Department of Health

Medicaid Program: Recovering Managed Care Payments for Inpatient Services on Behalf of Recipients With Third-Party Health Insurance

Report 2021-S-24 | September 2023

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

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid overpayments for inpatient services on behalf of managed care recipients who had third-party health insurance were appropriately recovered. The audit covered the period from January 2017 through August 2021.

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, where the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient. In turn, the MCOs are required to pay for the services their recipients require, including inpatient services. Many recipients have other third-party health insurance (TPHI) in addition to Medicaid (e.g., employer-based coverage or Medicare Part A). Medicaid is considered the payer of last resort, and, as such, MCOs are required to coordinate benefits with the recipient's TPHI prior to paying for Medicaid services. The Office of the Medicaid Inspector General (OMIG) contracts with Health Management Systems, Inc. (a Gainwell Technologies company [Gainwell]) to identify and recover payments made for services that should have been paid for by a recipient's TPHI.

Key Findings

We found that the Department and OMIG lacked adequate oversight of the third-party liability (TPL) recovery process to ensure all available recoveries were made. During the audit period:

- Gainwell did not bill TPHI carriers or initiate provider reviews for the recovery of $52.2 million in inpatient claims where MCOs paid as the primary insurance despite recipients having TPHI inpatient coverage. This included $8.5 million in claims where recovery was not attempted due to the Department's improper and/or questionable exclusion rules.
- Gainwell's recovery files contained $39.3 million in inpatient claims that were in an unresolved status due to TPHI carrier or provider non-response – of which $15.4 million had been in an unresolved status for over 2 years; as well as an additional $2.1 million in claims that were denied by TPHI carriers for reasons that could potentially be rectified.
- Neither the Department nor OMIG performed reviews, reconciliations, or other monitoring of Gainwell's recovery efforts by comparing claims MCOs paid on behalf of recipients with TPHI inpatient coverage with the claims Gainwell recovered.

Key Recommendations

- Review the $52.2 million in claims for inpatient services on behalf of recipients with TPHI inpatient coverage and ensure overpayments are appropriately recovered.
- Assess the $41.4 million ($39.3 million + $2.1 million) in claims for inpatient services that were billed to TPHI carriers or were part of provider reviews that did not result in a recovery, and ensure all necessary follow-up actions are taken to obtain appropriate recoveries.
- Assess the TPL recovery process for managed care inpatient services to identify all factors that led to improper payments not being recovered, and ensure corrective actions are taken where appropriate.

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

September 27, 2023

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

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 entitled *Recovering Managed Care Payments for Inpatient Services on Behalf of Recipients With Third-Party Health Insurance*. 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
Department	Department of Health	*Auditee*
CMS	Centers for Medicare & Medicaid Services	*Agency*
eMedNY	Department's Medicaid claims processing and payment system, which also contains information on recipients' TPHI	*System*
Encounter	Record of a health care service provided to a recipient	*Key Term*
FFS	Fee-for-service	*Key Term*
Gainwell	Gainwell Technologies, LLC	*Contractor*
MCO	Managed care organization	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*
TPHI	Third-party health insurance	*Key Term*
TPL	Third-party liability	*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. For the State fiscal year ended March 31, 2022, New York's Medicaid program had approximately 7.8 million recipients and Medicaid claim costs totaled about $74.6 billion (comprising $27.5 billion in fee-for-service payments and $47.1 billion in managed care premium payments). The federal government funded about 57.1% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 42.9%.

The State's Medicaid program is administered by the Department of Health (Department). The Department uses two methods to pay for Medicaid inpatient services: fee-for-service (FFS) and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays Medicaid-enrolled providers directly for each Medicaid recipient inpatient stay. Under the managed care method, the Department makes monthly premium payments to managed care organizations (MCOs) for each enrolled Medicaid recipient and, in turn, the MCOs arrange for the provision of inpatient services and reimburse providers for those services. MCOs then submit claims (referred to as encounter claims) to the Department's Encounter Intake System to inform the Department of each service provided to their enrollees. In addition, MCOs report their medical costs and administrative costs annually to the Department in Medicaid Managed Care Operating Reports. The Department uses this information to establish MCOs' managed care premium payment amounts.

Many Medicaid recipients have other sources of health care coverage in addition to Medicaid, such as Medicare Part A hospital insurance and commercial health insurance (hereafter referred to as third-party health insurance [TPHI]). Per federal law and State regulations, Medicaid is always the payer of last resort. If a Medicaid recipient has TPHI coverage, Medicaid providers and MCOs are required to coordinate benefits in order to exhaust the benefits of the TPHI coverage before billing the Medicaid program. While the Department maintains information on recipients' TPHI in eMedNY, in many instances, this information isn't available in time to prevent Medicaid from being identified as the primary payer.

