Department of Health

Medicaid Program: Claims Processing Activity April 1, 2022 Through September 30, 2022

Report 2022-S-12 | May 2023

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

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to providers. The audit covered the period April 2022 through September 2022, and certain claims going back to January 2022.

About the Program

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the 6-month period ended September 30, 2022, eMedNY processed over 224 million claims, resulting in payments to providers of nearly $38 billion. The claims are processed and paid in weekly cycles, which averaged about 8.6 million claims and nearly $1.5 billion in payments to providers.

Key Findings

The audit identified over $16.7 million in improper Medicaid payments, as follows:

- $10.2 million was paid for managed care premiums on behalf of Medicaid recipients who also had concurrent comprehensive third-party health insurance;
- $2.5 million was paid for claims where Medicaid was incorrectly designated as the primary payer instead of another insurer;
- $2.1 million was paid for fee-for-service inpatient claims that should have been paid by managed care;
- $784,905 was paid for inpatient claims that were billed at a higher level of care than what was actually provided;
- $652,210 was paid for practitioner, clinic, inpatient, and pharmacy claims that did not comply with Medicaid policies; and
- $555,731 was paid for maternity and newborn birth claims that contained inaccurate information, such as the diagnosis code or newborn's birth weight.

As a result of the audit, about $4.3 million of the improper payments had been recovered by the end of the audit fieldwork. We also identified 11 providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. We advised Department officials of the providers and, by the end of the audit fieldwork, the Department had removed three of the providers from the Medicaid program and referred two to the New York State Office of the Attorney General's Medicaid Fraud Control Unit; the remaining six providers were under the Office of the Medicaid Inspector General's review.

Key Recommendations

- We made eight recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claims processing controls.

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

May 11, 2023

James V. McDonald, M.D., M.P.H.
Acting 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 of the Medicaid program entitled *Claims Processing Activity April 1, 2022 Through September 30, 2022*. 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*
ALC	Alternate Level of Care	*Key Term*
eMedNY	The Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
GME	Graduate Medical Education	*Key Term*
Local Districts	Local Departments of Social Services	*Agency*
MCO	Managed care organization	*Key Term*
NYSOH	NY State of Health	*System*
TPHI	Third-party health insurance	*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. Individuals can enroll in Medicaid through Local Departments of Social Services (Local Districts) or the NY State of Health (NYSOH), the State's online health plan marketplace. 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. 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 Department of Health's (Department's) Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the 6-month period ended September 30, 2022, eMedNY processed over 224 million claims, resulting in payments to providers of nearly $38 billion. The claims are processed and paid in weekly cycles, which averaged about 8.6 million claims and nearly $1.5 billion in payments to providers.

The Medicaid program pays health care providers through the fee-for-service (FFS) method or through managed care. Under FFS, the Department makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, the Department pays managed care organizations (MCOs) a monthly premium for each Medicaid recipient enrolled in the MCOs. The MCOs are then responsible for ensuring recipients have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services rendered to recipients and are required to submit encounter claims to inform the Department about each medical service provided.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, we work with Department staff to resolve the exceptions in a timely manner so payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the 6 months ended September 30, 2022, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers.

However, we also identified the need for improvements in the processing of certain types of claims. We found over $16.7 million in improper payments pertaining to: MCO premiums for enrollees with concurrent comprehensive third-party health insurance (TPHI); claims where Medicaid was incorrectly designated as the primary payer instead of another insurer; FFS claims for inpatient services that should have been covered by each recipient's MCO; hospital claims billed at a higher level of care than what was actually provided; practitioner, clinic, inpatient, and pharmacy claims that did not comply with Medicaid policies; and newborn birth and maternity claims that contained inaccurate birth information or diagnosis codes.

At the time the audit fieldwork concluded, about $4.3 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about $12.4 million and recover funds, as warranted.

We also identified 11 providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. We advised Department officials of the providers and, by the end of the audit fieldwork, the Department had removed three of them from the Medicaid program and referred two to the New York State Office of the Attorney General; the remaining six providers were under the Office of the Medicaid Inspector General's review.

Improper Managed Care Premium Payments for Recipients With Comprehensive Third-Party Health Insurance

Medicaid recipients may have additional sources of coverage for health care services (i.e., TPHI). The Department's policy is to exclude Medicaid recipients from enrollment in mainstream managed care when they also have concurrent comprehensive TPHI (TPHI is considered comprehensive if it covers certain types of services, among them: hospital care, physician services, pharmacy, and hospice care). These recipients should, instead, be enrolled in Medicaid FFS.

