. Department officials also cited startup delays related to banks' issuing initial escrow payments.

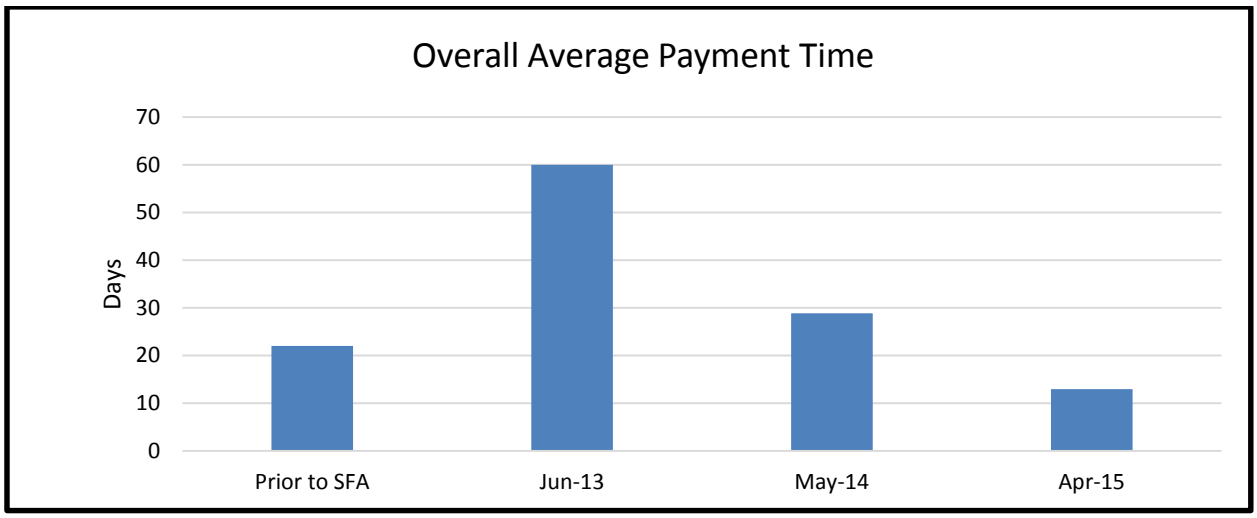
In August 2013, the Commissioner of Health issued a letter to health plan CEOs to urge their cooperation in helping to ensure timely payment of EI claims. The letter reminded recipients of the new law's requirements, and emphasized that health plan compliance was critical. It added that, since the April 1, 2013 implementation, only 23 percent of submitted EI claims had received a response from the insurer. In addition to insurers' lack of response, the letter cited errors and delays as contributing to late payments to providers for commercial insurance claims. Among these were insurers misdirecting EI payments to families instead of the provider, and remittance information being sent to providers instead of the SFA. The letter also included a link to guidance about the law. It also emphasized that the Department was working closely with health plans and the Department of Financial Services to identify ways for health plans to more quickly adjudicate EI provider claims.

To help address the payment delays, Department officials indicated that they took the following additional steps:

- Worked with the Department of Financial Services, which issued guidance to insurers in late June 2013 on specific changes in State law related to the SFA;
- Worked internally with Medicaid personnel to help remove barriers to faster payment;
- Increased the frequency of escrow payments from bi-weekly to weekly;
- Issued $6.8 million in "safety net" payments in to 172 providers for 75 percent of providers' outstanding claims that were submitted April 1 through July 29, 2013;
- Issued $2.6 million in additional payments to providers in accordance with a provision in the SFY 2014-15 budget that required payment for claims submitted to third-party payers, including Medicaid, for the period April 1 through June 30, 2013 that remained unpaid as of April 1, 2014. These payments were subject to any prior "safety net" reductions; and
- Agreed to an interim solution in which PCG, using eight additional full-time equivalent positions, would assist providers in entering Explanation of Benefits information to facilitate faster payment. The agreement had two areas of focus: resolving the oldest claims, and working with providers with the lowest adjudication rates. The agreement covered the period March 14 through June 30, 2015 at a cost to the Department of $75,000 per month, which did not increase the total contract cost.

