NEW YORK STATE | Department of Health

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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, **2024-F-18** entitled," **Medicaid Program – Excessive Payments for Durable Medical Equipment Rentals (Report 2021-S-36)**."

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

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

Enclosure

cc: Frank Walsh
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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2024-F-18 entitled, "Medicaid Program: Excessive Payments for Durable Medical Equipment Rentals (Report 2021-S-36)"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2024-F-18 entitled, "Medicaid Program: Excessive Payments for Durable Medical Equipment Rentals (Report 2021-S-36)." Included in the Department's response is 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

Formally determine whether it is efficient and appropriate under managed care to require a cap on the number of rental payments for oxygen-related equipment. If deemed appropriate, work with stakeholders to implement policy changes.

Status – Not Implemented

Agency Action – The initial audit found DOH could not support whether paying for oxygen equipment without a cap on the number of months of rental payments complied with Medicaid regulations, which require the total rental payments not exceed the actual purchase price of the item. The audit reviewed Medicaid, Medicare, and MCOs' rental policies related to oxygen equipment and identified costs that would be avoided if the Medicaid program adopted a policy similar to Medicare and one Medicaid MCO's 36-month cap on rental payments. In total, the audit identified $7.3 million in managed care rental payments for stationary and portable oxygen equipment that exceeded the 36-month payment cap that Medicare and the MCO uses.

Our follow-up found DOH had not formally determined whether it is efficient and appropriate under managed care to require a cap on the number of rental payments for oxygen equipment. DOH did not take any action to assess the efficiency and appropriateness of a capped payment structure in managed care and did not indicate it sought input from the Medicaid MCO that already has implemented a 36-month rental payment cap. In addition, DOH officials stated they do not have the ability to determine the efficiency and appropriateness of MCO policies and have no role in what policies MCOs implement for oxygen equipment outside of sharing Medicaid's FFS guidelines. We note that DOH is, in fact, responsible for overseeing MCOs and ensuring MCOs comply with established Medicaid standards.

Since the initial audit's scope period ended in December 2021, we identified an additional potential cost avoidance totaling over $6.1 million on encounter claims for oxygen equipment rentals from January 2022 through June 2024 had the Medicaid program adopted the 36-month cap on rental payments. DOH should take the necessary steps to formally evaluate the efficiency and appropriateness of the current oxygen equipment payment structure.

Response #1

Medicaid Managed Care Organizations per the Medicaid Model Contract (see Appendix K) are required to provide or arrange for Medicaid Durable Equipment and Services to their Medicaid members in accordance with the 18 NYCRR §505.5(a)(1) and Section 4.4 of the NYS Medicaid

Durable Medical Equipment, Medical and Surgical Supplies and Prosthetic, and Orthotic Appliances Provider Manual. The Contract prohibits plans from defining medically necessary services in a manner that limits the scope of benefits provided in the Social Services Law, the State Medicaid Plan, State regulations, or the Medicaid Provider Manuals. Managed Care Organizations are required to cover what Medicaid Fee-for-Service covers. However, they are responsible for contracting, negotiating rates, and setting appropriate utilization policies and performing medical necessity reviews. If the Fee-for-Service rental payment frequency limits change, the Department will provide notification in a Medicaid Update to the providers and Managed Care Organizations of the change in frequency limits to keep in line with Fee-for-Service.

Recommendation #2

Formally re-evaluate the existing policies for paying FFS DME rental claims for oxygen-related equipment, including an evaluation of the appropriateness of the uncapped continuous rental policy and the Medicaid reimbursement fees. If deemed appropriate, implement policy and claims processing changes.

Status – Partially Implemented

Agency Action – While DOH has not completed a formal re-evaluation of its existing FFS policies for payments of oxygen equipment rental claims, it has taken some initial steps. DOH officials stated they gathered input from two representatives—one from a regional association of medical equipment providers, the other from a national association of medical equipment providers and manufacturers—and were told a capped payment structure for oxygen equipment likely would not be sustainable. DOH stated any new payment structure would also need to account for equipment maintenance, provider staff hours, and general oxygen service support. In addition, DOH officials stated they have added this issue to their monthly meetings for an ongoing internal project regarding reimbursement policies.

