NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 7, 2023

Andrea Inman
Audit Director
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236
ainman@osc.ny.gov

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 2021-S-7 entitled, "Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 2021."

Should you have any questions, please feel free to contact Mischa Sogut, Assistant Commissioner for Governmental Affairs at (518) 473-1124 or mischa.sogut@health.ny.gov.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Mischa Sogut

Department of Health Comments to Final Audit Report 2021-S-7 entitled, "Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 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 2021-S-7 entitled, "Medicaid Program: Claims Processing Activity April 1, 2021 Through September 30, 2021" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $28.5 million in overpayments, make recoveries, and disenroll the members from managed care, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) continuously performs audits of Medicaid payments on behalf of recipients with third party health insurance. 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:

Update the disenrollment procedures to ensure accurate and timely disenrollment of recipients with comprehensive TPHI from managed care.

Response #2:

The Department systems and NYSOH staff will collaborate on changing the existing disenrollment process for recipients who have comprehensive TPHI and who enrolled for Medicaid coverage through NYSOH. The Department continues to evaluate and improve the accuracy of the disenrollment process for recipients who enrolled for Medicaid coverage through the Local Districts.

Regarding non-NYSOH members, the Department is aware that the current process of using the MDW to pull data is not as accurate as the process that was in place prior to the January 2021 implementation of the standard Health Insurance Portability and Accountability Act-compliant 834 electronic enrollment transaction for WMS cases.

The MDW process removed certain reports from the Health Commerce System that had previously been used to pull data. The Department is reviewing the current process and looking into other avenues to pull the data for the monthly Disenrollment List to create a more timely and comprehensive monthly disenrollment file for New York Medicaid Choice.

Recommendation #3:

Review the $723,422 ($532,477 + $190,945) in overpayments and make recoveries, as appropriate.

Response #3:

OMIG is performing analysis on the OSC-identified inpatient 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to New York State (NYS) Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #4:

Review the $40,867 in overpayments and make recoveries, as appropriate.

Response #4:

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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #5:

Remind providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid.

Response #5:

The Department published a Medicaid Update reminder in April 2022 entitled, *Reminder to Providers: New York State Medicaid Requires Coordination of Benefits*, which addresses the OSC recommendation. The article can be found in Volume 38 – Number 4: https://health.ny.gov/health_care/medicaid/program/update/2022/no04_2022-04.htm#benefits.

Recommendation #6:

Review the $663,211 in improper payments and make recoveries, as appropriate.

Response #6:

OMIG continuously performs audits of multiple CINs. 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #7:

Ensure all multiple CINs identified in this report have been resolved to prevent future improper payments.

Response #7:

All 14 duplicate CIN pairs identified by OSC as having duplicate FFS inpatient claims were identified by the Department through ongoing internal control practices and duplicate coverage was terminated prior to receipt of the audit findings. As of October 3, 2022, the consumers who remain eligible for Medicaid continue to only have one active CIN which will prevent future improper payments.

Of the 16 duplicate CIN pairs OSC identified as having FFS claims paid in addition to managed care claims:

- Ten were identified by the Department through ongoing internal control practices and duplicate coverage was terminated prior to the receipt of the audit findings. As of October 3, 2022, the consumers who remain eligible for Medicaid continue to only have one active CIN which will prevent future improper payments.

- Five were referred for termination of the duplicate coverage.
    - One was terminated as of June 16, 2022 and remains closed as of October 3, 2022.
    - One was terminated as of June 17, 2022 and remains closed as of October 3, 2022.
    - One was terminated as of June 30, 2022 and remains closed as of October 3, 2022.
    - One was terminated as of September 30, 2022 and remains closed as of October 3, 2022.
    - One was terminated as of October 31, 2022 and remains closed as of December 6, 2022.

- The remaining CIN pair belongs to two discrete individuals (i.e., the CINs are not assigned to the same individual as indicated by OSC). Therefore, the FFS payment and managed care payment are appropriate.

Recommendation #8:

Review the $355,621 in overpayments and make recoveries, as appropriate.

Response #8:

OMIG continuously performs audits of alternate level of care 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #9:

Advise the providers identified in this report to bill claims at the appropriate level of care.

Response #9:

The Department published a Medicaid Update reminder in June 2022 entitled, *Attention Inpatient Hospital Providers Billing for Alternate Level of Care Status,* which addresses the OSC recommendation. This article can be found in Volume 38-Number 7: https://www.health.ny.gov/health_care/medicaid/program/update/2022/no07_2022-06.htm#alc

In addition, the Department directly advised the hospitals identified by OSC in this audit to accurately report alternate levels of patient care when billing Medicaid.

Recommendation #10:

Review the $85,330 ($77,081 + $4,997 + $3,252) in overpayments and make recoveries, as appropriate.

Response #10:

The Department has reviewed the pharmacy claim in question. This claim was reversed on May 26, 2021.

OMIG continuously performs audits of practitioner, clinic, and pharmacy 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #11:

Work with the provider identified in this report to ensure they are properly billing no-cost drugs.