MCOs conduct post-payment reviews to identify instances where a TPHI may be liable for the services provided to a Medicaid recipient. MCOs have 6 months after the payment date or the date the TPHI was added to eMedNY, whichever is later, to initiate review and recovery efforts. After 6 months, post-payment recovery efforts become the Department's responsibility. The Office of the Medicaid Inspector General (OMIG), an independent entity created within the Department, contracts with Health Management Systems, Inc. (a Gainwell Technologies company [Gainwell]) to perform these reviews and pursue recoveries from TPHI carriers or providers. Under State and federal laws, the Department – or Gainwell as its third-party liability (TPL) contractor – must initiate the process of recovering payments by billing the TPHI carriers within 3 years of the claim date of service. Once the TPHI carrier is billed for

the claims, the Department (or Gainwell) has up to 6 years from the submission of the bill to enforce its right to recover any amount for which the TPHI carrier is liable.[1]

Medicare, which can be a recipient's TPHI, will not accept a demand for a claim recovery directly from a State Medicaid program. Therefore, Gainwell (acting as the State's agent) is not able to bill Medicare Part A directly for inpatient recoveries. Instead, on a quarterly basis, Gainwell initiates encounter claim recovery through provider reviews where providers are instructed to bill Medicare Part A, and after Medicare pays for a claim, providers return the Medicaid payment to the State. The Centers for Medicare & Medicaid Services (CMS) generally requires providers to submit claims to Medicare within 12 months after the date of service unless the recipient was retroactively enrolled in Medicare. In this case, an additional 6 months is allowed following the date of Medicare coverage notification for the submission of claims.

1 Social Services Law § 367-a; Insurance Law § 3212; Social Security Act § 1902 (42 U.S.C. § 1396a).

Audit Findings and Recommendations

Comprehensive and effective monitoring of TPHI-related payments and post-payment reviews and recoveries are critical to ensure that Medicaid is the payer of last resort and that all inappropriate payments are pursued for recovery and collected. We determined that neither the Department nor OMIG provided sufficient oversight of Gainwell's activities to ensure that all inpatient encounter claims paid on behalf of Medicaid recipients with TPHI inpatient coverage were identified and adequately pursued for recovery.

For the period January 2017 through August 2021, MCOs paid $52.2 million as the primary insurance on 5,170 inpatient encounter claims where the recipients had TPHI coverage on file in eMedNY. However, Gainwell did not bill the TPHI carriers or initiate provider reviews for recovery. Further, a significant portion of the $52.2 million in payments may be unrecoverable because they exceed either Medicare's 12-month or New York State's 3-year statute of limitations for TPL recoveries. Gainwell's recovery processes are guided, in part, by business rules that remove claims Gainwell believes are unlikely to have a successful recovery. In many instances, lack of recovery likely stemmed from deficiencies in Gainwell's business rules that may have improperly excluded recoverable claims.

We also identified unresolved billing attempts on $39.3 million in encounter claims as a result of non-response from TPHI carriers and providers, as well as $2.1 million in claims that were denied by TPHI carriers for administrative or other reasons that could potentially be rectified. Follow-up actions by the Department, OMIG, and Gainwell to obtain payment on these unresolved and denied claims were limited.

According to Department and OMIG officials, TPHI coordination of benefits is a complex process, and there are numerous impediments to successful TPL recoveries, such as erroneous TPHI policy information, incomplete billing information on encounter claims, inadequate TPHI carrier and provider responses, denials by TPHI carriers, and difficulty in compelling cooperation from insurance carriers for the purposes of coordination of benefits. Officials indicated that Gainwell ran all appropriate inpatient claims through its internal processes during our audit period, and any inpatient claims not billed to TPHI carriers or otherwise not recovered were appropriately excluded. While we agree TPHI coordination of benefits and TPL recoveries are complex processes, weaknesses in the Department and OMIG's oversight of these processes likely contributed to significant lost opportunities for the recovery of improper payments.

Inadequate Oversight of the TPL Recovery Process and Coordination of Benefits

Claims Not Found in Gainwell's Recovery Files

Our review found that Gainwell's recovery files – containing all claims recovered, all claims billed to TPHI carriers, and all claims where provider reviews were initiated – did not account for about $52.2 million in encounter claims where the recipient had inpatient TPHI coverage on the date of service. Because Gainwell historically did

not keep track of the claims it excluded from its recovery efforts, we were unable to identify why about $9.9 million of the $52.2 million was not in the recovery files. For the remaining $42.3 million, we found that $33.8 million in claims were likely excluded from recovery attempts due to Gainwell's ineffective use of Medicare data files, and the remaining $8.5 million in claims were not recovered due to the Department's improper and/or questionable exclusion rules.

Data on the claims that Gainwell excludes from recovery is critical for proper monitoring purposes. However, according to Gainwell officials, during our audit period, their system was set up to track claims that were deemed likely recoverable but not claims that were excluded from recovery attempts; therefore, they did not report the excluded claims to OMIG. As a result of our prior audits (2020-S-39 and 2021-S-20), OMIG began receiving additional reports from Gainwell in November 2022. The reports include a monthly summary of the number of claims that were excluded from recovery attempts and the reasons for the exclusions. Since these reports are generated at a summary level, purportedly due to the volume of claims, OMIG would have to separately request details for specific claims. We encourage the Department and OMIG to use Gainwell's reports to assess the appropriateness of Gainwell's claim exclusions from TPHI carrier billings and provider reviews.

