Department of Health

Medicaid Program: Claims Processing Activity April 1, 2023 Through September 30, 2023

Report 2023-S-9 | April 2024

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 from April 2023 through September 2023, and certain claims going back to January 2022.

About the Program

The Department of Health (DOH) administers the State's Medicaid program. DOH'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 ending September 30, 2023, eMedNY processed over 420 million claims, resulting in payments to providers of more than $47.1 billion. The claims are processed and paid in weekly cycles, which averaged about 16 million claims and $1.8 billion in payments to providers.

Key Findings

The audit identified about $13.5 million in improper Medicaid payments, as follows:

- $9.3 million was paid for managed care premiums on behalf of Medicaid recipients who had other concurrent comprehensive third-party health insurance;
- $2.4 million was paid for fee-for-service inpatient claims that should have been paid by managed care;
- $985,786 was paid for newborn birth and maternity claims that contained inaccurate information, such as the newborn's birth weight;
- $582,101 was paid for inpatient, clinic, referred ambulatory, lab, and practitioner claims that did not comply with Medicaid policies;
- $167,098 was paid for claims where Medicaid was incorrectly designated as the primary payer instead of another insurer; and
- $77,703 was paid for managed care premiums on behalf of incarcerated recipients whose managed care coverage should have been suspended.

As a result of the audit, more than $2.8 million of the improper payments was recovered. We also identified 12 Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs or who were otherwise barred from participating in the Medicaid program.

Key Recommendations

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

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

April 24, 2024

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 of the Medicaid program entitled *Claims Processing Activity April 1, 2023 Through September 30, 2023*. 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.

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
DOH	Department of Health	*Auditee*
eMedNY	DOH's Medicaid claims processing and payment system	*System*
MCO	Managed care organization	*Key Term*
NYSOH	NY State of Health	*System*

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 or NY State of Health (NYSOH), the State's online health plan marketplace. For the State fiscal year ended March 31, 2023, New York's Medicaid program had approximately 8.4 million recipients and Medicaid claim costs totaled about $80.2 billion. The federal government funded about 56.9% of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.1%.

The Department of Health's (DOH's) Office of Health Insurance Programs administers the State's Medicaid program. DOH'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, 2023, eMedNY processed over 420 million claims, resulting in payments to providers of more than $47.1 billion. The claims are processed and paid in weekly cycles, which averaged about 16 million claims and $1.8 billion in payments to providers.

The Medicaid program pays health care providers through the fee-for-service method or through managed care. Under fee-for-service, DOH makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, DOH 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 provided to recipients and are required to submit encounter claims to inform DOH 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 cycles, we work with DOH 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, 2023, 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 about $13.5 million in improper payments pertaining to: MCO premiums for enrollees with concurrent comprehensive third-party health insurance; fee-for-service claims for inpatient services that should have been covered by each recipient's MCO; newborn birth and maternity claims that contained inaccurate birth information or diagnosis codes; inpatient, clinic, referred ambulatory, lab, and practitioner claims that did not comply with Medicaid policies; claims where Medicaid was incorrectly designated as the primary payer instead of another insurer; and MCO premiums for incarcerated recipients whose managed care coverage should have been suspended.

By the time the audit fieldwork concluded, more than $2.8 million of the improper payments had been recovered. DOH officials need to take additional actions to review the remaining inappropriate payments totaling about $10.7 million and recover funds, as warranted.

We also identified 12 providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs, or were otherwise barred from participation in the Medicaid Program. We advised DOH officials of the providers and, by the end of the audit fieldwork, DOH had removed 10 of them from the Medicaid program and referred two to the New York State Office of the Attorney General.

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., third-party health insurance). DOH's policy is to exclude Medicaid recipients from enrollment in mainstream managed care when they also have concurrent comprehensive third-party health insurance (third-party health insurance 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 fee-for-service, which is generally more cost-effective in these circumstances.

