NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

August 8, 2022

Honorable 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 2020-S-54 entitled, "Medicaid Program: Claims Processing Activity October 1, 2020 through March 31, 2021".

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

Sincerely,

Kristin M. Proud

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Acting Executive Deputy Commissioner

Enclosure

cc: M. Sogut

Department of Health Comments on the Final Audit Report 2020-S-54 entitled, "Medicaid Program: Claims Processing Activity October 1, 2020 Through March 31, 2021" 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 2020-S-54 entitled, "Medicaid Program: Claims Processing Activity October 1, 2020 Through March 31, 2021" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $483,221 ($195,083 + $288,138) in overpayments and make recoveries, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) performed analysis on the OSC data and will perform its own extraction of data from the Medicaid Data Warehouse (MDW), 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2:

Develop a process to timely identify and recover improper Medicaid payments for managed care services resulting from retroactive updates to recipients' managed care eligibility.

Response #2:

OMIG routinely performs audits of retroactive beneficiary disenrollments. However, based upon the ongoing public health emergency (PHE) and programmatic accommodations that needed to be made in response to the PHE, which align with the OSC scope period, OMIG will be limited as to its audit and recovery efforts to avoid impacting a recipient's ability to access necessary medical care.

OMIG is collaborating with the Department to explore opportunities to help prevent these improper Medicaid payments, including issuing additional guidance to providers and Managed Care Organizations (MCOs).

Recommendation #3:

Review the $462,180 in overpayments and make recoveries, as appropriate.

Response #3:

OMIG continuously performs audits of alternate level of care (ALC) claims. OMIG will perform its own extraction of data from the MDW, 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years

between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #4:

Work with providers identified in this report to ensure they bill claims at the appropriate level of care, including developing a remedy for the provider unable to bill for ALC services due to the recipient's coverage type.

Response #4:

The Department is publishing a Medicaid Update in July 2022. The article formally advises the hospitals indicated in this audit to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment and reiterates Medicaid program policy and rules for billing of ALC. The Department also includes information on how hospitals should handle reimbursement for patients whose coverage does not allow ALC services.

Recommendation #5:

Review the $22,471 in overpayments and make recoveries, as appropriate.

Response #5:

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 MDW, 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #6:

Review the $731,776 ($652,747 + $58,292 + $20,737) in overpayments and make recoveries, as appropriate.

Response #6:

OMIG continuously performs audits of practitioner, clinic, and durable medical equipment claims. OMIG will perform its own extraction of data from the MDW, 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #7:

Formally advise the MCOs and hospitals identified in this audit to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Response #7:

The Department is issuing a reminder to MCOs, through routine MCO communication channels, to report newborn claim information accurately when billing Medicaid outside of their capitated payment structure.

Recommendation #8:

Review the $81,762 ($63,156 + $18,606) in overpayments and make recoveries, as appropriate.

Response #8:

OMIG has Certified Home Health Agency episodic payment audit protocols which address the findings in this OSC report. OMIG has previously performed audits of episodic payments. OMIG will perform its own extraction of data from the MDW, 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #9:

Review the 332 claims totaling $46,193 and make recoveries, as appropriate.

Response #9:

OMIG performed analysis on the OSC data and will perform its own extraction of data from the MDW, 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #10:

Review the $8,835 in overpayments and make recoveries, as appropriate.

Response #10:

The Office of Mental Health (OMH) has reviewed the nine Comprehensive Psychiatric Emergency Program (CPEP) claims identified by OSC and agrees that these claims occurred

on the same date of service as a psychiatric inpatient admission. The respective providers have been instructed to review the identified payments and remedy the errors as appropriate.

OMIG has CPEP audit protocols which address the findings in this OSC report. OMIG has previously performed audits of CPEP claims. OMIG will perform its own extraction of data from the MDW, 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. To allow providers the authorized time to adjust or void any claims or encounters, there are customarily two years between the last date of service and the beginning of the OMIG audit period. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #11:

Implement controls to prevent Medicaid payments for CPEP services that occur on the same date of service as a psychiatric hospital stay.

Response #11:

OMH worked with the Department to add the affected CPEP rate codes to Rate Category Code R124. This change went into effect on July 28, 2021 and should prevent CPEP claims from overlapping with rate code 2852 for an inpatient stay.

Recommendation #12:

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

Response #12:

OMIG sanctions individuals based on unacceptable practices discovered during investigations or audits of providers, as well as taking derivative actions that originate from other agencies including the 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 and/or 18 NYCRR § 515.7. OMIG maintains an exclusion list that is updated on the OMIG website, which contains both enrolled providers and non-enrolled persons/entities.