Ineffective Use of Medicare Data Files

We identified inpatient encounter claims totaling $33.8 million (of the $52.2 million) where the recipient had Medicare TPHI coverage for the date of service, yet the claims were excluded from Gainwell's TPHI carrier billings and provider reviews. Through discussions with OMIG and Gainwell officials, we determined Gainwell wasn't always able to identify or confirm Medicare coverage. When asked to comment regarding claims for recipients with Medicare TPHI where the claims were not attempted for recovery, Gainwell officials stated they were unable to confirm Medicare retroactive coverage. However, since the recipients did have Medicare coverage, and in some instances the Medicare coverage was in eMedNY prior to the service date, it is likely that provider reviews or TPHI carrier billings should have been initiated. For claims totaling $8.7 million (of the $33.8 million), Medicare TPHI coverage was on file in eMedNY prior to the date of service. For the remaining claims, totaling $25.1 million, Medicare TPHI coverage was added to eMedNY after the date of service (retroactively).

Retroactive Medicare coverage provides for an exception to the 12-month filing limit for Medicare claims and allows for an additional 6 months from the date of Medicare coverage notification to initiate a recovery. In OMIG's Gainwell Work Plan Modules, it states Gainwell "performs special analysis of Medicare eligibility dates to identify those with retro enrollment, enabling us to assist providers to recover outside the CMS imposed 12-month timely filing period for Medicare recovery for those individuals who are retro-enrolled in Medicare coverage." According to Gainwell officials, the specific details of their process to identify potential retroactive Medicare coverage are proprietary, and they review various factors – such as the date the Medicare enrollment data was received, the Medicare coverage start date, and

whether the recipient appears to be newly enrolled. As part of its process, Gainwell removes instances that it believes are “false positive” retroactive Medicare coverage, which we found may have contributed to the lack of recovery efforts.

We found Gainwell could be using the Medicare data files more effectively to identify and confirm Medicare coverage. Gainwell officials stated the Medicare enrollment data used doesn’t indicate whether Medicare was granted retroactively. However, we note the Medicare coverage start and end dates are sufficient to show when recipients have Medicare benefits. If this information is received within Medicare recovery time frames, Gainwell should seek recoveries through provider reviews or TPHI carrier billings. We encourage the Department and OMIG to review Gainwell’s use of Medicare data files as well as Gainwell’s Medicare coverage identification process to ensure appropriate recoveries are made for recipients with Medicare TPHI.

Improper and/or Questionable Exclusion Rules

About $8.5 million of the $52.2 million in encounter claims for which Gainwell did not bill TPHI carriers or initiate provider audits for recovery were subject to Department exclusion rules.

Claims totaling $4.9 million (of the $8.5 million) were removed from the recovery process because the Department and OMIG instructed Gainwell to remove all claims containing certain medical diagnoses of a confidential nature from recovery efforts. We were provided with a list of 1,412 diagnosis codes that generally fell into two broad categories: HIV and pregnancy related. According to Department officials, these claims are excluded from recovery efforts due to concerns regarding unintended disclosures of confidential diagnoses. We acknowledge the Department’s concerns; however, we recommend the Department reassess these blanket exclusions and determine whether there is a solution that would allow these types of claims to be recovered without the risk of unintended disclosures. Additionally, OMIG officials stated that OMIG is not precluded from engaging TPHI carriers or providers to seek recoveries, and as part of OMIG’s normal audit process (outside of the Gainwell TPL recovery process), OMIG reviews for TPHI coverage regardless of diagnosis code.

The remaining $3.6 million (of the $8.5 million) in claims were removed from the recovery process because they contained a diagnosis code related to COVID-19. The Department and OMIG instructed Gainwell to remove claims containing certain medical diagnoses related to COVID-19 from the early days of the public health emergency until June 23, 2021. As a result, recovery attempts never occurred for claims with COVID-19 diagnosis codes occurring before June 23, 2021. Gainwell officials stated they can reverse edits that previously excluded claims related to COVID-19. However, in response to our preliminary findings, OMIG officials stated it’s the Department’s decision when and if to seek recoveries for excluded COVID-19 claims, and they are waiting for guidance to be issued. We encourage the Department to consider issuing guidance to prevent further lost opportunities for recovery.

MCOs' Coordination of Benefits and Recovery Efforts

Of the $52.2 million not accounted for in Gainwell's recovery files, we found encounter claims, totaling $38.6 million, where the MCOs should have coordinated benefits or sought recoveries because the TPHI information was in eMedNY prior to or within 6 months of the MCO payment date. The responsibility for recovery of payments not recouped by MCOs – including the remaining $13.6 million in claims where the TPHI was not known until 6 months or more after the payment date – would fall to OMIG and Gainwell.

