Department of Health

Medicaid Program: Improper Supplemental Maternity Capitation Payments to Managed Care Organizations

Report 2020-S-57 | November 2021

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid made improper Supplemental Maternity Capitation Payments to managed care organizations. The audit covered the period from August 1, 2015 through July 31, 2020.

About the Program

The Department of Health (Department) administers New York's Medicaid program. Many of the State's Medicaid recipients receive their services through managed care, whereby the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient and, in turn, the MCOs pay for services their members require. In addition to the monthly premiums, MCOs can receive a one-time Supplemental Maternity Capitation Payment (SMCP) for the prenatal and postpartum physician care and hospital or birthing center delivery costs associated with the maternity care of a recipient. However, MCOs are not eligible to receive SMCPs for maternity cases that end in termination or a miscarriage, as these are considered reimbursed to the MCO through the monthly premium for the recipient. Further, an MCO is only eligible to receive the SMCP if it submits encounter data as evidence of the delivery and any other inpatient and outpatient services for the maternity care of the recipient. From August 1, 2015 to July 31, 2020, Medicaid SMCPs totaled almost $4.7 billion.

Key Findings

We identified about $55 million in improper and questionable SMCPs to MCOs, as follows:

- $29.1 million was paid without the required supporting encounter data;
- $23.4 million was paid where the encounter data or other evidence indicated the maternity case ended in termination or miscarriage; and
- $2.4 million was paid when the SMCP date of service preceded the birth by 1 to 6 months.

In many instances, MCOs agreed their SMCP claims were inappropriately billed and, by the end of the audit fieldwork, had reversed about $1.8 million of the payments.

The Department's eMedNY claims processing system does not have access to maternity encounter data to verify that SMCP claims are eligible for reimbursement. Instead, the Department relies on audits by the Office of the Medicaid Inspector General (OMIG) to identify and recoup inappropriate SMCPs. However, OMIG does not perform these audits in a timely manner, and its last such audit, with a scope period ended December 31, 2016, was not sufficiently inclusive to capture all improper SMCPs.

Key Recommendations

- Review the remaining payments of approximately $53 million and make recoveries, as appropriate.
- Monitor the accuracy of SMCP claims and take formal corrective actions with non-compliant MCOs.

Office of the New York State Comptroller
Division of State Government Accountability

November 29, 2021

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Supplemental Maternity Capitation Payments to Managed Care Organizations*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
APR-DRG	All Patient Refined Diagnosis Related Groups	*Key Term*
CDC	Centers for Disease Control and Prevention	*Agency*
CIN	Client Identification Number	*Key Term*
Contract	Medicaid Managed Care Model Contract	*Key Term*
Department	Department of Health	*Auditee*
EIS	Encounter Intake System	*System*
eMedNY	Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
GME	Graduate Medical Education	*Key Term*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
SMCP	Supplemental Maternity Capitation Payment	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the Department of Health (Department). For the State fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $68.1 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5 percent.

The Department uses two methods to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays health care providers directly for services rendered to Medicaid recipients. Under the managed care method, Medicaid pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient and, in turn, the MCO arranges for the provision of health care services and reimburses providers for those services. MCOs submit claims (referred to as encounter claims) to the Department's Encounter Intake System (EIS) to inform the Department of each service provided to their enrollees. Services reported on encounter claims are identified by procedure and diagnosis codes. Additionally, MCOs use the All Patient Refined Diagnosis Related Groups (APR-DRG) classification system to reimburse hospitals for inpatient medical care, which is also reported on encounter claims. The APR-DRG methodology classifies hospital inpatients according to their reason for admission, severity of illness, and risk of mortality.

For some maternity-related services, such as prenatal and postpartum physician care and hospital and birthing center deliveries, Medicaid pays MCOs a Supplemental Maternity Capitation Payment (SMCP), which is a one-time, fixed-amount reimbursement for the outpatient and inpatient medical costs of services normally provided as part of maternity care. This SMCP is in addition to the monthly premium for the recipient. According to the Medicaid Managed Care Model Contract (Contract), an MCO is not eligible to receive an SMCP for maternity cases that end in termination or miscarriage, as these are considered reimbursed to the MCO through the monthly premium for the recipient. Accordingly, MCOs are eligible to receive SMCPs for live births and stillbirths. Per the Centers for Disease Control and Prevention (CDC) website, a miscarriage is usually defined as the loss of a baby before 20 weeks gestation, and a stillbirth is the loss of a baby at or after 20 weeks. The Contract also stipulates that an MCO is only eligible to receive an SMCP if it submits encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the recipient. For the audit period, Medicaid SMCPs totaled almost $4.7 billion.