In response to the coronavirus disease 2019 state of emergency, declared under Executive Order 202 on March 7, 2020, the Department paused disenrollment of recipients with comprehensive TPHI from managed care for the period March 30, 2020 through February 27, 2021. However, we found problems with the disenrollment process after the pause ended that led to improper managed care premium payments of nearly $10.2 million between April 2022 and September 2022 (see the following table).

Enrollment Type	Number of Claims	Premium Amount
NYSOH	10,614	$4,727,123
Non-NYSOH	8,067	5,440,222
Totals	**18,681**	**$10,167,345**

According to Department procedures, disenrolling managed care enrollees through NYSOH is an automatic process done prospectively at the end of the current month, or the end of the following month (based on when TPHI is identified). Additionally, a monthly query is used to identify non-NYSOH-enrolled members (members enrolled in Medicaid by Local Districts) for disenrollment. We found instances where the disenrollment processes were not done timely. For example, one managed care enrollee's comprehensive TPHI was updated in eMedNY via NYSOH in September 2021. Although the managed care enrollment should have been terminated beginning October 1, 2021, this recipient's managed care enrollment continued through the audit period. As a result, Medicaid made six improper premium payments totaling $3,252 on behalf of this recipient during the audit period. Department officials stated they are monitoring the current process that automatically disenrolls members with TPHI from managed care to identify and correct any problems.

Recommendation

1. Review the nearly $10.2 million in overpayments, make recoveries, and disenroll the members from managed care, as appropriate.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, health care providers must verify whether recipients had other insurance coverage on the date services were provided. If a recipient had other insurance coverage, the other insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the recipient's normal financial obligation, including coinsurance. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer.

Errors in the designation of the primary payer may result in improper Medicaid payments. We identified overpayments totaling $2,527,939 on 14 claims in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. We contacted the providers and advised them Medicaid was incorrectly billed as the primary payer. At the conclusion of our audit fieldwork, providers had adjusted 13 claims, resulting in Medicaid savings of $2,524,704. However, the one remaining claim overpaid by $3,235 still needed to be adjusted.

Recommendation

2. Review the $3,235 overpayment and recover, as appropriate.

Improper Fee-for-Service Payments for Inpatient Services Covered by Managed Care

We identified 143 overpayments, totaling $2,060,181, for inpatient claims with service dates between January 2022 and July 2022 where FFS payments were made for recipients enrolled in managed care plans that should have paid for the services. Of these overpayments, 87 were due to retroactive managed care coverage, including 42 for newborns. For instance, a child born to a mother enrolled in a managed care plan should be enrolled in the mother's plan from the child's date of birth. However, the Department does not have a process in place to timely identify and recover improper FFS payments resulting from retroactive updates to a recipient's managed care plan enrollment, including retroactive enrollment of a newborn into their mother's plan back to the child's date of birth. The remaining 56 overpayments occurred due to providers incorrectly billing FFS when the recipient had managed care coverage or failing to support the validity of the claim. We contacted the providers for each of the claims we identified and 63 were adjusted, saving Medicaid $898,955. However, the remaining 80 claims totaling $1,161,226 still needed to be adjusted.

Recommendation

3. Review the nearly $1.2 million in overpayments and make recoveries, as appropriate.

Incorrect Billing of Alternate Level of Care

Certain levels of care are more intensive and, therefore, more expensive than others. Hospitals are required to indicate a patient's level of care on claims to ensure accurate processing and payment. When a patient is placed in a lower Alternate Level of Care (ALC) setting, hospitals should not bill Medicaid for more intensive acute levels of care. Rather, hospitals should bill less expensive ALC per diem rates.

The Department published billing guidance in the July 2019, June 2020, October 2021, and June 2022 Medicaid Updates, reminding hospitals to accurately report the ALC status of a patient when billing Medicaid to ensure appropriate payment. Despite the Department issuing guidance, providers continue to bill claims at the incorrect level of care. We identified nine overpayments, totaling $784,905, to providers who billed for a higher (and more costly) level of care than what was actually provided to the Medicaid recipients. As a result of our review, three of the nine claims were adjusted, saving Medicaid $29,320. However, six claims that were overpaid by $755,585 still need to be adjusted.

Recommendations

4. Review the $755,585 in overpayments and make recoveries, as appropriate.
5. Directly advise the providers identified in this report to bill claims at the appropriate level of care.