We contacted eight MCOs during the course of our audit to identify reasons why TPHI benefits weren't coordinated and why recoveries weren't made. The eight MCOs were selected judgmentally based on high payment amounts by the MCOs when the MCOs paid as the primary insurance for inpatient services on behalf of recipients with TPHI. Generally, the MCOs stated benefits were not coordinated and recoveries were not sought because they were not aware of TPHI at the time of service (even though the TPHI information was listed in eMedNY) and/or TPHI information was added to eMedNY more than 6 months after the MCOs paid the claim. In another instance, an MCO cited a flaw in its internal process, which resulted in the exclusion of claims for behavioral health services from the MCO's post-payment recovery efforts. In response to our audit work, the MCO stated it planned to adjust its internal processes to include behavioral health claims in future post-payment reviews. According to Department officials, any business rules set up by MCOs that exclude certain claims from coordination of benefits or recovery efforts are not reviewed or approved by the Department.

Additional Follow-Up Opportunities for Recoveries

New York State Social Services Law requires TPHI carriers to not deny payment for certain administrative reasons, such as a failure to obtain prior authorization (approval for services prior to payment), and to respond to requests for payment within 60 days.

We reviewed Gainwell's recovery files and identified $39.3 million in inpatient encounter claims with service dates ranging from 2017 to 2021 where the status was "open" or "flagged for recycle," meaning TPHI carriers or providers had not responded to Gainwell's recovery attempts. Of these claims, more than half were Gainwell's billing attempts through provider reviews (for recipients with either Medicare or commercial TPHI) that remained unresolved. Further, $15.4 million (of the $39.3 million) in claims have remained in this unresolved status for over 2 years. According to a Medicaid Update (the Department's official notification to providers) issued in August 2022, OMIG will issue audit reports to providers when responses to Gainwell's provider reviews were not received or payment was not made in full.

We also identified inpatient encounter claims, totaling $2.1 million, that were denied by TPHI carriers for administrative reasons or other reasons that may be rectifiable, such as "Invalid diagnosis code" or "Missing procedure code." These denials could ultimately be recoverable if appropriate follow-up actions are taken, such as

correcting deficiencies in the data used for carrier billing. As a result of our prior audits, OMIG began receiving additional reports from Gainwell in November 2022, including a quarterly summary of the number of claims where a recovery attempt was made but the claims were denied by TPHI carriers. However, since these reports are generated at a summary level, OMIG would have to separately request details on specific claims.

We encourage the Department and OMIG to use Gainwell reports to identify common TPHI carrier denial reasons and explore solutions that would result in a higher likelihood of recoveries when carriers deny claims, and work with Gainwell to resolve instances of carrier and provider non-response.

Recommendations

1. Review the $52.2 million in Medicaid payments for inpatient services on behalf of recipients with TPHI inpatient coverage and ensure TPHI carriers are billed and provider reviews are initiated, as appropriate, so overpayments are recovered, prioritizing encounter claims that are approaching the end of the recovery window.
2. Assess the recoverability of the $41.4 million ($39.3 million + $2.1 million) in Medicaid payments for inpatient services that were billed to TPHI carriers or were part of provider reviews that did not result in a recovery (due to carrier/provider non-response or carrier denials), and ensure all necessary follow-up actions are taken to obtain appropriate recoveries, prioritizing claims that are approaching the end of the recovery window.
3. Assess the TPL recovery process for managed care inpatient services to identify all factors that led to exclusions from TPHI carrier billings and provider reviews, and ensure corrective actions are taken where appropriate.
4. Ensure MCOs are aware of recipients' TPHI with inpatient coverage per eMedNY and take corrective actions where appropriate.
5. Ensure MCOs are not inappropriately excluding inpatient encounter claims from coordination of benefits or TPL recovery efforts, and follow up with the MCO that inappropriately removed behavioral health inpatient services from its recovery efforts to ensure corrections were made.
6. Reassess the exclusion of all claims with the 1,412 medical diagnosis codes of a confidential nature from TPL recovery efforts and identify solutions that would allow these claims to be recovered without the risk of disclosure.
7. Determine whether inpatient encounter claims excluded from TPL recovery efforts due to the COVID-19 public health emergency will be billed to carriers in order to maximize recoveries before the recovery window closes.
8. Continue to implement and develop Department and OMIG processes to assist Gainwell with TPL recovery efforts to ensure appropriate recoveries are made for inpatient encounter claims where: providers are not responsive to Gainwell's provider reviews (particularly regarding claims that should be paid

by original Medicare); TPHI carriers are not responsive to attempted billings; and TPHI carriers deny attempted billings for administrative reasons or other reasons that may be rectifiable.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid overpayments for inpatient services on behalf of managed care recipients who had TPHI were appropriately recovered. The audit covered the period from January 2017 through August 2021.

To accomplish our objective and assess related internal controls, we interviewed officials and obtained data from the Department, OMIG, Gainwell, and MCOs. We reviewed applicable State and federal guidance and regulations and examined the Department's relevant Medicaid policies and procedures. Our review focused on Medicaid managed care inpatient services provided through mainstream managed care, health and recovery plans, and special needs plans.

