NEW YORK STATE OF OPPORTUNITY. Department of Health

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October 5, 2022

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

Dear Ms. Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2019-S-72 entitled, "Medicaid Program: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program."

Please feel free to contact Mischa Sogut, Assistant Commissioner, Office of Governmental and External Affairs, at (518) 473-1124 with any questions.

Sincerely,

Kristin M. Proud

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Acting Executive Deputy Commissioner

Enclosure

cc: Mischa Sogut

Department of Health Comments to Final Audit Report 2019-S-72 entitled, "Medicaid Program: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Final Audit Report 2019-S-72 entitled, "Medicaid Program: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $965 million in payments to providers for Medicaid services that did not meet federal and State Ordering, Prescribing, Referring, or Attending (OPRA) regulations – particularly payments for services with an OPRA provider excluded from participating in the Medicaid program – and determine an appropriate course of action, including determining if any recoveries should be made.

Response #1:

The Department is collaborating with the Office of the Medicaid Inspector General (OMIG) on the development of a comprehensive strategy, including guidance and possible corrective actions for claims identified by OSC, to identify and make appropriate recoveries where services delivered by providers were not ordered, referred, or provided by eligible OPRA practitioners on the date of service, to the extent applicable. OMIG is performing 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.

The Department reviewed a sample of the claims in question and related federal OPRA policy. The Department disagrees that the claims reviews were paid inappropriately. Below is the rationale supporting our position:

- OSC stated that an actively enrolled referring provider ID is required to be entered on all referred ambulatory claims, clinic claims, laboratory claims, and practitioner claims. However, federal regulations state that the State Medicaid Agency must require all claims for payment for items and services ***that were ordered or referred*** to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. The claim must contain the NPI of an ordering/referring professional only if those services that were furnished required an order/referral. The Department reviewed a sample of the clinic and practitioner claims identified by OSC during this audit and found that many services had an attending provider such as a physician, physician assistant, nurse practitioner, midwife, psychologist, optometrist, dentist, or podiatrist and do not require an order or referral. Professional services provided by these practitioners do not require an order or referral. Since no order is required for professional services furnished by these

provider types, an actively enrolled referring provider is not required to be entered on the claim. The Department requests that any claims that do not require an order or referral be removed from this audit report.

See the State Comptroller's audit response in "OSC Comment #1" below.

- OSC states that the referring provider must be actively enrolled on the date of service. However, in some instances, even when the referring provider is not actively enrolled on the date of service, the claim may still be paid appropriately. The referral is valid when written, as long as the provider has a valid Medicaid provider enrollment at the time that the services were ordered. If, on the date of service, the referring provider is not actively enrolled, the claim can still be paid, if the referral was written when the referring practitioner was actively enrolled.

See the State Comptroller's audit response in "OSC Comment #2" below.

- The Department notes that the number of claims cited in the OSC audit report is overstated. The OSC is counting individual claim lines as unique encounters, claims, or patient visits. A single medical visit with a provider may have multiple procedures/claim lines reported for a single encounter. A count of unique Transaction Control Numbers would provide a more accurate representation of the number of claims reviewed during the scope of the audit.

See the State Comptroller's audit response in "OSC Comment #3" below.

- The Department also notes that there are still retroactive adjustments added by the Department regarding provider terminations. Some of this may be due to timeliness of ascertaining that information and applying it systematically.

- Furthermore, the Department did a special input to adjust pharmacy reimbursement due to a Centers for Medicare & Medicaid Services (CMS) requirement which changed our pricing methodology. This project entailed repricing the pharmacy claims retroactively. During this process edits were turned down to effectuate the adjustment of the previously adjudicated claim to correct the reimbursed amount.

As OSC states, the volume of providers excluded from participating in the Medicaid program dropped significantly after eMedNY claims edits were enhanced in February 2018. This enhancement to the edit addressed the majority of claims in the audit report.

To further enhance eMedNY, the Department has established an internal workgroup to support DOH executive leadership and staffed by subject matter experts dedicated to assisting all interagency policy owners – including but not limited to various DOH divisions, the Office of Mental Health (OMH), the Office of Alcohol and Substance Abuse Services (OASAS), the Office of Persons with Developmental Disabilities (OPWDD), and the Office of Children and Family Services (OCFS) – with their holistic review of all eMedNY edits associated with OPRA. Additionally, the workgroup is examining all edits to ensure compliance with federal OPRA and HIPAA X.12 reporting requirements. This ongoing review is anticipated to result in phased modifications to eMedNY as determined by executive leadership as necessary and appropriate. This holistic agile-based mitigation endeavor, otherwise known as Evolution Project 7008 entitled "*Interagency OPRA Remediation Initiative*," remains a significant and resource-intensive undertaking for all involved agencies and is expected to remain so throughout the course of the project's lifecycle.

Recommendation #2:

Review the $10.3 million payments to providers for Medicaid services where the attending provider on institutional claims was not affiliated with the billing facility, as required, and determine an appropriate course of action, including determining if any recoveries should be made.

Response #2:

The Department is collaborating with OMIG on the development of a comprehensive strategy, including guidance and possible corrective actions for claims identified by OSC, to identify and make appropriate recoveries where services delivered by providers were not ordered, referred, or provided by eligible OPRA practitioners on the date of service, to the extent applicable. OMIG is performing 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.