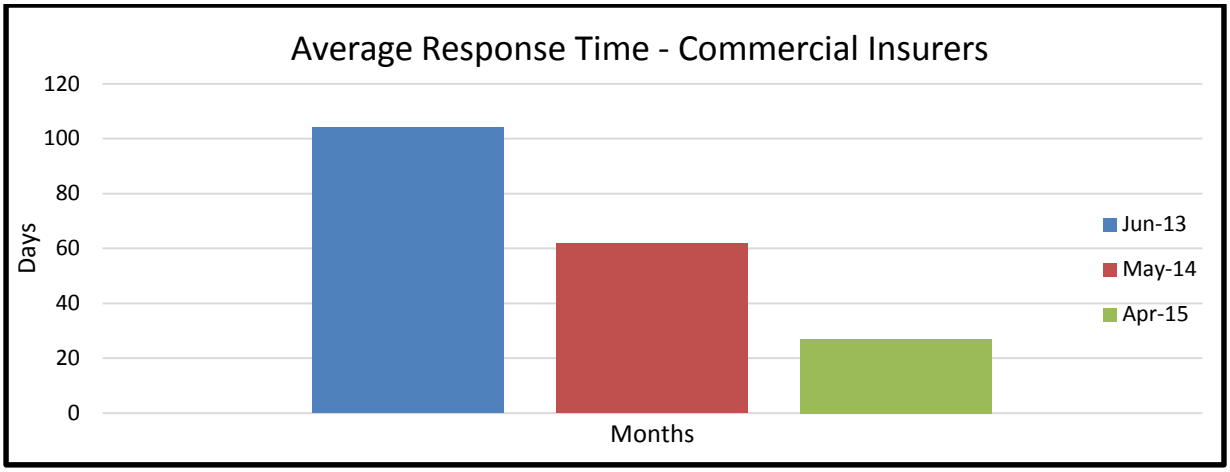
Department officials explained that they are also working with providers to enlist their participation in using a health care clearinghouse that will allow the SFA to electronically retrieve remittance data for submitted claims and therefore act to more quickly resolve and pay claims.

According to a report generated by the Department, the average time for a claim to be fully paid was 22 days in the quarter prior to the SFA taking effect, compared with 13 days in April 2015, more than two years into the SFA process. It is noteworthy that the data for June 2013, just two months after the SFA took effect, showed an average payment time of 60 days, reflecting the effect of some of the startup problems. The following bar chart summarizes the average payment time for these periods.



In addition, the percent of claims paid within 30 days of receipt improved. Based on our analysis of PCG claim data, in June 2013, 61 percent of the total claims submitted to PCG were paid within 30 days compared with 87 percent of total claims in April 2015, a 43 percent improvement.

In our sample of 1.8 million claims, 267,756 claims, or 15 percent, were commercial insurance-related. As indicated by the following chart, the average response time for commercial insurers improved. Based on our analysis of PCG claim data, in June 2013, it took on average 104 days for an insurer to either respond to, pay, deny, or pay part of a claim compared with 27 days in April 2015, a 77-day improvement.



The percentage of claims paid within 30 days of receipt also improved. In April 2015, 70 percent of claims submitted that month were paid within 30 days, a considerable improvement over June 2013, when just 27 percent of the claims were paid within that time.

Recommendation

1. Take prompt action to resolve the 169,615 unpaid claims by working with PCG, providers, and third-party payers. Continue to address any remaining barriers to timely payment of EI claims.

Other Deliverables

The Department generally provided effective oversight of the SFA's compliance with selected EI customer service and/or data and reporting deliverables. However, the Department should consider opportunities to work with the SFA to improve training efforts to better address stakeholder needs.

Customer Service

Based on our limited testing, Department oversight is effective in ensuring that selected elements of PCG's customer service are generally operating according to contract deliverables. However, there may be gaps in online training effectiveness that the Department, in cooperation with PCG, can improve upon to better meet stakeholder needs.

As part of the customer service deliverable, the contract requires that PCG provide a full Customer Service Center, including ongoing assistance to municipalities and EI providers via a call center, located in Nashville, Tennessee. Other elements of Customer Service include meeting correspondence operational requirements, web portal operations, and contact management systems. The Customer Service Center must meet the following standards:

- Answering all calls within four rings or 15 seconds;
- Resolving all information requests or questions within five business days; and
- Being staffed and available Monday through Friday, 7 a.m.–7 p.m.