We reviewed inpatient encounter claims data and TPHI policy data from the Medicaid Data Warehouse and eMedNY and determined the data was sufficiently reliable for the purpose of this audit. We analyzed the data to identify instances where the MCO was the primary payer for inpatient encounter claims on behalf of recipients with TPHI. We obtained recovery activities relating to inpatient encounter claims within our audit scope from Gainwell and eight MCOs. We compared this data to our inpatient encounter claim population where the MCO paid as the primary insurance on behalf of recipients who, according to eMedNY, had commercial or Medicare TPHI with inpatient coverage for the date of service. We removed claims recovered by Gainwell and the eight MCOs. We note that Gainwell's recovery process is ongoing; therefore, we adjusted the end date of the scope to June 2021 for our commercial TPHI population and to August 2021 for Medicare TPHI. To determine why the TPL recovery process did not result in billings to TPHI carriers, initiation of provider reviews, or recoveries of payments on the inpatient encounter claims we identified, we provided judgmental samples of claims to Gainwell and the eight MCOs for their review. We selected our samples for both Medicare and commercial TPHI coverage based on various factors, such as high payment amount. Because our samples were judgmentally selected, the results cannot be projected to the population as a whole.

We shared our methodology and findings with officials from the Department and OMIG during the audit for their review. We took their comments into consideration and adjusted our analyses as appropriate.

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 could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of recoveries of Medicaid managed care payments for inpatient services on behalf of recipients with TPHI.

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 final report and have included them in their entirety at the end of the report. In their response, Department officials indicated actions have been and will be taken to address certain audit recommendations. We address some Department remarks in our State Comptroller's Comments, which are embedded within the Department's response.

Within 180 days after 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

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

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

August 31, 2023

Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2021-S-24 entitled, "Medicaid Program: Recovering Managed Care Payments for Inpatient Services on Behalf of Recipients With Third-Party Health Insurance."

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

Johanne E. Morne, M.S.
Acting Executive Deputy Commissioner

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Andrea Martin
James Dematteo
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Department of Health Comments to Draft Audit Report 2021-S-24 entitled, "Medicaid Program: Recovering Managed Care Payments for Inpatient Services on Behalf of Recipients With Third-Party Health Insurance" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2021-S-24 entitled, "Medicaid Program: Recovering Managed Care Payments for Inpatient Services on Behalf of Recipients With Third-Party Health Insurance" by the Office of the State Comptroller (OSC).

General Comments:

The following comments address specific statements made in the draft audit report.

Background (page 5, paragraph 4):

"MCOs conduct post-payment reviews to identify instances where a TPHI may be liable for the services provided to a Medicaid recipient. MCOs have 6 months after the payment date, or the date the TPHI was added to eMedNY, to initiate review and recovery efforts."

Department's Comments:

The Office of the Medicaid General (OMIG) proposes the following edits to the language above:

> *"MCOs conduct post-payment reviews to identify instances where a TPHI may be liable for the services provided to a Medicaid recipient. MCOs have 6 months after the payment date, or the date the TPHI was added to eMedNY**, whichever is later**, to initiate review and recovery efforts."*

State Comptroller's Comment – We added the phrase "whichever is later" to the report.

Background (page 6, last paragraph):

"Therefore, Gainwell (acting as the State's agent) is not able to bill Medicare Part A directly for inpatient recoveries. Instead, on a quarterly basis, Gainwell initiates recovery through provider reviews where providers are instructed to bill Medicare Part A, and after Medicare pays for a claim, providers return the Medicaid payment to the State."

Department's Comment:

OMIG proposes the following edits to the language above:

> *"Therefore, Gainwell (acting as the State's agent) is not able to bill Medicare Part A directly for inpatient recoveries. Instead, on a quarterly basis, Gainwell initiates **encounter claim** recovery through provider reviews where providers are instructed to bill Medicare Part A, and after Medicare pays for a claim, providers return the Medicaid*

payment to the State.

State Comptroller's Comment – We added the phrase "encounter claim" to the report.

Claims Not Found in Gainwell's Recovery Files (page 8, paragraph 2):

"Data on the claims that Gainwell excludes from recovery is critical for proper monitoring purposes. However, according to Gainwell officials, during our audit period, their system was set up to track claims that were deemed likely recoverable but not claims that were excluded from recovery attempts; therefore, they did not report the excluded claims to OMIG. As a result of our prior audits, (2020-S-39 and 2021-S-20), OMIG began receiving additional reports from Gainwell in November 2022. The reports include a monthly summary of the number of claims that were excluded from recovery attempts and the reasons for the exclusions. Since these reports are generated at a summary level, purportedly due to the volume of claims, OMIG would have to separately request details for specific claims. We encourage the Department and OMIG to use Gainwell's reports to assess the appropriateness of Gainwell's claim exclusions from TPHI carrier billings and provider reviews."

Department's Comment:

Gainwell has adjusted their process and maintains a record of the claim detail for each billing cycle. Additionally, claims that may have been triggered by an edit, are reprocessed in subsequent cycles to maximize the opportunity to bill in the event an edit changes or the information on a claim may change, thereby allowing the claim to pass through for billing.