Improper Payments for Practitioner, Clinic, Inpatient, and Pharmacy Claims

We identified $652,210 in overpayments on 21 practitioner claims, 14 clinic claims, four inpatient claims, and four pharmacy claims that resulted from errors in billing. At the time our fieldwork concluded, 12 claims had been adjusted, saving Medicaid $340,702. However, corrective actions were still required to address the remaining 31 claims with overpayments totaling $311,508.

The overpayments occurred under the following scenarios:

- Providers are responsible for submitting claims with correct information. We identified $550,174 in overpayments on nine claims resulting from provider errors. For example, three providers entered incorrect discharge code information on four inpatient claims. We contacted these providers, and they confirmed the claims were coded incorrectly and stated they would work to adjust the claims. In total, at the end of our fieldwork, providers had adjusted four claims, saving Medicaid $320,750. However, Medicaid paid $229,424 for the remaining five unadjusted claims, which should be followed up on for recovery.
- Medicaid providers are required to maintain all records for a period of 6 years and to have them readily accessible for audit purposes. We requested records for eight claims from five providers, who did not respond to our records request. As a result, we consider the services unsupported. Medicaid paid $66,773 for the unsupported claims, and this amount should be followed up on for recovery.
- Providers may be entitled to reimbursement of drug administration charges for drugs obtained at no cost. For correct reimbursement of certain claims, providers should submit claims using either the modifier code “FB” (for non-psychotropic medications) or an injection-only procedure code (for psychotropic medications) to inform eMedNY that the facility did not pay for the drug, which results in payment for the injection service only. We identified $29,209 in overpayments on 13 clinic claims where Medicaid paid providers for drugs obtained at no cost. These overpayments occurred because providers failed to follow applicable Medicaid policy guidance. At the end of our fieldwork, providers had adjusted eight claims, saving Medicaid $19,952. However, the remaining five claims totaling $9,257 still needed to be adjusted.
- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified $6,054 in overpayments on 13 claims where the providers billed more than the acquisition costs for practitioner-administered drugs. All 13 claims needed to be adjusted.

Recommendation

6. Review the $311,508 ($229,424 + $66,773 + $9,257 + $6,054) in overpayments and make recoveries, as appropriate.

Incorrect Maternity and Newborn Birth Claims Involving Managed Care

In addition to monthly premium payments, Medicaid pays MCOs a one-time Supplemental Maternity Capitation Payment for the inpatient birthing costs of each newborn as long as it is a live birth or a still birth. If the pregnancy ends in a termination or miscarriage, the MCO should not receive the Supplemental Maternity Capitation Payment. Additionally, if a newborn weighs less than 1,200 grams (approximately 2.64 pounds) at birth, Medicaid also pays MCOs a one-time Supplemental Low Birth Weight Newborn Capitation Payment to cover the higher cost of care these newborns require. In addition to the supplemental payments to the MCOs, there is also a FFS Graduate Medical Education (GME) claim (hospitals receive FFS GME payments for care provided to recipients enrolled in MCOs to cover the costs of training residents).

Errors in reporting information, such as incorrect birth weight or diagnosis code, on newborn and maternity claims can result in improper Medicaid payments. We identified such errors on 36 claims, resulting in overpayments totaling $555,731. By the end of the audit fieldwork, providers had adjusted all 36 claims, resulting in Medicaid savings of $555,731.

Supplemental Maternity Capitation Payments

We identified 34 claims totaling $330,384 for improper Supplemental Maternity Capitation Payments to MCOs. In each case, either there was no indication of a birth in eMedNY or the pregnancy ended in a termination or miscarriage. Therefore, the MCOs were not eligible for the supplemental payment. According to the MCOs we contacted, the payments occurred because of billing errors. At the end of our fieldwork, MCOs had adjusted all 34 claims, saving Medicaid $330,384.

Supplemental Low Birth Weight Newborn Capitation Payments

We identified $225,347 in overpayments for two Supplemental Low Birth Weight Newborn Capitation claims. The overpayments occurred because an MCO reported an inaccurate newborn birth weight on one claim, and a hospital reported an inaccurate birth weight to the MCO on the second claim. For example, the MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 628 grams. We reviewed the corresponding GME claim and noted the hospital had reported a birth weight of 3,827 grams on the newborn's inpatient GME claim. We contacted the MCO and notified it of the discrepancy. The MCO admitted its error and corrected the claim, saving Medicaid $112,674. At the time our fieldwork concluded, both Supplemental Low Birth Weight Newborn Capitation claims had been corrected, for a savings of $225,347.