Audit Findings and Recommendations

The Department has not provided adequate oversight to ensure SMCPs are made to MCOs in accordance with the Contract. For the period August 1, 2015 through July 31, 2020, we identified nearly $55 million in improper and questionable SMCPs, where either: the MCO did not submit the required corresponding encounter claim, the corresponding encounter claim or other evidence contradicted a live birth or stillbirth event, or the SMCP date of service preceded the date of the actual birth event by 1 to 6 months.

The eMedNY system has various automated controls, or edits, to determine whether FFS or managed care claims are eligible for reimbursement. However, it does not have access to maternity encounter data in EIS to confirm that SMCP claims submitted by MCOs are eligible for reimbursement. Department officials stated that, due to the lack of system edits, they must trust that MCOs are submitting claims for SMCPs appropriately. They also rely on post-payment audits by the Office of the Medicaid Inspector General (OMIG) to identify and recoup inappropriate SMCPs made to MCOs. In conducting these audits, OMIG includes an analysis of the diagnosis codes on SMCP corresponding encounter claims to determine the actual outcome of maternity cases. However, we found OMIG's list of diagnosis codes did not contain all relevant codes (particularly codes issued in 2015), rendering these audits less effective in identifying all improper payments. In response to our preliminary report, OMIG indicated it would update its SMCP review process to include all relevant diagnosis codes. However, we also note that OMIG does not perform these audits in a timely manner: as of January 22, 2021, its last SMCP audit was completed for the scope period ended December 31, 2016.

Improper SMCPs Made to MCOs

MCOs receive SMCPs for live births and stillbirths. MCOs are not eligible to receive SMCPs for maternity cases that end in termination or a miscarriage because those are considered to be reimbursed through the monthly premium. Further, an MCO is only eligible to receive the SMCP if it submits encounter data as evidence of the services for the maternity care. To identify improper payments, we analyzed SMCPs, MCOs' corresponding encounter claims, and hospitals' corresponding Graduate Medical Education (GME) claims that they submit to eMedNY for reimbursement of expenses related to residents' training during the maternity-related hospitalization.

From August 1, 2015 to July 31, 2020, Medicaid made $54,958,838 in improper and questionable SMCPs to MCOs, as shown in Table 1.

Table 1 – Improper and Questionable Medicaid SMCPs

Category	Number of SMCPs	Total SMCPs
Corresponding GME or encounter claim indicated termination or miscarriage	978	$8,739,946
Corresponding GME or encounter claim indicated gestation period < 20 weeks	1,687	14,696,725
No corresponding inpatient or live birth clinic encounter claim within 31 days of the SMCP service date	3,266	29,112,076
SMCP service date predates live birth date on corresponding GME or encounter claim by 1–6 months	261	2,410,091
Totals	**6,192**	**$54,958,838**

Corresponding GME or Encounter Claim Indicates Termination or Miscarriage

Medicaid made 978 SMCPs to 26 MCOs, totaling $8,739,946, where the corresponding GME or encounter claim indicated a maternity outcome of termination or miscarriage or contained conflicting diagnoses (i.e., termination or miscarriage as well as live birth or stillbirth), as shown in Table 2.

Table 2 – SMCPs With a Corresponding GME or Encounter Claim Indicating Termination or Miscarriage

Category	Number of SMCPs	Total SMCPs
GME claim indicated termination or miscarriage	282	$2,567,926
GME claim indicated termination or miscarriage and live birth/stillbirth	134	1,203,523
Encounter claim indicated termination or miscarriage	459	4,063,092
Encounter claim indicated termination or miscarriage and live birth/stillbirth	71	627,869
Encounter claims for same case indicated conflicting outcomes (i.e., one indicated termination or miscarriage, another indicated termination or miscarriage and live birth/stillbirth)	32	277,536
Totals	**978**	**$8,739,946**

We judgmentally sampled 184 SMCPs (from the first four categories in Table 2), totaling $1,679,737 billed by 11 MCOs, and requested that the MCOs review the payments to determine the correct outcome of the maternity case. Nine MCOs agreed that 51 claims, totaling $471,200, were inappropriately billed and paid. These improper billings generally occurred because the MCO's APR-DRG grouped the diagnosis and procedure codes on the encounter claims to a DRG that automatically initiated a claims submission for an SMCP, despite the conflicting diagnosis codes. As a result of our inquiry, eight MCOs were re-evaluating their methodology and planned to include additional diagnosis codes in an effort to accurately identify the

outcome of the maternity case. At the time the audit fieldwork ended, seven MCOs had reversed 37 of the 51 claims, saving Medicaid $346,006. The remaining 133 claims (184 claims - 51 claims) were still being reviewed for appropriateness by the remaining MCOs. We also found that seven MCOs had reversed 29 additional SMCP claims that were not in our sample, resulting in $256,633 in further savings.