The additional reports that Gainwell generates are at the summary level due to the substantial volume of claims. Many claims are removed from a billing attempt for multiple reasons and would appear on the subsequent edit report multiple times. Sending the claim level detail for a monthly edit report would equate to the transmission of over 111 million rows of data. It would be impractical to send such a large amount of data. By receiving the data in a summarized form, OMIG is able to obtain an overview of the edits that were employed. As OSC noted, Gainwell will provide specific claim examples from any of the edit categories upon request by OMIG.

Ineffective Use of Medicare Data Files (page 8, paragraphs 2 & page 9 paragraph 1):

"Retroactive Medicare coverage provides for an exception to the 12-month filing limit for Medicare claims and allows for an additional 6 months from the date of Medicare coverage notification to initiate a recovery. In OMIG's Gainwell Work Plan Modules, it states Gainwell "performs special analysis of Medicare eligibility dates to identify those with retro enrollment, enabling us to assist providers to recover outside the CMS imposed 12-month timely filing period for Medicare recovery for those individuals who are retro-enrolled in Medicare coverage." According to Gainwell officials, the specific details of their process to identify potential retroactive Medicare coverage are proprietary, and they review various factors – such as the date the Medicare enrollment data was received, the Medicare coverage start date, and whether the recipient appears to be newly enrolled. As part of its process, Gainwell removes instances that it believes are "false positive" retroactive Medicare coverage, which we found may have contributed to the lack of recovery efforts.

We found Gainwell could be using the Medicare data files more effectively to identify and confirm Medicare coverage. Gainwell officials stated the Medicare enrollment data used doesn't

indicate whether Medicare was granted retroactively. However, we note the Medicare coverage start and end dates are sufficient to show when recipients have Medicare benefits. If this information is received within Medicare recovery time frames, Gainwell should seek recoveries through provider reviews or TPHI carrier billings. We encourage the Department and OMIG to review Gainwell's use of Medicare data files as well as Gainwell's Medicare coverage identification process to ensure appropriate recoveries are made for recipients with Medicare TPHI."

Department's Comment:

The existence of overlapping TPHI, in and of itself, does not mean a Medicaid claim is recoverable. As part of Gainwell's standard process, all Medicaid encounters/paid claims Gainwell receives are reviewed. When overlapping TPHI is discovered, edits within Gainwell's system identify claims where a recovery may not be appropriate. The absence of a billing attempt does not indicate that a recovery should have or would have occurred. For example, edits may remove claims the provider properly submitted to the TPHI carrier prior to submitting to Medicaid for payment. By way of another example, Gainwell does not include claims that are confidential in nature and non-covered services.

As it relates to retroactive Medicare coverage, Gainwell utilizes the monthly Medicare Modernization Act File and considers various factors and data points such as the Medicare start date, the date Gainwell received the Medicare data, and whether the member appears to be newly enrolled. After the initial population of potential retroactive coverage is identified, Gainwell reviews the coverage in an effort to eliminate instances of "false positive" retroactive coverage. As OSC noted, per CMS guidelines, Medicare will not accept a claim directly from a State Medicaid Agency. Therefore, in an effort to reduce abrasion when conducting Medicare reviews with providers, Gainwell only includes confirmed retroactive coverage.

State Comptroller's Comment – The audit demonstrated that the third-party liability (TPL) recovery process ineffectively used the Medicare coverage data, resulting in missed opportunities to recover significant overpayments. Examples were provided that showed inpatient encounter claims for recipients with valid Medicare coverage on file in eMedNY, yet Gainwell officials indicated that Medicare could not be confirmed and, therefore, recovery actions were not taken. If the Department and OMIG do not implement recommendations contained in this audit report and work with the contractor to correct the deficiencies, it is likely that millions of dollars will continue to be wasted.

Additional Follow-Up Opportunities for Recoveries (page 10, paragraph 3 & page 11, paragraph 1)

"We also identified inpatient encounter claims, totaling $2.1 million, that were denied by TPHI carriers for administrative reasons or other reasons that may be rectifiable, such as 'Invalid diagnosis code' or 'Missing procedure code'. These denials could ultimately be recoverable if appropriate follow-up actions are taken, such as correcting deficiencies in the data used for carrier billing. As a result of our prior audits, OMIG began receiving additional reports from Gainwell in November 2022, including a quarterly summary of the number of claims where a recovery attempt was made but the claims were denied by TPHI carriers. However, since these reports are generated at a summary level, OMIG would have to separately request details on specific claims.

We encourage the Department and OMIG to use Gainwell reports to identify common TPHI carrier denial reasons and explore solutions that would result in a higher likelihood of recoveries when carriers deny claims, and work with Gainwell to resolve instances of carrier and provider non-response."

Department's Comment:

OSC initially provided the Department, OMIG and Gainwell with the claim level detail comprising $3.2 million that were denied by TPHI carriers, but OSC felt were potentially rectifiable. After reviewing the denial codes that OSC selected, Gainwell disagreed that these denials are likely to result in a recovery and provided specific examples to OSC. For example:

- Codes A3~26~IL, A3~88~QC, and A7~88~QC are eligibility related denials.
- Code A3~21 is often an eligibility denial as well.

