Department of Health

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Executive Deputy Commissioner

DATE 3/15/2021

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 Follow-Up Audit Report, 2020-F-8 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Care" (Follow Up to Report 2017-S-74) .

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen
Jonah Bruno
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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2020-F-8 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Care" (Report 2017-S-74)

The following are the responses from New York State Department of Health (Department) to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2020-F-8 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Care (Report 2017-S-74)."

Recommendation #1:

Review the $36 million in improper Medicaid FFS payments we identified and make recoveries, as appropriate.

Status – Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. During the initial audit, we provided OMIG with a file containing the overpayments we identified. As of May 6, 2020, OMIG had only recovered $359,518 of the $36 million in improper payments we identified.

Over $22.3 million (of the $36 million) in overpayments were for newborn inpatient claims. According to OMIG officials, OMIG still plans to pursue improper payments made to various hospitals for services provided to newborns retroactively enrolled into managed care, including four of the hospitals that had the highest number of inappropriate FFS claims identified by our audit. We note, however, that about $13.7 million (38 percent) of the total $36 million in overpayments were not related to newborn inpatient claims and these recoveries should be pursued. In addition, OMIG may have already lost the opportunity to recover about $5.3 million in overpayments due to federal lookback provisions. Therefore, we encourage the Department and OMIG to take prompt action on all of the remaining improper payments identified by the initial audit to prevent further loss of recoveries.

Response #1:

To date, OMIG has recovered $190,594 and verified additional provider-initiated voids totaling $252,341. It is also currently conducting data analysis to perform the next audit cycle of newborn inpatient claims. OMIG performs 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. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2:

Work with Maximus and the LDSSs to ensure newborn managed care eligibility is updated promptly, retroactive to the month of birth.

Status – Partially Implemented

Agency Action - The Department contracts with Maximus Inc. (Maximus) to operate a statewide enrollment center for public health insurance programs, including Medicaid. Maximus handles managed care enrollments in most counties of New York, including New York City. Our initial audit found delays in newborn enrollment can be prolonged in counties for which Maximus

handles the enrollment process because Maximus cannot enroll newborns retroactively. Rather, Maximus must coordinate with LDSSs and LDSSs must manually correct the effective enrollment date, retroactively enrolling the newborns to the first day of the birth month.

In response to our audit, the Department sent letters to LDSSs to inform them of our audit findings and to remind them of the importance of timely newborn enrollments into the mothers' Plans. However, the Department has not had any formal discussion or other follow-up action with any LDSSs, or Maximus, since sending the letters.

We analyzed inpatient claims since the initial audit, for the period May 1, 2018 through December 31, 2019, and found Medicaid improperly paid 641 claims totaling $4.5 million on behalf of 601 newborns who were retroactively enrolled into Plans. We also calculated the number of days after birth it took to enroll the 601 newborns into Plans. The results are shown in the following table.

Timing of Newborn Enrollment	Number of Claims	Medicaid Payments	Number of Newborns
Within 30 days	156	$751,904	152
Between 31 to 60 days	141	737,614	135
Between 61 to 90 days	112	996,802	104
More than 90 days	**232**	**2,066,727**	**210**
Totals	**641**	**$4,553,047**	**601**

Note: 75 percent of cases took over 30 days to enroll newborns.

Overall, the timeliness of retroactive enrollment for newborns has shown modest improvement since our initial audit. While the initial audit found that 80 percent of the newborns associated with our findings required over 30 days to be enrolled, our updated analysis showed it still took more than 30 days for 75 percent of the newborn retroactive enrollments. As such, Medicaid is at risk of making improper payments for services provided to newborns until they are properly enrolled in their mothers' Plans.

Of note, Rockland County LDSS was identified in our initial audit as a district with one of the highest number of improper newborn Medicaid Fee-for-Service FFS claims. In response to the audit and the Department's letter, Rockland established and implemented procedures to better identify reported pregnant mothers and newborns within the district and enroll these newborns into managed care more promptly. Our updated analysis determined Rockland improved the timeliness of enrollment and was no longer among the LDSSs in our findings population with the highest number of improper claims. We commend Rockland County for taking these steps and encourage the Department to work with other LDSSs to do the same. As shown in the Agency Action section of Recommendation 1, recovering these improper Medicaid payments does not always happen, and it is best to implement preventive measures to avoid improper payments in the first place.

