Department of Health

Medicaid Program: Claims Processing Activity October 1, 2023 Through March 31, 2024

Report 2023-S-41 | February 2024

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

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 providers. The audit covered the period from October 2023 through March 2024, and certain claims outside this period when trends in the claims were observed that warranted follow-up.

About the Program

The Department of Health (DOH) administers the State's Medicaid program. DOH's eMedNY computer system processes claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the 6-month period ended March 31, 2024, eMedNY processed over 370 million claims, resulting in payments to providers of nearly $49.6 billion. The claims are processed and paid in weekly cycles, which averaged about 14 million claims and $1.9 billion in payments to providers.

Key Findings

The audit determined eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers. However, we also identified the need for improvements in the processing of certain types of claims. The audit identified over $16.2 million in improper payments, as follows:

- $11.8 million was paid for managed care premiums on behalf of Medicaid recipients who should not have had managed care coverage because they had other concurrent comprehensive third-party health insurance;
- $2 million was paid for fee-for-service inpatient claims that should have been paid by managed care;
- $1.3 million was paid for newborn birth and maternity claims that contained inaccurate information, such as low newborn birth weights that increased reimbursements;
- $964,333 was paid for inpatient, pharmacy, referred ambulatory, and clinic claims that did not comply with Medicaid policies;
- $126,786 was paid for claims where Medicaid was incorrectly designated as the primary payer instead of another insurer; and
- $35,441 was paid for managed care premiums on behalf of incarcerated recipients whose managed care coverage should have been suspended.

As a result of the audit, more than $2.8 million of the improper payments was recovered. We also identified 10 Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. In response to the findings, DOH removed nine of the providers from the Medicaid program and had not yet resolved the program status of the remaining provider.

Key Recommendations

- We made 10 recommendations to DOH to recover the remaining inappropriate Medicaid payments and improve controls.

Office of the New York State Comptroller
Division of State Government Accountability

February 6, 2025

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the 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 *Claims Processing Activity October 1, 2023 Through March 31, 2024*. 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,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
eMedNY	DOH's Medicaid claims processing and payment system	*System*
DRG	Diagnosis Related Groups	*Key Term*
MCO	Managed care organization	*Key Term*
NYSOH	NY State of Health	*System*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Individuals can enroll in Medicaid through Local Departments of Social Services or the NY State of Health (NYSOH), the State's online health plan marketplace. For the State fiscal year ended March 31, 2024, New York's Medicaid program had approximately 9.1 million recipients and Medicaid claim costs totaled about $87.5 billion. The federal government funded about 56.8% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.2%.

The Department of Health's (DOH's) Office of Health Insurance Programs administers the State's Medicaid program. DOH'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 6-month period ended March 31, 2024, eMedNY processed over 370 million claims, resulting in payments to providers of nearly $49.6 billion. The claims are processed and paid in weekly cycles, which averaged about 14 million claims and $1.9 billion in payments to providers.

The Medicaid program pays health care providers through the fee-for-service method or through managed care. Under fee-for-service, DOH makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, DOH pays managed care organizations (MCOs) a monthly premium for each Medicaid recipient enrolled in the MCOs. The MCOs are then responsible for ensuring recipients have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services provided to recipients and are required to submit encounter claims to inform DOH about each medical service provided.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY 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, we work with DOH 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 6 months ended March 31, 2024, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers.

However, we also identified the need for improvements in the processing of certain types of claims. We found over $16.2 million in improper payments pertaining to: MCO premiums for enrollees with concurrent comprehensive third-party health insurance; fee-for-service claims for inpatient services that should have been covered by each recipient's MCO; newborn birth and maternity claims that contained inaccurate birth information or diagnosis codes; inpatient, pharmacy, referred ambulatory, and clinic claims that did not comply with Medicaid policies; claims where Medicaid was incorrectly designated as the primary payer instead of another insurer; claims where Medicaid overpaid for drugs that should have been discounted as part of the 340B Drug Pricing Program; and MCO premiums for incarcerated recipients whose managed care coverage should have been suspended.

At the time the audit fieldwork concluded, more than $2.8 million of the improper payments had been recovered. DOH officials need to take additional actions to review the remaining inappropriate payments totaling almost $13.4 million and recover funds, as warranted.

We also identified 10 providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. We advised DOH officials of the providers and, by the end of the audit fieldwork, DOH had removed nine of them from the Medicaid program and was still reviewing one.