If the TPHI carrier does not show the member as having active coverage on the date of service, this is a final denial that is not rectifiable.

Since OSC has updated the TPHI carrier denial amount to $2.1 million, it is assumed that OSC is in agreement that the above example codes are not recoverable.

As part of Gainwell's denial follow up efforts, each denial reason code is reviewed to ensure that claims are re-billed to the commercial payers, where appropriate. Additionally, Gainwell's follow up efforts go beyond rebilling claims. For example, Gainwell holds meetings with carriers to discuss submitted claim elements, root cause analysis, Health Insurance Portability and Accountability Act (HIPAA) standard transaction processing, and TPHI source data eligibility gaps. Gainwell also engages with providers to obtain necessary information to supply to the carriers such as medical records. However, despite this follow up, carriers may re-deny claims or uphold their original adjudication decision. Thus, the presence of a denial does not indicate that follow up activity was not performed. Furthermore, there would still be a population of claims that remain unrecoverable due to missing or incorrect carrier information, non-covered services, etc.

State Comptroller's Comment – As stated in the report in the "Additional Follow-Up Opportunities for Recoveries" section, New York State Social Services Law requires TPHI carriers to not deny payment for certain administrative reasons, such as a failure to obtain prior authorization, and to respond to requests for payment within 60 days. Furthermore, in addition to the $2.1 million in claims denied by TPHI carriers due to administrative or other potentially rectifiable reasons, this section of the report identifies $39.3 million in inpatient encounter claims with service dates ranging from 2017 to 2021 where the status of recovery was "open" or "flagged for recycle," meaning TPHI carriers or providers had not responded to Gainwell's recovery attempts. Further, $15.4 million (of the $39.3 million) in claims have remained in this unresolved status for over 2 years. The Department and OMIG need to start providing adequate oversight to ensure that all appropriate recoveries are made and that TPHI carriers and providers are responding as required.

Audit Recommendation Responses:

The following are responses to the audit recommendations.

Recommendation #1:

Review the $52.2 million in Medicaid payments for inpatient services on behalf of recipients with TPHI inpatient coverage and ensure TPHI carriers are billed and provider reviews are initiated, as appropriate, so overpayments are recovered, prioritizing encounter claims that are approaching the end of the recovery window.

Response #1:

The existence of overlapping TPHI, including Medicare coverage, in and of itself, does not mean a Medicaid claim is recoverable. As part of Gainwell's standard process, all Medicaid encounters/paid claims Gainwell receives are reviewed. When overlapping TPHI is discovered, edits within Gainwell's system identify claims where a recovery may not be appropriate. The absence of a billing attempt does not indicate that a recovery should have or would have occurred. Additionally, claims reviewed as part of HMS' standard process but for which no recovery is made will be resubmitted in future cycles in the event a change is made that allows a claim to become billable. The contract between Gainwell and OMIG is structured to provide robust TPHI identification and recovery procedures. The State's and Gainwell's interests are aligned to maximize the identification and recovery of inappropriate payments for the Medicaid program.

State Comptroller's Comment – As mentioned in our audit report, the Department and OMIG lacked adequate oversight of the TPL recovery process and have not ensured that all available recoveries were made. Department and OMIG officials need to start providing adequate oversight of the TPL recovery contractor's activities, proactively, on a recurring basis and with sufficient depth of detail to ensure overpayments do not continue to go unrecovered.

Recommendation #2:

Assess the recoverability of the $41.4 million ($39.3 million + $2.1 million) in Medicaid payments for inpatient services that were billed to TPHI carriers or were part of provider reviews that did not result in a recovery (due to carrier/provider non-response or carrier denials), and ensure all necessary follow-up actions are taken to obtain appropriate recoveries, prioritizing claims that are approaching the end of the recovery window.

Response #2:

OSC initially provided the Department, OMIG and Gainwell with the claim level detail comprising $3.2 million that were denied by TPHI carriers, but OSC felt were potentially rectifiable. After reviewing the denial codes that OSC selected, Gainwell disagreed that these denials are likely to result in a recovery and provided specific examples to OSC. For example:

- Codes A3~26~IL, A3~88~QC, and A7~88~QC are eligibility related denials.
- Code A3~21 is often an eligibility denial as well.

If the TPHI carrier does not show the member as having active coverage on the date of service, this is a final denial that is not rectifiable.

Since OSC has updated the TPHI carrier denial amount to $2.1 million, it is assumed that OSC is in agreement that the above example codes are not recoverable.

As part of Gainwell's denial follow up efforts, each denial reason code is reviewed to ensure that claims are re-billed to the commercial payers, where appropriate. Additionally, Gainwell's follow up efforts go beyond rebilling claims. For example, Gainwell holds meetings with carriers to discuss submitted claim elements, root cause analysis, HIPAA standard transaction processing, and TPHI source data eligibility gaps. Gainwell also engages with providers to obtain necessary information to supply to the carriers such as medical records. However, despite this follow up, carriers may re-deny claims or uphold their original adjudication decision. The presence of a denial does not indicate that follow up activity was not performed. Additionally, there would still be a population of claims that remain unrecoverable due to missing or incorrect carrier information, non-covered services, etc. However, as OSC stated in its report, OMIG will be issuing draft and final audit reports to non-compliant providers.