Notably, for 279 of the 978 SMCPs with a corresponding GME or encounter claim that indicated an outcome of termination or miscarriage (totaling $2,471,797), the GME or encounter claim also indicated a gestation period of less than 20 weeks – a combination of data that increases the likelihood that the outcome was miscarriage, and not a live birth/stillbirth, and that the SMCP was improper. Of the 51 claims from our sample that MCOs agreed were inappropriate, 27 (53%) had a GME or encounter claim that also indicated a gestation period of less than 20 weeks. We encourage the Department to prioritize a review of this higher-risk subpopulation of SMCPs.

Corresponding GME or Encounter Claim Indicates Gestation Period Less Than 20 Weeks

A GME or encounter claim with a diagnosis code indicating less than 20 weeks gestation could suggest the maternity case ended in miscarriage, and the MCO would not be entitled to an SMCP. Medicaid made 1,687 SMCPs, totaling $14,696,725, where the corresponding GME or encounter claim did not have a termination or miscarriage diagnosis code, but did have a diagnosis code indicating gestation less than 20 weeks (see Table 3).

Table 3 – SMCPs With a Corresponding GME or Encounter Claim Indicating Gestation Less Than 20 Weeks

Category	Number of SMCPs	Total SMCPs
GME claim did not indicate termination or miscarriage but indicated gestation < 20 weeks	526	$4,758,618
Encounter claim did not indicate termination or miscarriage but indicated gestation < 20 weeks	1,161	9,938,107
Totals	**1,687**	**$14,696,725**

We judgmentally sampled 52 SMCPs (from both categories in Table 3) totaling $520,698 billed by seven MCOs, and requested documentation to support the appropriateness of the claims. We determined 18 of the 52 claims, totaling $179,874, were inappropriately billed. One MCO was unaware of the 20-week gestation criterion distinguishing between a miscarriage and a stillbirth (per the CDC) and planned to update its SMCP processing to exclude diagnosis codes indicating less than 20 weeks gestation. For the remaining 34 claims, the MCOs provided documentation that each of the maternity cases ended in a live birth or stillbirth and stated that the diagnosis code indicating less than 20 weeks gestation was due to clerical error. At the time the audit fieldwork ended, five MCOs had reversed 10

claims from our sample, saving Medicaid $99,745 in SMCPs. We also found that four MCOs had reversed 16 additional SMCP claims that were not in our sample, resulting in $149,085 in additional savings.

Within this population of SMCPs, our analysis of the sampled claims pinpointed a subset of claims that are at high risk of improper payment. In eMedNY, each Medicaid recipient is assigned a Client Identification Number (CIN) and assigned to a Client Case. Case assignment is typically address-based; individuals, and CINs, with a shared address are assigned to the same case. It is thus reasonable to conclude that a client case would include both the CIN assigned to the mother and the CIN assigned to the newborn. Of the 1,687 SMCPs, we found 590, totaling $5,297,741, where there was no CIN within the mother's case with a date of birth within 31 days of the SMCP service date. This combination of criteria – less than 20 weeks gestation and no newborn CIN in the mother's case – indicates a higher risk that a live or stillbirth did not occur. Of the 18 SMCPs that the MCOs agreed were inappropriate, 16 (89%) met these criteria. We encourage the Department to prioritize its review of this higher-risk subpopulation of SMCPs.

SMCPs With No Corresponding Encounter Within 31 Days

Encounter claim information is transmitted weekly from EIS to the Medicaid Data Warehouse (MDW), the State's clearinghouse for Medicaid claims data. Based on our review of claims in the MDW, we determined Medicaid made 3,266 SMCPs, totaling $29,112,076, that did not have a corresponding inpatient encounter claim or clinic encounter claim with a diagnosis code of a live birth or stillbirth that occurred within 31 days of the SMCP service date (i.e., birth date). It is not uncommon for MCOs to subsequently adjust or void claims if an error is identified and the claim needs to be corrected or resubmitted. We examined the population of 3,266 SMCPs to determine the extent to which this scenario was a factor. Most of the SMCPs (93%) were for dates of service from 2015 to 2018, allowing the MCOs ample time to submit accurate, appropriate encounters justifying the SMCPs by the time we conducted our work.