Response #11:

The Department is reviewing the recommendation and, if warranted, will draft correspondence to the provider identified by OSC in this audit to reiterate Medicaid program policy and rules for billing no-cost drugs.

Recommendation #12:

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

Response #12:

On July, 28, 2022, the Department sent an email to all MCOs advising them to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Blast email sent July 28, 2022:

To: Health Plan CEOs and Government Program Liaisons

Please share this information with all staff as appropriate.

This applies to all Mainstream Medicaid Managed Care Plans, HIV Special Needs Plans, and Health and Recovery Plans (collectively MMC Plans).

This is a reminder that when billing for a Low Birth Weight (LBW) Kick Payment, MMC Plans should **report the newborn's birth weight accurately in grams.** Billing in pounds instead of grams with the LBW rate code results in inappropriate payments to the MMC Plan.

MMC Plans may only bill the LBW Kick Payment (rate code 2291) for newborns less than 1200 grams. For newborns weighing 1200 grams (2 lbs. 10.328 oz) or more, MMC Plans should bill for the Supplemental Newborn Capitation Payment (rate code 2298).

Please direct any questions to MCSYS@health.ny.gov.

The Department sent a previous reminder on June 22, 2020 advising all MCOs to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Blast email sent June 22, 2020:

To all Mainstream Plans, HIV Special Needs Plans, and Health and Recovery Plans:

This is a reminder when billing for a Low Birth Weight (LBW) Kick Payment, plans should **report the newborn's birth weight accurately in grams**. Billing in pounds instead of grams with the LBW rate code results in inappropriate payments to the plan.

Plans may only bill the LBW Kick Payment (rate code 2291) for newborns less than 1200 grams. For newborns weighing 1200 grams (2 lbs. 10.328 oz) or more, plans should bill for the Supplemental Newborn Capitation Payment (rate code 2298).

Please direct any questions to OMCMail@health.ny.gov.

Additionally, the Department published a Medicaid Update reminder in June 2020 entitled, *Billing Guidance for Reporting Newborn Birth Weights,* which address the OSC recommendation. The article can be found in Volume 38 – Number 7: https://www.health.ny.gov/health_care/medicaid/program/update/2020/no11_2020-06.htm#newborn

Recommendation #13:

Review the 1,966 claims totaling $132,108 and make recoveries, as appropriate.

Response #13:

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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #14:

Review the $82,059 ($68,887 + $13,172) in overpayments and make recoveries, as appropriate.

Response #14:

OMIG has CHHA episodic payment audit protocols which address the findings in this OSC report and 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #15:

Review the $13,330 in overpayments and make recoveries, as appropriate.

Response #15:

The Office of Mental Health (OMH) has reviewed the 11 claims totaling $10,044 for CPEP claims on the same date of service as a psychiatric hospital stay and agrees with OSC's

conclusion. It should be noted that these claims were all for dates of service prior to adding the CPEP rate codes to Rate Category Code R124, which went in to effect on July 28, 2021. OMH will contact the providers and request that they review the identified payments and remedy the errors as appropriate. Additionally, regarding the three claims totaling $3,286 where the provider billed multiple days of service per episode of care on different claims, OMH will work with the OMIG to review the claims in question and make any necessary recoveries. Since the dates of service are not overlapping the three sets of claims identified could be appropriate (i.e., an individual could have been discharged on the same day as admission and get admitted to the CPEP again the next day).

OMIG has CPEP audit protocols which address the findings in this OSC report and 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #16:

Ensure the implemented eMedNY system updates prevent the improper payment of CPEP claims identified in this audit.

Response #16:

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. As indicated in the response to recommendation #15, the CPEP claims that were duplicative to a psychiatric hospital stay all occurred prior to the addition of CPEP rate codes to Rate Category Code R124, indicating that this change is now working as intended.

Additionally, OMH's transmittal package was processed and corrected the issues identified (i.e., rate codes that had been mistakenly changed back to "daily" from "monthly") which had previously resulted in some of OSC's identified overpayments. This process is working as intended, with very few exceptions. In this case, there were only three claims totaling $3,286 which could be appropriate and occurred prior to the original transmittal on May 6, 2019.

Recommendation #17:

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

Response #17:

OMIG sanctions individuals based on findings of unacceptable practices discovered during investigations or audits of providers, as well as taking derivative actions that originate from other

agencies including 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 (Sanctions for Unacceptable Practices), 18 NYCRR § 515.7 (Immediate Sanctions), and/or 18 NYCRR § 515.8 (Mandatory Exclusions). OMIG maintains an exclusion list that is updated on the OMIG website, which contains both enrolled providers and non-enrolled persons/entities.

Recommendation #18:

Expand the Department's search to include additional resources, such as Justice.gov, to ensure the Department is identifying all providers who are potentially abusing the Medicaid program.

Response #18:

In January 2022, OMIG implemented changes to our process which resulted in an increase in the scope and frequency of reviews. These reviews were expanded to include reviewing additional federal and district attorney websites, including Justice.gov, to assist in identifying NYS health care providers who have either been charged with or convicted of a crime related to health care.