Improper Managed Care Premium Payments for Recipients With Comprehensive Third-Party Health Insurance

Medicaid recipients may have additional sources of coverage for health care services (i.e., third-party health insurance). DOH's policy is to exclude Medicaid recipients from enrollment in mainstream managed care when they also have concurrent comprehensive third-party health insurance (third-party health insurance is considered comprehensive if it covers certain types of services, among them: hospital care, physician services, pharmacy, and hospice care). These recipients should, instead, be enrolled in Medicaid fee-for-service, which is generally more cost effective in these circumstances.

We found problems with the managed care disenrollment process that led to improper managed care premium payments of approximately $11.8 million between October 2023 and March 2024 (see the following table).

Enrollment Type	Number of Claims	Premium Amount
NYSOH	16,655	$5,822,853
Non-NYSOH	10,825	5,973,916
Totals	27,480	$11,796,769

According to DOH procedures, disenrolling managed care enrollees through NYSOH is an automatic process done prospectively at the end of the current month or the end of the following month (based on when the third-party health insurance is identified). Additionally, DOH generates a monthly list to identify non-NYSOH enrolled members (members enrolled in Medicaid through Local Departments of Social Services) for disenrollment. We found instances where the disenrollment processes were not done timely. For example, one managed care enrollee's comprehensive third-party health insurance was updated in eMedNY in April 2023. Although the managed care enrollment should have been terminated prior to the start of the audit period (October 2023), this recipient's managed care enrollment continued through the end of the audit period (March 2024). As a result, Medicaid made six improper premium payments totaling $2,121 on behalf of this recipient during the audit period.

Recommendation

1. Review the $11.8 million in overpayments, disenroll the members from managed care plans, and make recoveries, as appropriate.

Improper Fee-for-Service Payments for Inpatient Services Covered by Managed Care

When a provider accepts a Medicaid managed care enrollee as a patient, the provider agrees to bill the enrollee's managed care plan for covered services and should not bill DOH directly for payment under the fee-for-service method. We identified 88 overpayments, totaling $1,969,028 for inpatient claims with service dates between January 2023 and February 2024, where fee-for-service payments were made for recipients enrolled in managed care plans that should have paid for the services. Of these overpayments, 74 were due to retroactive managed care coverage, including 61 for newborns. For instance, a child born to a mother enrolled in a managed care plan is enrolled in the mother's plan from the child's date of birth. However, DOH lacks an effective process to timely identify and recover improper fee-for-service payments resulting from retroactive updates to a recipient's managed care plan enrollment, including retroactive enrollment of a newborn into their mother's plan back to the child's date of birth. The remaining 14 overpayments occurred due to providers incorrectly billing fee-for-service when the recipient had managed care coverage. We contacted the providers for each of the claims we identified and 49 were adjusted, saving Medicaid $966,524. However, the remaining 39 claims totaling $1,002,504 still needed to be adjusted.

Recommendation

2. Review the $1,002,504 in overpayments and make recoveries, as appropriate.

Incorrect Newborn Birth Claims

New York State Medicaid uses Diagnosis Related Groups (DRGs) to serve as the basis of payment for inpatient neonatal claims. The assignment of DRGs on neonatal claims is based on various factors, including birth weight. Newborns with low birth weights require higher levels of care and, therefore, Medicaid pays a higher reimbursement for these claims. As such, errors in reporting birth weight on newborn claims can result in improper Medicaid payments. We identified seven neonatal claims totaling $784,741 that contained unusual characteristics, such as low birth weights combined with discharges home after short lengths of stay. In one case, a newborn's birth weight was erroneously reported to Medicaid as 150 grams (roughly 0.33 pounds) when the correct birth weight was 2,910 grams (roughly 6.4 pounds). As a result of the error, Medicaid overpaid the claim by $91,766. By the end of our fieldwork, providers had adjusted all seven claims, resulting in cost savings of $707,116.

Recommendation

3. Formally advise the hospitals identified to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Incorrect Maternity and Newborn Birth Claims Involving Managed Care

In addition to monthly premium payments, Medicaid pays MCOs a one-time Supplemental Maternity Capitation Payment for the inpatient birthing costs of each newborn as long as it is a live birth or a stillbirth. If the pregnancy ends in a termination or miscarriage, the MCO should not receive the Supplemental Maternity Capitation Payment. Additionally, if a newborn weighs less than 1,200 grams (approximately 2.64 pounds) at birth, Medicaid also pays MCOs a one-time Supplemental Low Birth Weight Newborn Capitation Payment to cover the higher cost of care these newborns require. In addition to these supplemental payments to the MCOs, hospitals receive a fee-for-service graduate medical education claim payment for the care provided to newborns enrolled in MCOs to cover the costs of training residents.