Response #2:

As part of the follow-up audit, OSC conducted a supplemental 20-month review of inpatient newborn claims for the period May 1, 2018 to December 31, 2019. The results of this

supplemental review were mischaracterized to assert that only modest improvements occurred since the initial audit based on following reasons:

1. More than one-third of the supplemental review period occurred *before* November 2018, which is when OSC first shared a draft audit report with the Department; and
2. Over half of the review period was before the Department was even capable of implementing corrective actions in March 2019.

Despite the skewed time frame used for the follow-up review, OSC's report later indicates significant progress was made by Rockland County LDSS to adhere to the Department's rules and guidance regarding timely newborn enrollments after the Department issued a letter to all districts reminding them of the importance of timely newborn enrollments into their mothers' Plans.

Since issuing the letter, the Department continues to make advancements with newborn enrollments to ensure improvements continue to be realized in other districts. For example, an analysis conducted by the Department determined that many of the follow-up audit cases with delayed managed care enrollment were newborns receiving Temporary Assistance/Medicaid. To address this issue, the Department partnered with the Office of Temporary and Disability Assistance to issue a General Information System (GIS) Message in December 2020 to re-educate Temporary Assistance workers on correct policy and procedure for newborn enrollment, as well as the need to timely enroll newborns in managed care (https://otda.ny.gov/policy/gis/2020/20DC110.pdf). The GIS was also distributed to all LDSS Medicaid Directors as a follow-up reminder to the March 2019 letter.

In addition, a new monthly report is being developed to assist Department staff in identifying newborns with delayed managed care enrollment. This report process will evaluate newborns added to upstate Welfare Management System (WMS) cases in the preceding month to determine whether they are enrolled in Medicaid managed care within 10 days after being added to the case. The Department will notify districts of any cases with delayed enrollments and will assist districts as needed to decrease their enrollment timeframes. Department staff is expected to receive the first test report in March 2021 and will begin using the report to ensure it assists with identifying delayed newborn enrollments. The Department anticipates the report will be ready to be distributed to districts in May 2021. A monthly report for NYC WMS cases is also being developed.

Recommendation #3:

Coordinate with the entities responsible for managed care enrollments to prevent inappropriate FFS payments, particularly for newborn enrollees. Steps should include, but not be limited to:

- Working with Plans to identify pregnant enrollees and to ensure Plans promptly notify LDSSs and NYSOH of pregnancies to allow for the timely creation of Unborn CINs;

- Reminding hospitals that they must contact Plans and not bill Medicaid FFS for newborn-related medical services when the mother is enrolled in a Plan but the newborn's managed care does not exist; and

- Ensuring Plans correct their procedures and processes to make timely payments to

hospitals for newborns not yet enrolled in mothers' Plans, including when newborns are not on the monthly rosters.

Status – Partially Implemented

Agency Action - Generally, Plans are required to pay for medical services for newborns whose mothers are Plan enrollees. Our initial audit found that when a newborn is not enrolled in a mother's Plan prior to birth, the newborn's managed care enrollment may be delayed, resulting in hospitals improperly billing Medicaid FFS for the newborn's medical services. We also found that certain Plans did not have processes and procedures in place to pay for services billed by hospitals on behalf of newborns not yet enrolled in a Plan.

On February 5, 2019, the Department sent a letter to Plans reminding them of their responsibility to coordinate with LDSSs to ensure newborns are promptly enrolled into Plans. This includes notifying NYSOH (the State's online health insurance marketplace) or the LDSS in writing within five days of learning of a pregnancy. The letter also explained that Plans are required to cover the infant's hospital stay when the mother is enrolled in a Plan at the time of birth, even if the newborn is not yet on the Plan's roster of enrollees. However, the Department was unable to demonstrate steps were taken to ensure Plans (such as the ones identified in our initial audit) corrected processes and procedures to make such payments.