We found problems with the disenrollment process that led to improper managed care premium payments of approximately $9.3 million between April 2023 and September 2023 (see the following table).

Enrollment Type	Number of Claims	Premium Amount
NYSOH	10,896	$3,733,235
Non-NYSOH	10,365	5,550,802
Totals	**21,261**	**$9,284,037**

According to DOH 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 the third-party health insurance is identified). Additionally, DOH generates a monthly list to identify non-NYSOH enrolled members (members enrolled in Medicaid through Local Departments of Social Services) for disenrollment. We found instances where the disenrollment processes were not done timely. For example, one managed care enrollee's comprehensive third-party health insurance was updated in eMedNY in October 2022. Although the managed care enrollment should have been terminated prior to the start of the audit period (April 2023), this recipient's managed care enrollment continued through the end of the audit period (September 2023). As a result, Medicaid made six improper premium payments totaling $3,073 on behalf of this recipient during the audit period.

Recommendation

1. Review the $9.3 million in overpayments, disenroll the members from managed care plans, and make recoveries, as appropriate.

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

When a provider accepts a Medicaid managed care enrollee as a patient, the provider agrees to bill the enrollee's managed care plan for covered services and should not bill DOH directly for payment under the fee-for-service method. We identified 134 overpayments, totaling $2,377,359, for inpatient claims with service dates between October 2022 and June 2023, where fee-for-service payments were made for recipients enrolled in managed care plans that should have paid for the services. Of these overpayments, 105 were due to retroactive managed care coverage, including 83 for newborns. For instance, a child born to a mother enrolled in a managed care plan is enrolled in the mother's plan from the child's date of birth. However, DOH lacks an effective process to timely identify and recover improper fee-for-service 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 29 overpayments occurred due to providers incorrectly billing fee-for-service 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 88 were adjusted, saving Medicaid $1,492,214. However, the remaining 46 claims totaling $885,145 still needed to be adjusted.

Recommendation

2. Review the remaining $885,145 in overpayments and make recoveries, as appropriate.

Incorrect Newborn Birth and Maternity 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 these supplemental payments to the MCOs, hospitals receive a fee-for-service graduate medical education claim payment for the care provided to newborns 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 that resulted in overpayments totaling $985,786. By the end of the audit fieldwork, providers had adjusted 34 claims, resulting in Medicaid savings of $968,705. However, actions were still needed to address the remaining two claims totaling $17,081. Following the end of fieldwork, in October 2023, DOH sent an email to MCOs reminding them to accurately report newborn and maternity claim information when billing Medicaid.

Supplemental Low Birth Weight Newborn Capitation Payments

We identified $693,110 in overpayments for six Supplemental Low Birth Weight Newborn Capitation claims. Although DOH issued a Medicaid Update in June 2023 reminding hospitals to accurately report newborn birth weights on claims, the overpayments we identified occurred because hospitals sometimes reported inaccurate birth weights to MCOs and because MCOs sometimes reported inaccurate birth weight information on claims. For example, an MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 465 grams. We reviewed the corresponding graduate medical education claim and noted the hospital reported a birth weight of 3,365 grams. We contacted the MCO and notified it of the discrepancy. The MCO admitted its error and corrected the claim, saving Medicaid $120,771. By the time our fieldwork concluded, all six Supplemental Low Birth Weight Newborn Capitation claims had been corrected for a cost savings of $693,110.

Supplemental Maternity Capitation Payments

We identified 30 claims totaling $292,676 for improper Supplemental Maternity Capitation Payments to MCOs between November 2022 and September 2023. In each case, there was either 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 payments. According to the MCOs we contacted, the payments occurred because of billing errors. Following our outreach, one MCO reported they would initiate a self-audit of these claims to further identify inappropriate claims, and another stated they would be updating their payment logic to avoid submitting inappropriate claims in the future. By the end of our fieldwork, MCOs had adjusted 28 of the claims, saving Medicaid $275,595. However, two claims totaling $17,081 still needed to be adjusted.