Errors in reporting information, such as incorrect birth weight or diagnosis code, on newborn and maternity claims can result in improper Medicaid payments. We identified such errors on 17 claims that resulted in overpayments totaling $622,446. By the end of our fieldwork, providers had adjusted 16 claims, resulting in Medicaid savings of $504,684. However, actions were still needed to address the remaining claim, totaling $117,762. In July 2024, DOH sent an email to MCOs reminding them to accurately report newborn and maternity claim information when billing Medicaid.

Supplemental Low Birth Weight Newborn Capitation Payments

We identified $473,317 in overpayments for four Supplemental Low Birth Weight Newborn Capitation claims. The overpayments occurred because MCOs reported inaccurate birth weight information on claims and because they claimed Supplemental Low Birth Weight Newborn Capitation Payments on stillbirths. For example, an MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 1,115 grams. We reviewed the corresponding medical records provided by the MCO and noted a reported birth weight of 1,241 grams. We notified the MCO of the discrepancy. The MCO admitted its error and corrected the claim, saving $117,666.

By the time our fieldwork concluded, three of the Supplemental Low Birth Weight Newborn Capitation claims had been corrected for a cost savings of $355,555. However, actions were still needed to address the remaining one claim, totaling $117,762.

Supplemental Maternity Capitation Payments

We identified 13 claims totaling $149,129 for improper Supplemental Maternity Capitation Payments to MCOs between September 2023 and February 2024. In each case, there was either no indication of a birth in eMedNY or the pregnancy ended in a termination or miscarriage. Therefore, the MCOs were not eligible for the supplemental payment. According to the MCOs we contacted, the payments occurred because of billing errors. By the end of our fieldwork, the MCOs had adjusted all 13 of the claims, saving Medicaid $149,129.

Recommendation

4. Review the $117,762 in overpayments and make recoveries, as appropriate.

Improper Payments for Inpatient, Referred Ambulatory, and Clinic Claims

We identified $569,435 in overpayments on four inpatient claims, 30 referred ambulatory claims, and two clinic claims that resulted from errors in billing. By the time our fieldwork concluded, four claims had been adjusted, saving Medicaid $531,322. However, corrective actions were still required to address the remaining 32 claims with overpayments totaling $38,113.

The overpayments occurred under the following scenarios:

- Providers are responsible for submitting claims with correct information. We identified $531,322 in overpayments on four inpatient claims on which the providers entered incorrect information. For example, one provider entered incorrect discharge information on a claim. After we contacted the provider,

they voided the claim and re-submitted a corrected claim, saving Medicaid $193,490. By the end of our fieldwork, the providers had adjusted all four claims, resulting in Medicaid savings of $531,322.

- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified 30 claims for practitioner-administered drugs billed by one hospital at more than the acquisition cost, resulting in overpayments of $34,350. By the end of our fieldwork, all 30 claims needed to be adjusted.
- Medicaid providers are required to maintain all records for a period of 6 years and to have them readily accessible for audit purposes. We requested records for two claims from clinics that did not respond to our records request. As a result, we consider the services unsupported. Medicaid paid $3,763 for these unsupported claims, and this amount should be followed up on for recovery.

Recommendations

5. Review the $38,113 ($34,350 + $3,763) in overpayments and make recoveries, as appropriate.
6. Formally advise the hospital identified in this report to accurately bill Medicaid for the acquisition cost of certain practitioner-administered drugs.

Questionable Pharmacy Claims

The New York Medicaid Pharmacy Program covers drugs that are indicated for U.S. Food and Drug Administration-approved or -compendia supported uses. For example, Targretin 1% gel is indicated for the topical treatment of cutaneous lesions in patients with Cutaneous T-cell Lymphoma. It also has compendia support for the treatment of Kaposi sarcoma, plaque psoriasis, and lymphomatoid papulosis.