On March 12, 2019, the Department sent a letter to hospitals reminding them of their requirement to report each live birth to the Department within five business days of the date of birth, or face a $3,500 fine per occurrence. The letter outlined the hospitals' responsibilities in the newborn managed care enrollment process. In addition, hospitals were reminded not to bill Medicaid FFS for newborns of a mother enrolled in a Plan. Rather, the hospital should bill the Plan for the birth-related services.

Response #3:

The Department continues to work with hospitals as needed to clarify policy around Medicaid newborns and to resolve enrollment issues. The Department is reminding hospitals of requirements for billing newborns as part of an upcoming Medicaid Update article.

Additionally, the Department's operational survey of Plans includes verification of compliance by the Plan that the Plan notified the Local Districts of Social Services (LDSSs) or NY State of Health (NYSOH) within five days, and that the Plan's policies and procedures reflect this requirement. Through the established complaint process, hospitals may notify the Department should payments from a Plan be delayed, which will result in a focused survey.

Recommendation #4:

Remind hospitals to report every live birth to the Department within five business days and monitor the timing of their reporting, assessing penalties, if warranted.

Status – Implemented

Agency Action - The Department's March 12, 2019 letter reminded hospitals of their statutory responsibility to report every live birth within five business days of birth. In addition, the Department developed a database that allows hospitals to report these births and allows the

Department to verify the dates that births were reported. The database is updated weekly by all birthing hospitals in New York. Additional functionality is being developed to allow the Department to use the database to track reporting and identify data entry errors made by hospitals in order to monitor hospitals' compliance with reporting requirements.

Response #4:

The Department confirms agreement with this recommendation.

Recommendation #5:

Develop a process to routinely identify and recover improper Medicaid FFS payments for managed care services resulting from retroactive updates to recipients' managed care eligibility and scope of benefits information in eMedNY.

Status – Not Implemented

Agency Action - Our initial audit determined the Department and OMIG did not have a process to identify and recover improper FFS payments for managed care-covered services resulting from non-newborn-related retroactive updates to recipients' managed care eligibility and scope of benefits information in eMedNY. Although the Department's response to our audit indicated it would work with OMIG to develop such a process, the Department has been unable to substantiate efforts made to do so.

Subsequent to the initial audit, for the period May 1, 2018 through December 31, 2019, we determined the Department made $2.4 million in improper Medicaid FFS payments for 299 non-newborn FFS inpatient claims that should have been covered by a recipient's Plan. We strongly urge the Department to prioritize the development of a routine process to identify and recover these types of improper payments.

Response #5:

OMIG continues to work with the LDSSs to encourage proper submission of retroactive disenrollment notifications. In this process, the LDSS corrects a member's enrollment status in cases where a disenrollment is delayed, or a member's enrollment is otherwise not appropriate, per the terms of the managed care model contract. OMIG maintains the database of LDSS enrollment notifications and performs second level reviews, as appropriate.

The Department agrees that OMIG is appropriately positioned with regard to establishment of processes to routinely identify and recover improper Medicaid FFS payments for managed care services. As needed, the Department will assist OMIG in the identification of potential improper payments.

Recommendation #6:

Assess the feasibility of implementing eMedNY edits to deny improper FFS payments for newborns of mothers enrolled in Plans.

Status – Implemented

Agency Action - The Department assessed the feasibility of implementing eMedNY edits and decided not to pursue them. According to Department officials, significant and complex changes to eMedNY, the WMS, and NYSOH would be required. Even with such changes, certain circumstances may prevent an edit from functioning properly, such as when a mother's Medicaid managed care coverage does not extend to the newborn (e.g., mothers with third-party health insurance). Furthermore, the eMedNY system may not always be able to identify the newborn's mother during claims processing and therefore determine whether the mother is enrolled in managed care. We encourage the Department to consider other controls to address weaknesses that contribute to improper payments.

Response #6:

The Department confirms agreement with this recommendation.