The initial audit identified a potential cost avoidance totaling $1.3 million in FFS oxygen equipment rental claims had DOH officials adopted a capped payment structure similar to Medicare's. Since the initial audit, we identified an additional potential cost avoidance totaling $772,213 on FFS claims for oxygen equipment rentals from January 2022 through June 2024 had the Medicaid program adopted the 36-month cap on rental payments. We encourage DOH to formally reevaluate the current uncapped oxygen equipment payment structure. Such a review should include additional actions such as a cost-analysis comparing the current payment structure to a capped payment structure and seeking information from the Medicaid MCO that had already implemented a capped payment structure for oxygen equipment.

Response #2

The Department continues to evaluate the recommendation of following Medicare's oxygen rental policy. Medically fragile Medicaid members require a sustainable model of oxygen delivery services without compromising the population's access to oxygen therapy. The recommendation is based solely on a fiscal comparison of Medicare and Medicaid's reimbursement policies without taking into consideration accessibility to care in this vulnerable population.

The Medicare model only provides reimbursement for a 36-month period for oxygen therapy. After the initial 36-month rental period, only two additional payments for maintenance of equipment are rendered per year to the provider while the provider is responsible for continuing to provide all equipment and related supplies for the additional two years. These two years of limited payments for services are financially unviable for the providers and if a provider stops providing oxygen to the program, gaps of service would be common if new providers are not found in a timely fashion.

The Department is committed to evaluating alternative fiscal payment methods that could result in savings to Medicaid. We have raised the issue to an external Durable Medical Equipment Group of other state Medicaid programs and have received several responses from states that do not follow Medicare policies due to the factors listed above. We continue to partner with vendors, national and state Durable Medical Equipment trade groups, and comparable state Medicaid programs to make sure that we balance financial responsibility with access to oxygen services for Medicaid members. The Department will also continue to evaluate the current oxygen policies for other methods of efficiency that do not compromise member care.

Recommendation #3

Follow up with the MCO that made payments in excess of its policy limits on oxygen equipment to ensure that the $200,657 is reviewed and recovered, as appropriate.

Status – Not Implemented

Agency Action – The initial audit identified one MCO that made $200,657 in overpayments for oxygen equipment rentals where claims exceeded the MCO's 36-month payment cap, and some claims were paid without proper authorization. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of DOH, such as the excess oxygen equipment rental payments identified by the initial audit. In addition, New York State statute allows OMIG to audit providers' claims and recover overpayments up to 6 years from the date when the services or supplies were furnished or billed, whichever is later.

At the time of our follow-up, six oxygen equipment claims totaling $481 (of the $200,657) were voided and 19 claims totaling $2,127 were unrecoverable because of the 6-year statutory limit. The remaining $198,049 (99%) of overpayments made by the MCO still needed to be resolved. OMIG stated it was working with DOH staff to review the claims. Nonetheless, we encourage OMIG to also work with the MCO to promptly review and make recoveries on the remaining $198,049 to avoid additional losses due to the 6-year statutory limit.

Response #3

OMIG is developing a process to follow up with the Managed Care Organizations to address the potential overpayments identified by OSC. OMIG's audit process accounts for the fact that providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Thus, OMIG's analysis will 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. Managed Care Organizations have the ability to enter into their own specific contracts with each of their providers. These contracts can vary and may not have the same components as Fee-for-Service rates. Depending on these contracts, the OSC identified overpayments may have

been appropriately paid to the provider. 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 $1.3 million in overpayments identified for DME rental claims and ensure recoveries are made, as appropriate.

Status – Not Implemented

Agency Action – The initial audit reviewed five MCOs and found they did not comply with their own policies for DME rentals of non-oxygen equipment, resulting in overpayments totaling $1.3 million. Of the $1.3 million, $22,467 was voided by the time of our follow-up and $288,508 became unrecoverable because of the 6-year statutory limit. There was still $973,337 remaining for review and recovery; however, $231,487 of this amount will reach the statutory recovery limit and become unrecoverable over the next year. OMIG stated it was working with Department staff to review the overpayments. Nonetheless, OMIG should also take prompt action and work with the Managed Care Organizations to review the encounter claims and make appropriate recoveries to avoid additional unrecoverable payments.

