Department of Health

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Executive Deputy Commissioner

March 18, 2024

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 Follow-Up Audit Report, 2023-F-24 entitled, "Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" (2019-S-72).

Thank you for the opportunity to comment.

Sincerely,

Johanne E. Morne

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

Enclosure

cc: Frank Walsh
Amir Bassiri
Jacqueline McGovern
Amber Rohan
Brian Kiernan
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Department of Health Comments to Follow-Up Audit Report 2023-F-24 entitled, "Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" (Report 2019-S-72) by the Office of the State Comptroller

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The following are the responses from the New York State Department of Health (the Department) to Follow-Up Audit Report 2023-F-24 entitled, "Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $965 million in payments to providers for Medicaid services that did not meet federal and State OPRA regulations - particularly payments for services with an OPRA provider excluded from participating in the Medicaid program – and determine an appropriate course of action, including determining if any recoveries should be made.

Status – Not Implemented

Agency Action – Our initial audit found $965 million in Medicaid payments for claims that required an active OPRA provider on the claim's order or service date but were instead provided by an inactive OPRA provider, including $5.8 million for providers who were excluded from participating in Medicaid due to past misconduct. In response to our initial audit, Department officials stated they were collaborating with OMIG on a comprehensive strategy, including guidance and possible corrective actions for claims we identified. However, at the time of our follow-up, less than 1% of the $965 million had been recovered, and OMIG was unable to demonstrate that any of the recoveries were related to projects initiated in response to our initial audit. Additionally, according to OMIG, a portion of the claims are non-recoverable because they were used in recovery calculations associated with other OMIG audits. We note OMIG may have already lost the opportunity to recover nearly $838 million of the payments due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the improper payments we identified to prevent further loss of recoveries.

Response #1:

OMIG has recovered $1,449,340 of the OSC-identified overpayments. Additionally, there are 45,996 claims totaling $4,722,271 that are already included in other OMIG audit universes. There are 1,856,268 claims totaling $757,846,189 which are no longer recoverable due to the statute of limitations.

Recommendation #2:

Review the $10.3 million payments to providers for Medicaid services where the attending provider on institutional claims was not affiliated with the billing facility, as required, and determine an appropriate course of action, including determining if any recoveries should be made.

Status – Not Implemented

Agency Action – Our initial audit found $10.3 million in Medicaid payments (most of which was part of the $965 million) where the attending provider was not affiliated with the billing facility

provider in eMedNY, the Department's claims processing and payment system, as required. Without this, the Department lacks assurance that the attending provider was screened by the facility. In response to our initial audit, Department officials stated they were collaborating with OMIG on the development of a comprehensive strategy to identify improper payments and make recoveries. At the time of our follow-up, the Department and OMIG were unable to provide evidence that any of the claims identified by our initial audit had been reviewed or recovered.

Response #2:

$10.2 million is included in the $965 million mentioned in Recommendation #1. OMIG has recovered $1,449,340 of the OSC-identified overpayments. Additionally, there are 45,996 claims totaling $4,722,271 that are already included in other OMIG audit universes. There are 1,856,268 claims totaling $757,846,189 which are no longer recoverable due to the statute of limitations.

Recommendation #3:

Improve controls to more timely identify OPRA providers with an inactive status to prevent the types of improper Medicaid payments we identified after the enhancements to eMedNY edits were made in February 2018.

Status – Not Implemented

Agency Action – The Department enhanced eMedNY system controls in February 2018 that significantly reduced the number of improper claims billed with an inactive OPRA provider. However, improper payments continued. In response to our initial audit, the Department stated that an extensive project to review and remediate system edits and to improve provider compliance with State and federal OPRA requirements was in progress. However, at the time of our follow-up, the project was on hold and the Department had not made any additional improvements to controls.

Response #3:

The Department has issued pharmacy guidance, as well as conducted outreach regarding enrollment in the Medicaid program and processes for exceptions to the OPRA requirement.

The Department is reviewing the edit changes made to eMedNY in February 2018 to determine if there are gaps in claims processing. The Department is also reviewing existing edits related to inactive providers. Deficiencies in claims processing identified during the review will be corrected through the Change Request process with the Fiscal Agent.

Recommendation #4:

Update and issue guidance clarifying OPRA billing requirements to providers, such as nursing home and home health, who have not yet received these communications.

Status – Not Implemented

Agency Action – Our initial audit found that the Department had issued guidance to certain providers to clarify OPRA requirements, such as pharmacy and intermediate care facilities for

the developmentally disabled, but had not issued guidance related to nursing home or home health services (these services accounted for about $629 million of the $965 million in overpayments we identified, or 65%). In response to our initial audit, Department officials stated that they would update billing guidelines to clarify which OPRA fields are required when the associated eMedNY system projects were complete. However, since the eMedNY system projects were put on hold, the Department had not yet updated and issued the guidance.

Response #4:

Although the Department has issued pharmacy guidance, and conducted outreach regarding enrollment in the Medicaid program and processes for exceptions to the OPRA requirement, updated guidance in other areas is dependent upon the identification and completion of system edits. An extensive project to identify necessary edits was put on hold during the public health emergency, and has not yet been resumed.

Recommendation #5:

Ensure providers who should be excluded from the Medicaid program are added to the provider sanction table in a timely manner.

Status – Not Implemented

Agency Action – The eMedNY provider sanction table contains information on excluded providers. If excluded providers are not in the provider sanction table, established system edits cannot prevent inappropriate claim payments for services provided by these individuals. Our initial audit identified 116 providers who were not on the provider sanction table but were on OMIG's Excluded Provider List or on the Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities. In response to our initial audit, OMIG stated that it implemented a process in January 2018 to confirm that eMedNY is updated accurately and timely in order to prevent claims from being paid when a provider was excluded. Upon our subsequent inquiry, OMIG confirmed that no updates had been made to this process since our initial audit. Because 16 of the 116 providers we identified were excluded after OMIG's 2018 process became effective, and the remaining 100 providers had still not been added to the provider sanction table at the time of the initial audit, we encourage the Department and OMIG to ensure providers who should be excluded from the Medicaid program are added to the provider sanction table in a timely manner.

Response #5:

Data entry and system controls currently exist. OMIG has a process in place and has enhanced that process which requires the eMedNY Sanction Table to be populated with non-enrolled providers and censures on the date the notice is issued. There is an internal control that requires OMIG to verify the data added to the Sanction Table. Through this process OMIG can confirm that eMedNY is updated accurately and timely, to prevent claims from being paid to an excluded provide.

Recommendation #6:

Formally remind facilities not to delete affiliations with providers in eMedNY who are no longer affiliated with the facility in order to maintain a record of the affiliation.

Status – Implemented

Agency Action – The eMedNY system requires the attending provider on institutional claims, such as clinic and inpatient claims, to be affiliated with the billing facility on the date of service. According to the Department's guidance, if the attending provider is not affiliated with the facility on the date of service, the claim will be denied. If, at any time, the attending practitioner ceases to be affiliated with the facility, the facility must enter an end date for the affiliation in eMedNY. Our initial audit found that, although Department guidance instructed facilities to deactivate affiliations in order to maintain a record of the affiliation period, facilities also had the option to delete affiliations. However, deleting affiliations effectively removed all evidence that the attending practitioner was ever affiliated with the facility. In the August 2022 edition of the Medicaid Update (the Department's official publication for Medicaid providers), the Department informed providers they could no longer delete affiliations and instead must enter the end date of the affiliation.

Response #6:

The Department confirms agreement with this recommendation status.