Recommendation

3. Review the remaining $17,081 in overpayments and make recoveries, as appropriate.

Improper Payments for Inpatient, Clinic, Referred Ambulatory, Lab, and Practitioner Claims

We identified $582,101 in overpayments on three inpatient claims, three clinic claims, three referred ambulatory claims, three lab claims, and one practitioner claim that resulted from errors in billing. By the time our fieldwork concluded, five claims had been adjusted, saving Medicaid $211,263. However, corrective actions were still required to address the remaining eight claims with overpayments totaling $370,838.

The overpayments occurred under the following scenarios:

- Providers are responsible for submitting claims with correct information. We identified $400,571 in overpayments on nine claims on which the providers entered incorrect information. For example, we identified one case where the provider billed Medicaid twice for the same services, once as a referred ambulatory claim and once as a hospital claim. After the provider was contacted, they voided one of the claims, saving Medicaid $8,637. By the end of our fieldwork, providers had adjusted four claims, resulting in Medicaid savings of $205,706. However, Medicaid paid $194,865 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 two claims from two different providers who did not respond to our records request. As a result, we consider the services unsupported. Medicaid paid $175,767 for these unsupported claims, and this amount should be followed up on for recovery.
- Certain practitioner-administered drugs must be billed to Medicaid at their

acquisition cost. We identified $5,763 in overpayments on two claims where the providers billed more than the acquisition costs for practitioner-administered drugs. As a result of our review, one claim was adjusted, saving Medicaid $5,557. The remaining claim for $206 still needed to be adjusted.

Recommendation

4. Review the remaining $370,838 ($194,865 + $175,767 + $206) in overpayments and make recoveries, as appropriate.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have additional 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 dates 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 obligations, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer. In July 2023, DOH issued a Medicaid Update reminding providers of their responsibility to bill applicable other insurance prior to billing Medicaid.

Errors in designation of the primary payer can result in improper Medicaid payments. We identified overpayments totaling $167,098 on six claims in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. For example, one provider billed Medicaid as primary despite the recipient having Medicare at the time of the service. We contacted the provider and officials acknowledged they had made an error, which resulted in the incorrect coverage being recorded in their system, and they voided the claim, saving Medicaid $13,420. By the conclusion of our fieldwork, providers had adjusted five claims, resulting in cost savings of $159,671. However, one claim overpaid by $7,427 still needed to be adjusted.

Recommendation

5. Review the remaining $7,427 in overpayments and make recoveries, as appropriate.

Improper Managed Care Premium Payments During Recipient Incarceration

Incarcerated individuals are not entitled to Medicaid payment of medical care, services, or supplies received while physically residing in the correctional facility. These individuals are only eligible for Medicaid payment of inpatient hospitalization services provided off the grounds of the correctional facility. Medicaid managed care recipients who are incarcerated for at least 30 days should be moved to

fee-for-service coverage, and managed care premium payments should not be paid on their behalf. We identified 35 improper managed care premium payments totaling $77,703 on behalf of five incarcerated recipients for the period from January 2022 through April 2023.

All five managed care recipients received inpatient care from the same hospital during our audit scope. We initially contacted the hospital to determine why Medicaid fee-for-service was billed for the inpatient stays instead of the recipients' managed care plans. However, according to information provided by hospital officials, each recipient was incarcerated at the time of the inpatient stay; therefore, billing fee-for-service was correct, but managed care premium payments were improper. For example, one recipient was incarcerated from December 2021 through March 2023 (i.e., over 30 days and should have been moved to fee-for-service coverage), and Medicaid paid $36,604 in improper managed care premiums during this time.