PCG must also provide technology capable of receiving, tracking, and resolving provider and municipality complaints, and identify and track those that require additional information or follow-up from Department personnel. In addition, it must ensure the quality and timeliness of the related responses and any quality improvement procedures. For the period April 1, 2013 to July 31, 2015, the Department paid PCG $4.4 million for the customer service deliverable, averaging about $158,000 per month.

To assess call center responsiveness, we called the center on five occasions, and in each case representatives answered promptly and were courteous. We also reviewed the monthly Service Level Agreements that PCG submits to the Department that provide details about its performance by deliverable. Agreements include a call summary, which reports number of calls taken, average

call time, and average wait time, and a case summary, which reports the number of new cases, average age of closed cases, and first call resolution rate. For example, in December 2014 PCG reported that it achieved 100 percent completion for hours of call center availability, average speed to answer, and timely resolution. For the same month, PCG reported that commercial insurance accounted for 48 percent of calls, followed by Medicaid at 17 percent and EI Billing at 15 percent. PCG also reports to the Department daily about unresolved calls for that day, including status of the calls, the date they were opened, and target resolution date.

PCG reports show a decrease in number of calls, number of new cases, and average time spent on calls from October 2013 to October 2015. They also show an increase in the percentage of issues that were resolved on the first call. All of these reported results reflect improvement in the four measures of call center performance, as follows:

- Call volume decreased from 2,185 calls in October 2013 to 1,141 calls in October 2015, a decrease of about 48 percent;
- The number of new cases was 1,538 in October 2013 versus 823 in October 2015, a decrease of about 46 percent;
- Average time per call was nearly 10 minutes in October 2013 versus about 7 minutes in October 2015, a decrease of about 27 percent; and
- First call resolution increased from 60 percent in October 2013 to 75 percent in October 2015.

We also contacted EI providers and insurance companies to ask about their experience with the SFA. We contacted ten providers (six agencies and four individuals) and asked for their feedback on PCG's customer service, including the call center and online training, which includes webinars and videos to assist providers and municipalities. Of the ten providers:

- Six said the call center was helpful;
- Five found the online training useful; two said it was too vague to be helpful; and the remaining three were either neutral or didn't take any training; and
- Six said they experienced payment delays in the early stages of the SFA.

Despite the complaints about payment delays, eight of ten providers indicated there has been improvement in the SFA process and in customer service since PCG took over as SFA in October 2013.

We recommend the Department seek input from stakeholders to determine if the current levels of customer service and training are meeting their needs, and to work with PCG as needed to address gaps in this area. Department officials agreed with our recommendation and emphasized collaboration with the Department of Financial Services to inform and educate insurers regarding the SFA implementation, including its August 2013 letter and reminder of the requirements. They also said they'll request that PCG work with the SFA Steering Committee and other work groups to improve the responsiveness of online activities to the needs of EI stakeholders.

We contacted ten insurance companies for similar feedback on experience with the SFA:

- Eight of the ten insurance companies said the Department did not provide enough information in the early stages of the SFA process; and
- Four of the ten cited confusion about what was expected of them at the beginning of the SFA, but that it has since improved.

Similar to the providers, eight of the ten insurance companies said the SFA process is better now than when PCG took over as SFA in October 2013, and some attributed this to frequent phone calls and emails from the Department and PCG to resolve issues.

Data and Reporting

We found the Department's oversight of PCG's development of a data warehouse was generally effective in ensuring that the information meets the Department's EI data and reporting needs.

The data and reporting deliverable, as described in the PCG contract, includes a requirement to develop a data warehouse to support both standard and ad hoc reports and fulfill the Department's full EI data lifecycle needs. Implementation of the data warehouse includes six phases: design; database; extract transform and load; data validation; performance testing/ tuning; and implementation. The data warehouse is an integral part of the Department's ability to effectively oversee critical aspects of the EI program, such as claim status, and assess SFA performance in this area. The contract did not include a deadline or expected completion date for its full implementation.

