NEW YORK STATE OF OPPORTUNITY. Department of Health

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September 29, 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 2021-F-4 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Long-Term Care Plans" (Follow-Up to Report 2018-S-65).

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen
Abigail Barker
Jill Montag
Frank Walsh
Brett Friedman
Amir Bassiri
Geza Hrazdina
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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2021-F-4 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Long-Term Care Plans" (Report 2018-S-65)

The following are the responses from the New York State Department of Health (Department) to Follow-Up Audit Report 2021-F-4 entitled, "Improper Fee-for-Service (FFS) Payments for Services Covered by Managed Long-Term Care (MLTC) Plans" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $16.4 million in improper Medicaid FFS payments and make recoveries, as appropriate.

Status – Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments of behalf of the Department. During the initial audit, we provided OMIG with a file containing the overpayments we identified. As of March 12, 2021, OMIG had only recovered $146,046 (less than 1%) of the $16.4 million in improper payments we identified. Another $94,531 was recovered through provider-initiated claim voids unrelated to OMIG efforts.

According to OMIG officials, all claims identified in the initial audit are being reviewed as part of OMIG projects and improper payments identified will be pursued. However, officials were unable to provide an expected completion date or supporting documentation to substantiate OMIG's review. Of the $16.1 million in unrecovered claims, OMIG may have already lost the opportunity to recover about $3.1 million (19%) due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the remaining improper payments to prevent further loss of recoveries.

Response #1:

OMIG has recovered more than $250,000 of the OSC-identified payments. OMIG is continuing to perform data analysis on the 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:

Correct eMedNY MLTC benefit package information and system edits to prevent FFS payments for MLTC covered services.

Status – Partially Implemented

Agency Action - Each MLTC plan type is assigned a benefit package that includes all covered services defined in the corresponding MLTC model contract. Certain information used to describe benefit package services (e.g., procedure code, specialty code, reimbursement

rate code, claim type, category of service) is maintained in eMedNY and is associated with a Global Identification Number (Global ID), which is then used in conjunction with eMedNY system edits to prevent improper FFS payments for MLTC covered services.

Our initial audit determined the majority of overpayments occurred because the Department did not configure eMedNY system edits and MLTC benefit packages correctly. For example, the MLTC benefit package and mainstream managed care benefit package shared the same Global ID despite significant differences between the services covered by these different plans. Of the initial audit's $16.4 million in overpayments, $13.6 million (83%) was for clinic, nursing home, and home health claims on behalf of members enrolled in Partial Capitation MLTC plans. Since the initial audit, we identified over $4 million in additional improper Medicaid FFS payments for these services from July 1, 2019 through February 15, 2021.

In April 2020, the Department created a Global ID specific to MLTC plans, which allows the Department to apply system edits that are separate from mainstream managed care plans and specific to MLTC plans. For example, system edits have been added that deny certain FFS nursing home payments for clients in Partial Capitation MLTC plans. In addition, officials stated the Department is currently performing internal audits to address other scenarios, such as improper FFS payments for MLTC covered professional services performed in a diagnostic and treatment center. We urge the Department to complete these audits and implement system edits timely to prevent further overpayments.

Response #2:

The Department implemented enhanced eMedNY editing in May 2020 to better manage adjudication of MLTC benefit claims and continues to pursue opportunities to improve eMedNY editing logic.

Recommendation #3:

Work with Local Districts to develop a process to identify and recover improper Medicaid FFS payments for MLTC services resulting from retroactive enrollments.

Status – Not Implemented

Agency Action - Retroactive enrollment occurs when recipients are enrolled in a MLTC plan with an effective date in the past. MLTC plans receive premium payments to cover the months of retroactive coverage. FFS payments made during a period covered by retroactive enrollment may be improper if it is determined the services should have been covered by the MLTC plan.

Our initial audit determined that Local Departments of Social Services (Local Districts) did not have a process to identify and recover improper FFS payments for MLTC covered services provided during retroactive enrollment periods. In response to our audit, the Department indicated it would work with Local Districts to develop such a process; however, officials were unable to provide evidence that changes have been made. Furthermore, we reviewed FFS claims paid between July 1, 2019 and February 15, 2021 and found an additional $270,413 in improper payments on 385 claims paid during a retroactive enrollment period. We encourage the Department to prioritize the development of a routine process to identify and recover these types of improper payments.

Response #3:

The Department contacted several Local Districts regarding developing an audit process to identify and recover Medicaid FFS payments. The Local Districts indicated they are not sufficiently resourced at this time to develop such a process. In addition, OMIG indicated that it does not have an audit process nor role in identifying or recovering such Medicaid FFS payments. As a result, the Department is in the process of allocating resources to implement a process that can identify and flag for recovery those Medicaid FFS payments during the period when an individual is retroactively enrolled into a MLTC plan and that should have been the payment responsibility of the MLTC plan.