DOH has long-standing agreements with the New York State Department of Corrections and Community Supervision, New York State Division of Criminal Justice Services, and New York City's Rikers Island facilities to provide DOH with information on individuals who have been incarcerated for more than 30 days. However, according to DOH officials, it can be difficult for DOH to identify when certain recipients are incarcerated as they lack notification agreements with some local jails. Of the five recipients we identified: two were incarcerated at a Rikers Island facility, two were at a local jail, and one had already been released, so the incarceration facility was not on file. According to DOH officials, the two recipients at Rikers Island were not included on the notification files they received, and they will work with officials at Rikers Island to determine the cause. By the end of our fieldwork, one premium payment was adjusted, saving Medicaid $2,397. The remaining 34 claims totaling $75,306 still needed to be adjusted.

Recommendations

6. Review the remaining $75,306 in overpayments and make recoveries, as appropriate.
7. Enhance processes, especially communication with local jails, to identify all incarcerated Medicaid recipients.

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, DOH 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 DOH 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 recipients, perhaps placing recipients

at risk of poor-quality care while the provider continues to receive Medicaid payments.

We identified 12 providers in the Medicaid program who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs or who were otherwise barred from participating in the Medicaid program. All 12 providers had an active status in the Medicaid program. We advised DOH officials of the 12 providers. By the end of the audit fieldwork, DOH removed 10 of them from the Medicaid program and referred the two remaining providers to the New York State Office of the Attorney General's Medicaid Fraud Control Unit.

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 DOH'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 from April 2023 through September 2023, 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 DOH and reviewed applicable sections of federal and State laws and regulations, examined DOH's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement.

We used a non-statistical sampling approach to review for accuracy and appropriateness. We selected judgmental and random samples for this work. Because we used a non-statistical sampling approach, we cannot project the results to the populations. Our samples, which are discussed in detail in the body of our report and summarized in the Exhibit, included:

- A judgmental sample of 2,157 claims totaling approximately $154 million selected based on dollar amount and on areas identified as risk on prior audits;
- A random sample of 78 pharmacy claims totaling approximately $2.3 million; and
- All claims that did not follow payment rules pertaining to comprehensive third-party health insurance coverage.

We relied on data from the Medicaid Data Warehouse and eMedNY that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit. We also relied on data obtained from the U.S. General Services Administration and U.S. Department of Health and Human Services, which are recognized as appropriate sources, and used this data for widely accepted purposes. Therefore, this data is sufficiently reliable for the purposes of this report without requiring additional testing.

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 DOH's oversight and administration of Medicaid claims processing activity from April 1, 2023 through September 30, 2023.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this report and have included them in their entirety at the end of it. In their response, DOH 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 third-party health insurance	21,261	21,261
Various claim types	2,157	224
Randomly selected pharmacy claims	78	0
Totals	**23,496**	**21,485**

Agency Comments

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.
Executive Deputy Commissioner

April 8, 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 Draft Audit Report 2023-S-9 entitled, "Medicaid Program: Claims Processing Activity April 1, 2023 Through September 20, 2023."

Thank you for the opportunity to comment.

Sincerely,

Johanne E. Morne

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

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Andrea Martin
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Rohan
Michael Atwood
OHIP Audit
DOH Audit

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2023-S-9 entitled, "Medicaid Program: Claims Processing Activity April 1, 2023 Through September 30, 2023"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2023-S-9 entitled, "Medicaid Program: Claims Processing Activity April 1, 2023 Through September 30, 2023." Included in the Department's response are the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

Recommendation #1:

Review the $9.3 million in overpayments, disenroll the members from managed care plans, and make recoveries, as appropriate.

Response #1:

The Department is reviewing the data that was provided by the auditors and conducting internal research. The Department is also examining the disenrollment processes.

OMIG continuously performs audits of comprehensive third-party health insurance, to ensure Medicaid is the payor of last resort. 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. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to New York State 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 #2:

Review the remaining $885,145 in overpayments and make recoveries, as appropriate.