State Comptroller's Comment – As stated in the report in the "Additional Follow-Up Opportunities for Recoveries" section, New York State Social Services Law requires TPHI carriers to not deny payment for certain administrative reasons, such as a failure to obtain prior authorization, and to respond to requests for payment within 60 days. Furthermore, in addition to the $2.1 million in claims denied by TPHI carriers due to administrative or other potentially rectifiable reasons, this section of the report identifies $39.3 million in inpatient encounter claims with service dates ranging from 2017 to 2021 where the status of recovery was "open" or "flagged for recycle," meaning TPHI carriers or providers had not responded to Gainwell's recovery attempts. Further, $15.4 million (of the $39.3 million) in claims have remained in this unresolved status for over 2 years. In response to the audit recommendation, we are pleased OMIG stated it is taking certain corrective actions.

Recommendation #3:

Assess the TPL recovery process for managed care inpatient services to identify all factors that led to exclusions from TPHI carrier billings and provider reviews, and ensure corrective actions are taken where appropriate.

Response #3:

OMIG agrees that TPL recovery processes, including edits and business rules, should be regularly reviewed, and understand that some claim types are inherently excluded due to confidentiality as well as heightened patient privacy. Gainwell has a long-standing, effective process in place to regularly review edits and business rules and update as appropriate. OMIG will continue to confer with Gainwell on updates to claim types necessitating exclusion, or to business rules that may require further update and/or modification.

State Comptroller's Comment – We are pleased OMIG agrees that the TPL recovery processes should be regularly reviewed. We encourage Department and OMIG officials to confer with Gainwell – with the depth of detail necessary – to identify all factors that led to the exclusions from TPHI carrier billings and provider reviews. We note that this should include a Department and OMIG review of Gainwell's use of Medicare enrollment data files and Gainwell's

Medicare coverage identification process to ensure appropriate recoveries are made for recipients with Medicare TPHI. As mentioned in the report, $33.8 million in claims where the recipient had Medicare TPHI coverage for the date of service were not included in Gainwell's recovery attempts as Gainwell was not always able to identify or confirm Medicare coverage.

Recommendation #4:

Ensure MCOs are aware of recipients' TPHI with inpatient coverage per eMedNY and take corrective actions where appropriate.

Response #4:

The Department is reviewing this recommendation to determine appropriate course of action.

Recommendation #5:

Ensure MCOs are not inappropriately excluding inpatient encounter claims from coordination of benefits or TPL recovery efforts, and follow-up with the MCO that inappropriately removed behavioral health inpatient services from its recovery efforts to ensure corrections were made.

Response #5:

The Department is reviewing this recommendation to determine the appropriate course of action.

Recommendation #6:

Reassess the exclusion of all claims with the 1,412 medical diagnosis codes of a confidential nature from TPL recovery efforts and identify solutions that would allow these claims to be recovered without the risk of disclosure.

Response #6:

There are circumstances for which the Department has determined that a third-party recovery should not be pursued by OMIG because these include confidential services that may put the Medicaid member at risk of harm. When a third-party recovery is pursued by OMIG, the third-party payer is required to send an explanation of benefits/remittance to the member's household. Services provided are identified, in part, by the member's diagnosis code reported on the Medicaid claim. The emotional or physical health, safety, and/or confidentiality of the Medicaid member may be jeopardized if an individual in the household other than the member gains access to the explanation of benefits/remittance. The Department has reviewed the list of confidential diagnosis codes and removed any that would not cause potential harm to a member.

Recommendation #7:

Determine whether inpatient encounter claims excluded from TPL recovery efforts due to the COVID-19 public health emergency will be billed to carriers in order to maximize recoveries before the recovery window closes.

Response #7:

For any OSC findings after March 2020, OMIG will utilize guidance issued by the federal government and NYS regarding the recovery of TPHI for encounters during the COVID-19 Public Health Emergency.

Recommendation #8:

Continue to implement and develop Department and OMIG processes to assist Gainwell with TPL recovery efforts to ensure appropriate recoveries are made for inpatient encounter claims where: providers are not responsive to Gainwell's provider reviews (particularly regarding claims that should be paid by original Medicare); TPHI carriers are not responsive to attempted billings; and TPHI carriers deny attempted billings for administrative reasons or other reasons that may be rectifiable.

Response #8:

OMIG actively oversees Gainwell activities, has visibility into all aspects of the process, and is currently implementing additional enhancements. In addition to generating a Monthly Recovery/Pre-payment Insurance Verification Overview Report, which is included in the annual OMIG-approved workplan, Gainwell also produces two additional reports which provide greater transparency into the TPL process. The first is a monthly report of claims that were excluded from recovery attempts and the reasoning behind the exclusion. Gainwell also provides OMIG with a quarterly report of claims where a recovery attempt was made but the claim was subsequently denied by the TPHI carrier. In addition, OMIG will be issuing draft and final audit reports to non-compliant providers.

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