For the period April 2013 through July 2015, the Department paid PCG $2.4 million for the data and reporting deliverable. Monthly payments ranged from a low of $21,237 in April 2013 (representing 20 percent of the monthly maximum amount of $106,183) to a high of $102,488 from November 2014 through July 2015 (representing 95 percent of the monthly maximum). The Department withheld the remaining 5 percent pending full implementation of the data warehouse. Department personnel stated in August 2015 that: all six phases were complete for claims submitted since April 1, 2013; PCG was working to extract data prior to April 1, 2013; and access to the warehouse would be complete by September 2015. As of November 2015, Department officials reported that the warehouse was fully functioning and that PCG had fulfilled its contract requirements in this area. We verified that access for one Department employee was in place and that the warehouse provided pertinent EI information, such as status of individual claims and escrow amounts paid to providers in a given period.

Recommendation

2. Work with PCG to gather input on potential enhancements to online training and customer service to better meet stakeholder needs.

Audit Scope and Methodology

Our performance audit determined whether the Department provided effective oversight of State Fiscal Agent contracts to ensure contractor compliance with contract deliverables, including timely processing of provider claims for Early Intervention services provided. The audit covered the period April 1, 2013 through December 10, 2015.

To accomplish our objective, we reviewed relevant laws, Department policies, contract documents, and contract performance reports for the period April 1, 2013 through October 31, 2015. We also reviewed minutes from Steering Committee and Leadership Committee meetings as well as those from Early Intervention Coordinating Council meetings that the Department participated in. We reviewed PCG claims data for three one-month periods and PCG-generated reports of outstanding claims from April 1, 2013 through August 31, 2015. We held numerous meetings with Department personnel involved in the Early Intervention Program to better understand the Program and the Department's role in overseeing the SFA. We also interviewed PCG personnel to better understand their process, their reports, and their data. We became familiar with and assessed the Department's internal controls as they related to its oversight of the SFA. We communicated our findings to Department management, and considered information they provided through December 10, 2015.

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

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. 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

This audit as performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered their comments in preparing this final report and have attached them in their entirety to it. In their response, Department officials indicated certain actions they took to address our recommendations.

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

Contributors to This Report

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Agency Comments

ANDREW M. CUOMO
Governor

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

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

March 14, 2016

Mr. John Buyce
Audit Director
New York State Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

Dear Mr. Buyce:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2015-S-22 entitled, "Oversight of Early Intervention Program's State Fiscal Agent."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Michael J. Nazarko
Ellen Anderson
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Diane Christensen
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-22 entitled,
Oversight of the Early Intervention
Program's State Fiscal Agent

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-22 entitled, "Oversight of the Early Intervention Program's State Fiscal Agent."

Recommendation #1

Take prompt action to resolve the 169,615 unpaid claims by working with PCG, providers, and third-party payers. Continue to address any remaining barriers to timely payment of EI claims.

Response #1

The 2016-17 Executive Budget includes a comprehensive proposal to improve insurance reimbursement and claiming procedures for early intervention services. This proposal would add new requirements on both Early Intervention Program (EIP) providers and insurers to achieve timely adjudication of EIP claims and administrative efficiencies in the claiming process. Specifically, under this proposal:

1. Providers would be required to submit all claims for payment of early intervention services within 90 days from the date of the service. Establishment of a timely filing requirement on EIP providers will ensure claims are received within payer requirements, expediting the claims adjudication process. The proposal allows for submission of claims by providers delayed due to extraordinary circumstances outside of the control of the provider with documentation.
2. Providers would be required to enroll in healthcare clearinghouses for processing of claims to third party payers and receipt of remittance advices from insurers in industry-standard, Health Insurance Portability and Accountability Act (HIPAA) compliant formats. This proposal would expedite the claims adjudication process by enabling the State Fiscal Agent (SFA) to continually retrieve claims adjudication information from insurers, and either work with providers to address issues necessary to resolve the claim or move the claim to the next payer for payment.
3. Insurers would be required to notify the provider as to whether the policy is subject to State Insurance law within 15 days of receipt of a claim. Insurers would also be required to request any additional information necessary to adjudicate the claim within that same timeframe. If an insurer fails to adhere to these standards, the claim would be deemed payable at rates established by the Department with approval of the Division of Budget, or rates the insurer negotiated with the provider, if higher.