We judgmentally sampled 25 such SMCPs, totaling $229,548, from four MCOs and requested supporting evidence of corresponding encounter information. Of this sample, 11 SMCPs, totaling $98,508, did not have any corresponding encounter data and were subsequently reversed by the MCOs. For the remaining 14 SMCPs (of the sample of 25 SMCPs), the MCOs provided documentation showing they were not inappropriate but rather had billing or other apparent errors that rendered them questionable at the time of our testing. We also found that 11 MCOs had reversed 92 additional SMCPs that were not in our sample, resulting in $812,828 in additional Medicaid savings.

We further analyzed the 3,266 SMCPs and found 502 (totaling $4,344,277) where there was no CIN within the mother's Medicaid case with a date of birth within 31 days of the SMCP service date. Notably, all of the 11 SMCPs that MCOs agreed were inappropriate fit this scenario and, therefore, we encourage the Department to prioritize its review of this higher-risk subpopulation of SMCPs.

SMCP Service Date Predates Live Birth Date

We identified 261 SMCPs, totaling $2,410,091, where the date of service was 1 to 6 months before the date on the corresponding GME or encounter indicating a live birth. We judgmentally sampled seven SMCPs, totaling $70,936, from one MCO, and requested documentation to support the appropriateness of the SMCP. The MCO confirmed that a live birth took place after the service date of the SMCP. According to the MCO, these seven SMCPs were the result of claims prematurely submitted to eMedNY because the MCO's process doesn't distinguish between physician and hospitalization services. Therefore, when a physician encounter claim containing maternity-related diagnosis codes was submitted for payment, the MCO's system generated a claim for an SMCP, even though the encounter claim was for a non-delivery service. As a result of our contact, the MCO stated it would adjust the seven SMCPs to reflect the correct date of service and, going forward, would make appropriate changes to its system logic.

Recommendations

1. Review the $205,323 in unadjusted SMCPs where the MCOs agreed they were not entitled to the payments and make recoveries as appropriate.
2. Review the $52,447,910 in SMCPs to MCOs that did not meet the criteria outlined in the Contract – beginning with the high-risk subpopulations discussed in this report – and determine an appropriate course of action, including making recoveries as well as requiring MCOs to submit missing encounter claims and reversing any unsupported SMCPs.
3. Formally remind MCOs of the SMCP Contract criteria for payment.
4. Ensure the 10 MCOs identified in this audit take corrective steps to resolve the identified problems in their claims processing systems pertaining to improper SMCP claims.
5. Routinely monitor the accuracy of SMCP claims and take formal corrective actions with non-compliant MCOs including, but not limited to, those that:
    - Do not submit encounter data as evidence of maternity care and delivery services before billing for SMCPs; and
    - Submit claims for SMCPs that have conflicting supporting encounter information (such as conflicting dates of birth and encounter data that indicates maternity cases ended in termination or miscarriage).
6. Ensure OMIG updates its audit processes for identifying improper SMCPs. Updates should include, but not be limited to:
    - Performing audits more timely;
    - Using all applicable diagnosis codes; and

- Examining the higher-risk categories identified in our audit, including:
  - When the corresponding GME or encounter claim indicates termination or miscarriage and a gestation period of less than 20 weeks;
  - When the corresponding GME or encounter claim indicates a gestation period of less than 20 weeks and there is no CIN within the mother's Medicaid case that has a date of birth within 31 days of the SMCP service date; and
  - When there is no corresponding encounter claim of a live birth or stillbirth that occurred within 31 days of the SMCP service date and there is no CIN within the mother's Medicaid case that has a date of birth within 31 days of the SMCP service date.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper SMCPs to MCOs. The audit covered the period from August 1, 2015 through July 31, 2020.