In addition, the Department has established an internal workgroup to support DOH executive leadership and staffed by subject matter experts dedicated to assisting all interagency policy owners – including but not limited to various DOH divisions, OMH, OASAS, OPWDD, and OCFS – with their holistic review of all eMedNY edits associated with OPRA, including edits which will prevent the payment of institutional claims where the attending provider does not have an active affiliation with the billing facility. Additionally, the workgroup is examining all edits to ensure compliance with federal OPRA and HIPAA X.12 reporting requirements. This ongoing review is anticipated to result in phased modifications to eMedNY as determined by executive leadership as necessary and appropriate. This holistic agile-based mitigation endeavor, otherwise known as Evolution Project 7008 entitled "*Interagency OPRA Remediation Initiative*," remains a significant and resource-intensive undertaking for all involved agencies and is expected to remain so throughout the course of the project's lifecycle.

Recommendation #3:

Improve controls to more timely identify OPRA providers with an inactive status to prevent the types of improper Medicaid payments we identified after the enhancements to eMedNY edits were made in February 2018.

Response #3:

The Department is continuously reviewing processes on an ongoing basis to identify areas for improvement. The Department notes that the Department is required to enroll OPRA providers to comply with the 21st Century Cures Act. By design, OPRA providers cannot bill and, therefore, don't receive payment. It would defeat the purpose of enrolling OPRA providers if the Department were to inactivate them for not receiving a Medicaid payment during a two-year timeframe, as these providers would no longer be able to order, prescribe, refer or attend within the Medicaid program. Prior to the 21st Century Cures Act, there was a code used for the reason indicated. The Department periodically ran a report to determine who had not billed in two years and then request to apply the enrollment code. However, since the 21st Century Cures Act, the

code has not been used for providers that have not billed in two years and instead has been repurposed for various other reasons.

See the State Comptroller's audit response in "OSC Comment #4" below.

Recommendation #4:

Update and issue guidance clarifying OPRA billing requirements to providers, such as nursing home and home health, who have not yet received these communications.

Response #4:

The Department is updating its billing guidelines to providers to clarify which OPRA fields are required when the associated eMedNY system projects are complete.

Recommendation #5:

Ensure providers who should be excluded from the Medicaid program are added to the provider sanction table in a timely manner.

Response #5:

Data entry and system controls currently exist. OMIG has a process in place to confirm that eMedNY is updated accurately and timely, in order to prevent claims from being paid when a provider was excluded. OMIG is currently working with the Department to automate the eMedNY updates of NYS Medicaid excluded entities.

Recommendation #6:

Formally remind facilities not to delete affiliations with providers in eMedNY who are no longer affiliated with the facility in order to maintain a record of the affiliation.

Response #6:

The Department is developing guidance to remind facilities not to delete affiliations with providers in eMedNY via an upcoming Medicaid Update article. In addition, the Department is exploring whether the delete function for affiliations can be removed from enrollment systems without impacting other processes.

OSC Comment #1:

None of the claims the Department reviewed were included in the final scope of the audit and, therefore, are not in the audit findings. Furthermore, we disagree with the Department's conclusion that professional services provided by the practitioner types listed in its response do not require an order/referral. In fact, subsequent to the Department's review of the claims referenced in its response, we provided the Department with specific examples of claims for clinic services where the attending provider was one of the professions listed, such as a physician. The Department, OPWDD, and other related agencies confirmed that the claim examples we provided did not comply with OPRA requirements.

Response to Comment #1:

The Department and other related agencies are evaluating any claims in question identified by OSC to determine if recovery of previously paid claims is warranted. The claims will be referred to OMIG for post payment review, as appropriate.

OSC Comment #2:

The Department's response contradicts previous guidance it issued to providers. According to the Department's own December 2013 Medicaid Update, "It is the billing provider's responsibility to ensure that all required documentation is in place prior to submission of the Medicaid claim, including checking the status of the ordering provider, who must be enrolled on the date of service." Further, the date a referral is written is not known during claims processing and therefore not considered as part of claim edit controls. If the issued guidance is inaccurate, the Department needs to update it with accurate information.

Response to Comment #2:

As identified in the responses above, the Department is reviewing the current disposition of existing OPRA edits to ensure appropriate edit controls exist, and will make changes to edit controls, as appropriate.

OSC Comment #3:

The Department's response is inaccurate. Our findings are clearly summarized throughout the report by a count of the number of services provided (including in each of the three tables), not by the number of claims.

Response to Comment #3:

The Department does not dispute the service counts provided in tables 1, 2 and 3. One claim can contain multiple services performed during a single appointment. OSC is using service count, which can include multiple services within a single date of service. Post payment reviews are conducted on claims. All claims contain a unique Transaction Control Number (TCN). A post payment audit could determine that all lines, some lines or a single line were paid inappropriately and if recovery is the appropriate course of action. Traditionally, audits use counts of TCNs instead of service counts. The Department asserts TCNs provide a better representation than service counts.

OSC Comment #4:

The inactive status code associated with many of the providers in our audit findings after February 2018 is "Inactive: two years no payment activity." The Department should update the description of this code if it no longer accurately reflects the reason a provider was deemed to be inactive so the information can be used to improve controls and prevent improper payments.

Response to Comment #4:

The Department is exploring whether it is feasible to change the description of the code that has been used to inactivate providers due to two years of no payment activity.