Response #2:

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, confirm the accuracy of the claims detail for use in OMIG audit activities, to determine those overpayments requiring recovery. 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. OMIG has recovered more than $43,000 in overpayments made in 2019 through 2022 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #3:

Review the remaining $17,081 in overpayments and make recoveries, as appropriate.

Response #3:

OMIG continuously performs audits of supplemental maternity capitation payments to Managed Care Organizations (MCO). 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. OMIG has recovered more than $875,000 in overpayments made in 2019 through 2022 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #4:

Review the remaining $370,838 ($194,865 + $175,767 + $206) in overpayments and make recoveries, as appropriate.

Response #4:

OMIG continuously performs audits of pharmacy, clinic, and practitioner 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. OMIG has recovered more than $485,000 in overpayments made in 2019 through 2022 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #5:

Review the remaining $7,427 in overpayments and make recoveries, as appropriate.

Response #5:

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. OMIG has recovered more than $545,000 in overpayments made in 2019 through 2022 that were identified as potential overpayments by OSC on similar prior claims processing activity audits.

Recommendation #6:

Review the remaining $75,306 in overpayments and make recoveries, as appropriate.

Response #6:

OMIG continuously performs audits of incarcerated individuals. OMIG conducts an annual outreach to county jails across New York State to identify incarcerated Medicaid managed care enrollees whose incarceration may not have otherwise been reported. 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:

Enhance processes, especially communication with local jails, to identify all incarcerated Medicaid recipients.

Response #7:

The Department acknowledges there is minimal direct communication between the Department and the 62 local jails throughout New York State. However, meaningful improvements to communication and coordination will be challenging.

Local jails are operated by individual counties throughout the State, and the Department is unaware of any central repository for booking information. Only a small percentage of individuals incarcerated in a local jail meet criteria that impacts their Medicaid status. The vast majority of individuals are only housed for short periods, held pending charges or held for parole violations. None of these scenarios meet the definition of incarcerated that would require Medicaid program staff to react by suspending coverage and disenrolling from managed care. According to data on https://www.criminaljustice.ny.gov/crimnet/ojsa/jail_population.pdf the statewide population of those residing in local jail and already sentenced averages less than 3,000 in any month.

Establishing relationships and the data exchange necessary to identify all incarcerated Medicaid recipients in local jails would require significant work for jail staff in most of New York's counties, as well as Department and Information Technology Services staff. All of these entities are operating with limited resources.

The Department will continue to work with the Federal Centers for Medicare and Medicaid Services (CMS) to develop waiver flexibilities allowing for expanding coverage of incarcerated persons prior to their release from institutions. If approved, communication and data sharing between the Department and county jails and prisons will improve and allow for streamlined Medicaid coverage suspensions as appropriate.

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

Executive Team

Andrea C. Miller - *Executive Deputy Comptroller*
Tina Kim - *Deputy Comptroller*
Stephen C. Lynch - *Assistant Comptroller*

Audit Team

Andrea Inman - *Audit Director*
Christopher Morris - *Audit Manager*
Thomas Sunkel, CPA - *Audit Supervisor*
Amanda Basle - *Examiner-in-Charge*
Justine Maloy - *Examiner-in-Charge*
Emily Proulx - *Examiner-in-Charge*
Dawn Daubney, RN - *Registered Nurse (Medical Care)*
Misty Daiyan - *Senior Examiner*
Michael Gouvakis - *Senior Examiner*
Jennifer Kirby - *Senior Examiner*
Emily Schwartz - *Senior Examiner*
Fiorella Seminario - *Senior Examiner*
Linda Thipvoratrum - *Senior Examiner*
Reid Vogel - *Senior Examiner*
Lindsey Winter - *Senior Examiner*
Julissa Guzman - *Staff Examiner*
Eric Spence - *Program Research Specialist*

Contact Information
(518) 474-3271
StateGovernmentAccountability@osc.ny.gov
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

For more audits or information, please visit: www.osc.state.ny.us/state-agencies/audits