The Department is also pleased to report that of $10.9 million in unpaid claims for the period July 1, 2013, through June 30, 2015, 58%, or $5.6 million, have now been paid. Of the remaining $5.3 million in unpaid claims, $3.9 million are unpaid insurance claims and $1.4 million are unpaid Medicaid claims.

Of the $3.9 million in unpaid insurance claims, 26% or $1,008,127 in claims are pending a response from insurers. An additional 54% require further action by providers, such as correction of an invalid subscriber ID, provider NPI not on file with the payer, or claim/services lacks

information which is needed for adjudication. Of the $1.4 million in unpaid Medicaid claims, 77% or $1,085,473 in claims are still outstanding due to further action required by the provider, primarily for correction of information related to the child or coordination of benefits (e.g. another insurer is on file with the Medicaid program).

The Department will continue to work with the SFA, providers, and third party payers to resolve all unpaid provider claims.

Recommendation #2

Work with PCG to gather input on potential enhancements to online training and customer service to better meet stakeholder needs.

Response #2

Currently the SFA offers training for providers and municipalities in the following areas:

Webinars

- Introduction to ICD-10 Diagnostic Codes
- Claim Rejections and Denial Training Presentation
- Accessing and Viewing Voided Claims in EI Billing
- Training 103, Part 1: Accurate Insurance Information Collection
- Training 103, Part 2: Insurance Data Entry for Claiming
- EI Billing Report Improvements and Tutorials
- Training for Providers Entering Insurance Information into NYEIS
- New York Early Intervention Provider Training 101 and 102
- Fiscal Agent Process For EI Providers
- DOH Webinar NYEIS Third Party Insurers
- DOH Webinar Early Intervention Billing and Claiming Part 1
- DOH Webinar Early Intervention Billing and Claiming Part 2

Tutorial Videos

- How to Sign Up for Electronic Funds Transfer (EFT)
- Calling Aetna's Dedicated Provider Service Center, for Service Coordinators
- EI Billing Reporting Enhancements & Functionality
- EI Billing Reports Tutorials:
  - Introduction, Logging In, and Exporting Data
  - Adjudicated Claims Turnaround by Municipality
  - Adjudicated Claims Turnaround by Payer
  - Adjudicated Claims Turnaround by Provider
  - Adjudicated Claims Turnaround Detail
  - Claims Aging Detail
  - Claims Aging Summary by Municipality
  - Claims Aging Summary by Payer
  - Claims Aging Summary by Provider
  - Detail Claims Report
  - Detail Transaction Report

- Medicaid Code 35 Error
- Summary by Municipality
- Summary by Payer for Provider Payments
- Summary by Provider
- Summary Trend by Month
- Setting Up a Provider Profile - This video will walk you through setting up your provider profile on EIBilling.com.
- Entering Service Record into EIBilling - A brief video tutorial detailing how to enter service records directly into EIBilling.com.
- Editing or Deleting Service Records - A brief video tutorial showing how to edit or delete service records once they are uploaded to EIBilling.com.
- Submitting a Bill - This video will show providers how to submit a bill using EIBilling.com.
- Using "My Dashboard" - A step by step summary of using the "My Dashboard" page once logged in to EIBilling.com.
- Downloading and Filling Out Excel Template - This video will walk you through the process of downloading, filling out, and saving the KIDS Service Records Excel Template.
- Uploading an Excel Spreadsheet - A video guide describing how to upload a saved Excel Spreadsheet to EIBilling.com.

All trainings are posted and available to EIP providers through the EI Billing website: https://www.eibilling.com/Public/TrainingVideos/PCGTraining.aspx. The EI Billing Website also has a Knowledge Base with over 280 informational articles for EIP providers.

The Department and the SFA are already developing and implementing new training programs that have been identified as areas of need by providers. For example, the SFA has developed a training program for providers on procedures for obtaining prior authorizations from insurers. This training is currently under final review by the Department and will be scheduled for delivery in the near future.

The Department will work with the SFA, and the SFA's Steering Committee on potential enhancements to online training and customer service to better meet stakeholder needs. Specifically, the Department will collaborate with the SFA and members of the Steering Committee to conduct a needs assessment to assess current training needs and customer satisfaction with the SFA's online training and customer service. Results of this needs assessment will be used to improve SFA services in this area.

The next meeting of the Steering Committee is being scheduled for the Spring, 2016.