Recommendation

7. Formally advise the MCOs and the hospital to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment.

Status of Providers Who Violate Program Requirements

If a Medicaid provider has violated statutory or regulatory requirements related to the Medicaid or Medicare programs, or has engaged in other unacceptable insurance practices, the Department can impose sanctions against the provider. These sanctions can range from excluding the provider from the Medicaid program to imposing participation requirements, such as requiring all claims to be reviewed manually before payment. If the Department does not identify a provider who should be excluded from the Medicaid program, or fails to impose proper sanctions, the provider remains active to treat Medicaid patients, perhaps placing recipients at risk of poor-quality care while the provider continues to receive Medicaid payments.

We identified 11 Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations of a health care program. Of the 11 providers, 10 had an active status in the Medicaid program and one had an inactive status. Inactive providers are required to seek reinstatement from Medicaid to submit new claims. We advised Department officials of the 11 providers. By the end of the audit fieldwork, the Department had removed three of them from the Medicaid program and referred two to the New York State Office of the Attorney General's Medicaid Fraud Control Unit; the remaining six providers were under the Office of the Medicaid Inspector General's review.

Recommendation

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

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to providers. The audit covered the period April 2022 through September 2022, and certain claims going back to January 2022.

To accomplish our audit objective and assess related internal controls, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments, and tested the operation of certain system controls. We spoke to officials from the Department and reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Based on our audit work, we believe the data obtained was sufficiently reliable for the purposes of this audit. We judgmentally sampled 2,067 claims, totaling approximately $137.3 million, and reviewed them for accuracy and appropriateness. We used a risk-based approach to judgmentally sample different claim types, including selecting the highest-dollar claims and claims identified as a risk area on prior audits. We also selected a random sample of 78 pharmacy claims, totaling nearly $1.2 million, and reviewed them for accuracy and appropriateness. We selected 100% of the claims that did not follow payment rules pertaining to comprehensive TPHI coverage. A summary of the sampled claims is presented in the Exhibit. The results of our samples cannot 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 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 Medicaid claims processing activity from April 1, 2022 through September 30, 2022.

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 it. In their response, Department officials agreed with the audit recommendations and indicated that certain actions have been and will be taken to address them.

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.

Exhibit

Summary of Sampled Claims

Sample Category	Claims Sampled	Claims With Findings
Comprehensive TPHI	18,681	18,681
Various claim types	2,067	245
Randomly selected pharmacy claims	78	0
Totals	**20,826**	**18,926**

Agency Comments

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

May 5, 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 2022-S-12 entitled, "Medicaid Program: Claims Processing Activity April 1, 2022 through September 30, 2022."

Thank you for the opportunity to comment.

Sincerely,

Megan Baldwin

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
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Department of Health Comments to Draft Audit Report 2022-S-12 entitled, "Medicaid Program: Claims Processing Activity April 1, 2022 Through September 30, 2022" 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 2022-S-12 entitled, "Medicaid Program: Claims Processing Activity April 1, 2022 Through September 30, 2022" by the Office of the State Comptroller (OSC).

General Comment

The audit concluded that "eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers."

Recommendation #1:

Review the nearly $10.2 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 (TPHI). 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.

The Department can assist with member disenrollment once OMIG has performed its analysis and determined if recoveries are indeed necessary.

Recommendation #2:

Review the $3,235 overpayment and recover, as appropriate.

Response #2:

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 #3:

Review the nearly $1.2 million 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 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 $755,585 in overpayments and make recoveries, as appropriate.

Response #4:

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 #5:

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

Response #5:

The Department published a Medicaid Update reminder in June 2022, titled *"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 #6:

Review the $311,508 ($229,424 + $66,773 + $9,257 + $6,054) in overpayments and make recoveries, as appropriate.

Response #6:

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 #7:

Formally advise the MCOs and the hospital to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment.

Response #7:

The Department published a Medicaid Update article in the February 2023 Issue, titled *"Billing Guidance for Reporting Newborn Birth Weights",* advising hospitals to accurately report maternity and newborn claim information when billing Medicaid to ensure appropriate payment. This article can be found in Volume 39 – Number 5: Billing Guidance for Reporting Newborn Birth Weights.

The Department will also remind the MCOs of the requirement to comply with Section 37 in the Model Contract, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

Recommendation #8:

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

Response #8:

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.

Contributors to Report

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