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OFFICE OF THE STATE COMPTROLLER

February 11, 2021

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Fee-for-Service Payments for Services Covered by Managed Care
Report 2020-F-8

Dear Dr. Zucker,

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 have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Improper Fee-for-Service Payments for Services Covered by Managed Care* (2017-S-74).

Background, Scope, and Objective

The Department of Health (Department) pays Medicaid providers using the fee-for-service (FFS) or managed care method. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays providers directly for services rendered to Medicaid recipients. Under the managed care method, the Department pays managed care plans a monthly premium for each Medicaid recipient enrolled in managed care, and the managed care plans pay providers for services rendered to their members.

The State's Medicaid program offers different types of managed care. Most recipients are enrolled in mainstream managed care plans (Plans), which provide comprehensive medical services ranging from hospital inpatient care to physician and dental services. Plans are responsible for providing most medical services to enrollees; however, some services are excluded (carved out) from the Plans' benefit packages and paid separately through FFS. Medicaid FFS claims are subject to various payment controls through the eMedNY claims processing and payment system. For example, eMedNY edits determine whether recipients are enrolled in Plans and will deny FFS claim payments unless the services are carved out from the recipient's Plan benefit package. The carved-out services are controlled by the scope of benefits information maintained in eMedNY.

We issued our initial audit report on January 10, 2019. The audit objective was to determine whether Medicaid made improper FFS payments for certain services covered by Plans. The audit covered the period January 1, 2013 through April 30, 2018. Our audit identified

over $36 million in improper Medicaid FFS payments for services that should have been covered by the recipients' Plans. The majority of the improper payments occurred because the managed care enrollment information was not updated timely in the Medicaid eligibility files used to process Medicaid claims, particularly for newborns. Of the $36 million in overpayments, over $22.3 million was paid for newborn inpatient claims. Plans are generally required to pay for medical services for newborns whose mothers are Plan enrollees. However, when newborns are not enrolled in a mother's Plan prior to birth, the newborns' managed care enrollment may be delayed, resulting in hospitals improperly billing Medicaid FFS for the newborns' medical services.

The objective of our follow-up was to assess the extent of implementation, as of August 26, 2020, of the six recommendations included in our original audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made some progress in addressing the problems we identified in the initial audit report. However, further actions are still needed. Of the initial report's six audit recommendations, two were implemented, three were partially implemented, and one was not implemented.

Follow-Up Observations

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.

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 Local Departments of Social Services (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 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.

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 NY State of Health (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.

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.

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.

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 Welfare Management System, 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.

Major contributors to this report were Salvatore D'Amato, Nareen Jarrett, Misty Daiyan, and Linda Thipvoratrum.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Mr. Robert Schmidt, Department of Health
Ms. Erin Ives, Acting Medicaid Inspector General