We identified 14 pharmacy claims totaling $394,898 on behalf of one Medicaid recipient for Targretin 1% gel. The prescriptions were filled from June 2023 through June 2024. Auditors obtained the medical documentation from the prescribing provider to determine the medical necessity of the prescriptions. According to written correspondence from the prescriber, the drug was being used to treat a rash on the recipient's stomach around the area of a percutaneous fluoroscopic gastrostomy (tube placement). We provided the documentation to DOH officials for review. Officials stated there was not enough medical history in the information from the prescriber to conclude on whether Targretin 1% gel was used appropriately. A DOH pharmacist contacted the prescriber on June 20, 2024; the prescriber failed to establish medical necessity and DOH educated the prescriber on appropriate uses of the Targretin 1% gel. Subsequent to DOH's communication with the prescriber in June 2024, we observed the pharmacy had not billed any additional claims for Targretin 1% gel on behalf of this Medicaid recipient. We found the prescriber could not support the appropriate use of the drug. Therefore, we encourage DOH to review the medical documentation needed to determine the appropriateness of the 14 claims billed prior to their contact with the prescriber.

Recommendation

7. Review the $394,898 in pharmacy payments and make recoveries, as appropriate.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have additional health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, health care providers must verify whether recipients had other insurance coverage on the dates that services were provided. If a recipient had other insurance coverage, the other insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the recipient's normal financial obligations, including deductibles, coinsurance, and copayments. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer.

Errors in the designation of the primary payer may result in improper Medicaid payments. We identified overpayments totaling $126,786 for two claims in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. We contacted the two providers and advised them that the recipients had other insurance coverage at the time the services were provided. As a result, one provider adjusted a claim, saving Medicaid $113,251. The second claim totaling $13,535 still needed to be adjusted.

Recommendation

8. Review the $13,535 in overpayments and make recoveries, as appropriate.

Improper Managed Care Premium Payments During Recipient Incarceration

When incarcerated individuals physically reside in a correctional facility, they are only eligible for Medicaid payment of inpatient hospitalization services provided off the grounds of the correctional facility. Medicaid managed care recipients who are incarcerated for at least 30 days should be moved to fee-for-service coverage, and managed care premium payments should not be paid on their behalf. We identified 25 improper premium payments totaling $35,441 on behalf of nine incarcerated recipients for the period from March 2021 through August 2023.

All nine managed care recipients received inpatient care from the same hospital during the audit period. We contacted the hospital and, according to information provided by hospital officials, each recipient was incarcerated at the time of the inpatient stay. For example, one recipient was incarcerated from May 2021 through October 2021 (i.e., over 30 days and should have been moved to fee-for-service coverage), and Medicaid paid $12,659 in improper managed care premiums during this time.

DOH has long-standing agreements with the New York State Department of Corrections and Community Supervision, New York State Division of Criminal Justice Services, and New York City's Rikers Island facilities to provide DOH with information on individuals who have been incarcerated for more than 30 days. However, according to DOH officials, it can be difficult for DOH to identify when certain recipients are incarcerated because they lack notification agreements with some local jails. Of the nine recipients we identified, six were incarcerated at a Rikers Island facility, and the remaining three had already been released, so the incarceration facility was not on file.

Recommendation

9. Review the $35,441 in overpayments and make recoveries, as appropriate.

Status of Providers Who Violate Program Requirements

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, DOH 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 DOH 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 recipients, perhaps placing recipients at risk of poor-quality care while the provider continues to receive Medicaid payments.

We identified 10 Medicaid providers, including individuals and individual owners of organizations, who were charged with or found guilty of crimes that violated laws or regulations of a health care program, or who were otherwise barred from participating in the Medicaid program. All 10 providers had an active status in the Medicaid program. We advised DOH officials of the 10 providers and by the end of the audit fieldwork, DOH had removed nine of them from the Medicaid program and one was still under review.

Recommendation

10. Ensure providers who violate Medicaid or other health insurance program provisions are subject to appropriate and timely sanctions, including removal from the Medicaid program.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether DOH'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 providers. The audit covered the period from October 2023 through March 2024, and certain claims outside this period when trends in the claims were observed that warranted follow-up.

To accomplish our audit objective and assess related internal controls, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments, and tested the operation of certain system controls. We spoke to officials from DOH and reviewed applicable sections of federal and State laws and regulations, examined DOH's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement.

We used a non-statistical sampling approach to review for accuracy and appropriateness. We selected judgmental and random samples for this work. Because we used a non-statistical sampling approach, we cannot project the results to the populations. Our samples, which are discussed in detail in the body of our report and summarized in the Exhibit, included:

- A judgmental sample of 1,831 claims totaling approximately $158.7 million selected based on dollar amount and on areas identified as risk on prior audits;
- A random sample of 78 pharmacy claims totaling approximately $2.6 million; and
- All claims that did not follow payment rules pertaining to comprehensive third-party insurance coverage.