To accomplish our audit objective and assess relevant internal controls, we interviewed Department and OMIG officials, and examined the Department's relevant Medicaid policies and procedures as well as applicable federal and State laws, rules, and regulations. We reviewed claims data from the MDW and eMedNY, the Medicaid claims processing system, and determined the data was reliable. We analyzed MDW and eMedNY claims data to identify instances in which improper SMCPs may have been made based on information in corresponding GMEs and encounter claims. We contacted MCO officials to gain an understanding of their processes and procedures regarding SMCP submissions. We shared our methodology and findings with Department and OMIG officials during the audit for their review. We took their comments into consideration and adjusted our analyses as appropriate.

For purposes of our analyses, we judgmentally selected four types of higher-risk claims for SMCPs, as follows: 184 claims from 11 MCOs with the highest total SMCPs where the corresponding GMEs or encounter claims indicated that the maternity cases ended in termination or miscarriage; 52 claims from seven MCOs with the highest total SMCPs where the corresponding GMEs or encounter claims did not indicate terminations but did indicate gestation periods of less than 20 weeks; 25 claims from four MCOs with the highest total SMCPs where there were no corresponding encounters in the MDW; and seven claims from one MCO with the highest payment total for SMCPs where a live birth occurred 1 to 6 months after the service date of the SMCP. We sent all sampled claims to the MCOs for their review to determine the appropriateness of the payments. The results of our samples are not intended to be projected to the population.

Statutory Requirements

Authority

The audit was performed 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 conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight of SMCPs.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments, which are embedded in the Department's response.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA PINO, M.A., J.D.
Executive Deputy Commissioner

September 9th, 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 Draft Audit Report 2020-S-57 entitled, "Medicaid Program: Improper Supplemental Maternity Capitation Payments to Managed Care Organizations."

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen
Frank Walsh
Amir Bassiri
Brett Friedman
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Abigail Barker
Jill Montag
Brian Kiernan
Timothy Brown
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2020-S-57 entitled, "Medicaid Program: Improper Supplemental Maternity Capitation Payments to Managed Care Organizations"

The following are the responses from the New York State Department of Health (Department) to Draft Audit Report 2020-S-57 entitled, "Medicaid Program: Improper Supplemental Maternity Capitation Payments (SMCP) to Managed Care Organizations (MCOs)" by the Office of the State Comptroller (OSC).

General Comment:

Audit Findings and Recommendation (Page 6, Paragraph 2):

- *However, we also note that OMIG does not perform these audits routinely: as of January 22, 2021, its last SMCP audit was completed December 31, 2016.*

The Office of the Medicaid Inspector General (OMIG) has performed SMCP audits since 2012 and continues to perform them on an ongoing basis. OMIG finalized 21 SMCP audits in 2018 and 2019, that all had an audit scope period through December 31, 2016. Audits currently in process are addressing the subsequent timeframes, through 2018. To allow providers the authorized time to adjust or void any claims or encounters, the OMIG generally provides for two years between the last date of service and the beginning of the OMIG audit period.

State Comptroller's Comment – We encourage OMIG to perform these audits more timely in order to prioritize recoveries of Medicaid overpayments.

Recommendation #1:

Review the $205,323 in unadjusted SMCPs where the MCOs agreed they were not entitled to the payments and make recoveries as appropriate.

Response #1:

OMIG performs audits of SMCPs on an ongoing basis. This project historically looked to identify instances where there was not encounter data supporting the SMCP. It did not specifically look for SMCPs associated with terminations, miscarriages, or gestation less than twenty weeks. OMIG is updating its audit criteria to include this information in the next audit. OMIG 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. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2:

Review the $52,447,910 in SMCPs to MCOs that did not meet the criteria outlined in the Contract – beginning with the high-risk subpopulations discussed in this report – and determine an appropriate course of action, including making recoveries as well as requiring MCOs to submit missing encounter claims and reversing any unsupported SMCPs.

Response #2:

OMIG performs audits of SMCPs on an ongoing basis. This project historically looked to identify instances where there was not encounter data supporting the SMCP. It did not specifically look for SMCPs associated with terminations, miscarriages, or gestation less than twenty weeks. OMIG is updating its audit criteria to include this information in the next audit. 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. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #3:

Formally remind MCOs of the SMCP Contract criteria for payment.

Response #3:

The Department is evaluating and verifying internal procedures, reviewing data and developing guidance to remind and/or instruct MCOs regarding the definition of a miscarriage as it relates to gestational age, the gestational age diagnosis codes on inpatient encounters to ensure that SMCPs are appropriately billed, that SMCPs may only be claimed for the appropriate delivery services for the dates on which they occurred, and that encounter data for delivery services related to SMCPs must be submitted prior to billing for such SMCPs.