Response #4

OMIG is developing a process to follow up with the Managed Care Organizations to address the potential overpayments identified by OSC. OMIG's audit process accounts for the fact that providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Thus, OMIG's analysis will 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. Managed Care Organizations have the ability to enter into their own specific contracts with each of their providers. These contracts can vary and may not have the same components as Fee-for-Service rates. Depending on these contracts, the OSC identified overpayments may have been appropriately paid to the provider. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #5

Monitor MCOs' DME rental claims for overpayments, including a review of the $503,619 identified, and take appropriate corrective steps, including ensuring recoveries are made.

Status – Not Implemented

Agency Action – The initial audit reviewed five MCOs' DME rental policies and found four of the five MCOs' rental limits (e.g., 10-month caps for most items) were similar to that of DOH's FFS limits. Accordingly, the initial audit then analyzed the DME encounter claims of the remaining MCOs (other than the five MCOs that were contacted) and, because their rental limits were unknown, compared their encounter claims with DOH's FFS rental limits to identify questionable payments in excess of typical rental limits. The audit identified $503,619 in questionable payments when the FFS rental limits and certain other conditions were applied.

At the time of our follow-up, nine claims totaling $412 had been voided and $136,392 was unrecoverable because of the 6-year statutory limit. The remaining $366,815 had not been addressed. OMIG stated it was working with DOH staff to review the claims. We encourage OMIG to promptly take the appropriate steps to review and recover any overpayments and monitor the MCOs' DME rental claims for future overpayments.

Response #5

OMIG is developing a process to follow up with the Managed Care Organizations to address the potential overpayments identified by OSC. OMIG's audit process accounts for the fact that providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Thus, OMIG's analysis will 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. Managed Care Organizations have the ability to enter into their own specific contracts with each of their providers. These contracts can vary and may not have the same components as Fee-for-Service rates. Depending on these contracts, the OSC identified overpayments may have been appropriately paid to the provider. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #6

Advise MCOs to evaluate the feasibility of developing controls to identify and prevent the types of DME rental overpayments identified by the audit, and take steps to ensure corresponding corrective actions are implemented.

Status – Not Implemented

Agency Action – The initial audit cited control weaknesses in MCOs' claims processing systems and billing procedures, which resulted in DME rental overpayments. In addition, the audit found neither DOH nor OMIG monitored whether the MCOs appropriately paid for DME. During our follow-up, DOH officials stated they plan to draft written directives to advise MCOs to study the feasibility of developing controls to identify and prevent overpayments for DME. However, until these directives are issued by DOH and preventive controls are implemented by the MCOs, the Medicaid program remains at risk for continued overpayments of DME rental encounter claims.

Response #6

The Department will prepare a communication to Managed Care Organizations that reminds them of the Durable Medical Equipment Manual, where it is located, and highlight limits on rental periods. If the Fee-for-Service rental payment frequency limits change, the Department will provide notification in a Medicaid Update to the providers and Managed Care Organizations of the change in frequency limits to keep in line with Fee-for-Service.

Recommendation #7

Formally determine the appropriateness of certain MCOs' policies that allow payments for a new rental period whenever there is a 60-day gap in rental payments or a change in provider. If deemed inappropriate, work with stakeholders to implement policy changes.

Status – Not Implemented

Agency Action – Medicaid regulations for DME state the total accumulated monthly rental charges may not exceed the actual purchase price of the item. The initial audit identified four MCOs with criteria in their DME rental policies that differed significantly from DOH's FFS policies. Specifically, the MCOs' policies allowed a new rental period to begin when there was either a gap in service, such as a period of 60 days without any rental payments, or a change in the DME provider.

At the time of our follow-up, DOH had not taken any action to determine the appropriateness of the MCOs' DME rental policies. DOH officials responded that they do not have the ability to determine the appropriateness of MCO policies and have no role in what policies MCOs implement for oxygen equipment. We note that DOH is, in fact, responsible for overseeing MCOs and ensuring MCOs comply with established Medicaid standards. We encourage DOH to formally determine the appropriateness of these policies.

Response #7

Managed Care Organizations are required to cover what Medicaid Fee-for-Service covers; however, they are responsible for contracting, negotiating rates, and setting appropriate utilization policies and performing medical necessity reviews.