We relied on data from the Medicaid Data Warehouse (MDW) and eMedNY that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit. We also relied on data obtained from the U.S. General Services Administration and U.S. Department of Health and Human Services, which are recognized as appropriate sources, and used this data for widely accepted purposes. Therefore, this data is sufficiently reliable for the purposes of this report without requiring additional testing.

Statutory Requirements

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.

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. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight and administration of Medicaid claims processing activity from October 1, 2023 through March 31, 2024.

Reporting Requirements

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

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Exhibit

Summary of Sampled Claims

Sample Category	Claims Sampled	Claims With Findings
Comprehensive third-party health insurance	27,480	27,480
Various claim types	1,831	188
Randomly selected pharmacy claims	78	1
Totals	**29,389**	**27,669**

Agency Comments

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

November 21, 2024

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

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2023-S-41 entitled, "Medicaid Program: Claims Processing Activity October 1, 2023 through March 31, 2024."

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Michael Lewandowski
Jennifer Danz
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Gentile
Michael Atwood
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DOH Audit

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

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2023-S-41 entitled, "Medicaid Program: Claims Processing Activity October 1, 2023 through March 31, 2024."

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2023-S-41 entitled, "Medicaid Program: Claims Processing Activity October 1, 2023 through March 31, 2024." Included in the Department's response is the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

Recommendation #1

Review the $11.8 million in overpayment, disenroll the members from managed care plans, and make recoveries, as appropriate.

Response #1

OMIG continuously performs audits of comprehensive third-party health insurance, to ensure Medicaid is the payor of last resort. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2

Review the $1,002,504 in overpayments and make recoveries, as appropriate.

Response #2

OMIG is performing analysis on the OSC-identified inpatient claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete, confirm the accuracy of the claims detail for use in OMIG audit activities, to determine those overpayments requiring recovery. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $121,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #3

Formally advise the hospitals identified to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Response #3

The Department has included a Medicaid Update article in the September 2024 issue, titled "*Reminder: Billing for Hospitals Reporting Newborn Claim Information*", which addresses the OSC recommendation. The article can be found in Volume 40-Number 10: Medicaid Update - New York State Department of Health.

Recommendation #4

Review the $117,762 in overpayments and make recoveries, as appropriate.

Response #4

OMIG continuously performs audits of supplemental maternity capitation payments to Managed Care Organizations. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $115,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #5

Review the $38,113 ($34,350 + $3,763) in overpayments and make recoveries, as appropriate.

Response #5

OMIG is performing analysis on the OSC-identified claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete, confirm the accuracy of the claims detail for use in OMIG audit activities, to determine those overpayments requiring recovery. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $461,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #6

Formally advise the hospital identified in this report to accurately bill Medicaid for the acquisition cost of certain practitioner-administered drugs.

Response #6

The Department will advise the provider identified, to accurately submit the actual acquisition cost of the drug per program policy.

Recommendation #7

Review the $394,898 in pharmacy payments and make recoveries, as appropriate.

Response #7

OMIG continuously performs audits of pharmacy claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #8

Review the $13,535 in overpayments and make recoveries, as appropriate.

Response #8

OMIG continuously performs audits of other insurance claims, to ensure Medicaid is the payor of last resort. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $136,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #9

Review the $35,441 in overpayments and make recoveries, as appropriate.

Response #9

OMIG continuously performs audits of incarcerated individuals. OMIG conducts an annual outreach to county jails across New York State to identify incarcerated Medicaid Managed Care enrollees whose incarceration may not have otherwise been reported. OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities.

Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #10

Ensure providers who violate Medicaid or other health insurance program provisions are subject to appropriate and timely sanctions, including removal from the Medicaid program.

Response #10

OMIG sanctions individuals based on findings of unacceptable practices discovered during investigations or audits of providers, as well as taking derivative actions that originate from other agencies including Office of Professional Discipline, Office of Professional Medical Conduct, US Health and Human Services - Office of Inspector General, and NYS Attorney General's Medicaid Fraud Control Unit. OMIG also performs searches of the internet to identify providers that have been arrested or convicted of health care related crimes, determines if they are participating in the Medicaid program and appropriately sanctions them. OMIG excludes providers from the Medicaid program under the provisions of 18 NYCRR § 515.3 (Sanctions for Unacceptable Practices), 18 NYCRR § 515.7 (Immediate Sanctions), and/or 18 NYCRR § 515.8 (Mandatory Exclusions). OMIG maintains an exclusion list that is updated daily on the OMIG website, which contains both enrolled providers and non-enrolled persons/entities.

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