Recommendation #4:

Ensure the 10 MCOs identified in this audit take corrective steps to resolve the identified problems in their claims processing systems pertaining to improper SMCP claims.

Response #4:

The Department is working with the 10 MCOs identified in this audit to ensure that they take corrective steps to resolve the identified problems in their claims processing systems pertaining to improper SMCP claims.

Recommendation #5:

Routinely monitor the accuracy of SMCP claims and take formal corrective actions with non-compliant MCOs including, but not limited to, those that:

- Do not submit encounter data as evidence of maternity care and delivery services before billing for SMCPs; and

- Submit claims for SMCPs that have conflicting supporting encounter information (such as conflicting dates of birth and encounter data that indicates maternity cases ended in termination or miscarriage).

Response #5:

The Department is exploring an eMedNY Evolution Project to edit claims for SMCP and Graduate Medical Education (GME) to ensure they are paid only after a valid hospital stay.

Additionally, the Department is exploring the viability of developing a process that would compare the SMCP and GME eMedNY fee-for-service (FFS) payments to the corresponding encounter data. The SMCPs payments are made within the eMedNY system while encounter records are reported by health plans through the Encounter Intake System. A systematic cross walk between the two systems currently does not exist.

Additionally, the Department is working with OMIG to explore a manual control/desk post-payment audit that could validate that GME payments made in eMedNY tie back to an inpatient claim and corresponding encounter data.

Recommendation #6:

Ensure OMIG updates its audit processes for identifying improper SMCPs. Updates should include, but not be limited to:

- Performing audits more timely;
- Using all applicable diagnosis codes; and
- Examining the higher risk categories identified in our audit, including:
    - When the corresponding GME or encounter claim indicates termination or miscarriage and a gestation period of less than 20 weeks;
    - When the corresponding GME or encounter claim indicates a gestation period of less than 20 weeks and there is no CIN within the mother's Medicaid case that has a date of birth within 31 days of the SMCP service date; and
    - When there is no corresponding encounter claim if a live birth or stillbirth that occurred within 31 days of the SMCP service date and there is no CIN within the mother's Medicaid case that has a date of birth within 31 days of the SMCP service date.

Response #6:

OMIG performs audits of SMCPs on an ongoing basis. OMIG is updating its audit criteria to include this information in the next audit, as appropriate. To allow providers with the authorized time to adjust or void any claims or encounters, the OMIG generally provides for two years between the last date of service and the beginning of the OMIG audit period.

State Comptroller's Comment – We encourage OMIG to perform these audits more timely in order to prioritize recoveries of Medicaid overpayments.

OSC confirmed that in many cases the Plan demonstrated in its review of sample claims that OSC's determination of less than 20 weeks gestation was inaccurate. OMIG conducted an in-depth review of a sample of the claims identified by OSC and found that of the eleven reviewed in depth, eight were paid appropriately with substantial justification in the encounter data, including but not limited to payment to the hospital, an identified inpatient stay, and diagnostic and procedure codes indicating a full-term birth.

State Comptroller's Comment – The Department's response to this recommendation is outdated and not applicable to the final audit report or findings. During the audit, OMIG provided us with its review of these 11 sampled claims and, as a result, we updated our analysis and removed all claims that reflected OMIG's feedback, including the eight claims referenced in this response. We provided the updated claim findings population to the Department and OMIG at the close of our audit before the draft audit report was issued.

OMIG's experience in this area has found that claim type codes and service dates in encounter data can be unreliable and that a more comprehensive review, including additional claim type codes, service codes, diagnostic codes, diagnosis-related group (DRG) codes, procedure codes, and other factors, is a more effective way to identify inappropriate SMCPs. While ideally the encounter record would be accurate, OMIG would point out that the purpose of this review is not to evaluate the correctness of encounter data, but instead the appropriateness of SMCPs. OMIG has found it more effective to look at the preponderance of evidence within the encounter data to make such determinations regarding SMCPs.

OMIG's reviews of SMCPs already includes encounters with an inpatient or clinic claim type code and examines the encounter to determine if the diagnostic codes, procedure codes, or DRGs indicate a birth. OMIG's review also looks for encounters with a category of service for a physician/midwife that contain one of the DRG, diagnostic, or procedure codes that indicates a birth, and where there is also an inpatient or clinic claim occurring within five days of the physician or midwife claim. OMIG also reviews FFS claims to identify instances where an SMCP may be inappropriate.

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