Department of Health

Medicaid Program: Claims Processing Activity April 1, 2024 Through September 30, 2024

Report 2024-S-5 | June 2025

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 2024 through September 2024, 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 members and generates payments to reimburse the providers for their claims. During the 6-month period ended September 30, 2024, eMedNY processed almost 249 million claims, resulting in payments to providers of nearly $50.6 billion. The claims are processed and paid in weekly cycles, which averaged about 9.6 million claims and $1.9 billion in payments to providers.

Key Findings

The audit determined 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 improvement in the processing of certain types of claims. The audit identified over $11.5 million in improper Medicaid payments, as follows:

- $8.3 million was paid for managed care premiums on behalf of Medicaid members who should not have had managed care coverage because they had other concurrent comprehensive third-party health insurance;
- $1.6 million was paid for fee-for-service inpatient claims that should have been paid by managed care;
- $1.3 million was paid for managed care newborn birth and maternity claims that contained inaccurate information, such as low newborn birth weight, which caused increased payments;
- $222,220 was paid for inpatient, clinic, and referred ambulatory claims that did not comply with Medicaid policies; and
- $53,906 was paid for claims where Medicaid was incorrectly designated as the primary payer instead of another insurer.

As a result of the audit, more than $2.6 million of the improper payments was recovered. We also identified 14 Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. In response to these findings, DOH removed 13 of the providers from the Medicaid program and referred one to the Office of the New York State Attorney General.

Key Recommendations

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

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

June 18, 2025

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, 2024 Through September 30, 2024*. 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 the NY State of Health (NYSOH), the State's online health plan marketplace. For the State fiscal year ended March 31, 2024, New York's Medicaid program had approximately 9.1 million members and Medicaid claim costs totaled about $87.5 billion. The federal government funded about 56.8% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.2%.

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 members and generates payments to reimburse the providers for their claims. During the 6-month period ended September 30, 2024, eMedNY processed almost 249 million claims, resulting in payments to providers of nearly $50.6 billion. The claims are processed and paid in weekly cycles, which averaged about 9.6 million claims and $1.9 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 members. Under managed care, DOH pays managed care organizations (MCOs) a monthly premium for each Medicaid member enrolled in the MCOs. The MCOs are then responsible for ensuring members have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services provided to members 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 member, 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 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, 2024, 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 $11.5 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 member's MCO; newborn birth and maternity claims that contained inaccurate birth information or diagnosis codes; inpatient, clinic, and referred ambulatory claims that did not comply with Medicaid policies; and claims where Medicaid was incorrectly designated as the primary payer instead of another insurer.

At the time the audit fieldwork concluded, more than $2.6 million of the improper payments had been recovered. DOH officials need to take additional actions to review the remaining inappropriate payments totaling over $8.9 million and recover funds, as warranted.

We also identified 14 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 DOH officials of the providers and, by the end of the audit fieldwork, DOH had removed 13 of them from the Medicaid program and referred one to the Office of the New York State Attorney General.

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

Medicaid members may have additional sources of coverage for health care services (i.e., third-party health insurance). DOH's policy is to exclude Medicaid members 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 members should, instead, be enrolled in Medicaid fee-for-service, which is generally more cost effective in these circumstances.

We found problems with the managed care disenrollment process that led to improper managed care premium payments of over $8.3 million between April 2024 and September 2024 (see the following table).

Enrollment Type	Number of Claims	Premium Amount
NYSOH	5,963	$2,077,415
Non-NYSOH	10,124	6,257,906
Totals	16,087	$8,335,321

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 member's comprehensive third-party health insurance was updated in eMedNY in September 2023. Although the managed care enrollment should have been terminated prior to the start of the audit period (April 2024), this member's managed care enrollment continued through the end of the audit period (September 2024). As a result, Medicaid made six improper premium payments totaling $9,036 on behalf of this member during the audit period.

Recommendation

1. Review the $8.3 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 90 overpayments, totaling $1,609,501 for inpatient claims with service dates between July 2023 and May 2024, where fee-for-service payments were made for members enrolled in managed care plans that should have paid for the services. Of these overpayments, 84 were due to retroactive managed care coverage, including 75 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 member'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 six overpayments occurred due to providers incorrectly billing fee-for-service when the member had managed care coverage. We contacted the providers for each of the claims we identified and 70 were adjusted, saving Medicaid $1,255,443. However, the remaining 20 claims totaling $354,058 still needed to be adjusted.

Recommendation

2. Review the $354,058 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 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 22 claims that resulted in overpayments totaling $1,341,969. By the end of our fieldwork, providers had adjusted all 22 claims, resulting in Medicaid savings of $1,341,969. In July 2024, 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 $1,198,800 in overpayments for 10 Supplemental Low Birth Weight Newborn Capitation claims. Although DOH issued a Medicaid Update in July 2024 reminding MCOs 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 345 grams (less than 1 pound). However, we observed the newborn was discharged home after only 2 days. We contacted the MCO and asked that it review the claim. Upon review, MCO officials admitted the claim was billed in error and corrected the claim, saving Medicaid $126,348. By the time our fieldwork concluded, all 10 of the Supplemental Low Birth Weight Newborn Capitation claims had been corrected for a cost savings of $1,198,800.

Supplemental Maternity Capitation Payments

We identified 12 claims totaling $143,169 for improper Supplemental Maternity Capitation Payments to MCOs made during the audit period. 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 payment.

According to the MCOs we contacted, the payments occurred because of billing errors. By the end of our fieldwork, the MCOs had adjusted all 12 of the claims, saving Medicaid $143,169.

Recommendation

3. Formally advise the MCOs and hospitals identified in this audit to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Improper Payments for Inpatient, Referred Ambulatory, and Clinic Claims

We identified $222,220 in overpayments on one inpatient claim, nine referred ambulatory claims, and six clinic claims that resulted from errors in billing. By the time our fieldwork concluded, three claims had been adjusted, saving Medicaid $1,426. However, corrective actions were still required to address the remaining 13 claims with overpayments totaling $220,794.

The overpayments occurred under the following scenarios:

- Certain inpatient services are reimbursed on a per diem basis. If a member is disenrolled from managed care and placed in fee-for-service during a per diem inpatient stay, the MCO is responsible to pay for the period the member was enrolled in the MCO. We identified one fee-for-service per diem payment for a member's inpatient stay from January 10, 2022 to December 27, 2023. However, the member was enrolled in managed care at the time they were admitted to the hospital through June 30, 2022, and therefore the hospital should have billed the MCO for services provided during this time (i.e., January 10, 2022 to June 30, 2022). As a result, we determined Medicaid fee-for-service overpaid the hospital $195,721. By the end of our fieldwork, the hospital had not adjusted the claim.
- 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 four claims from a clinic that did not respond to our records request. As a result, we consider the services unsupported. Medicaid paid $12,465 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 nine claims for practitioner-administered drugs billed by two hospitals at more than the acquisition cost, resulting in overpayments of $8,717. As a result of our review, three claims were adjusted, saving Medicaid $1,426. By the end of our fieldwork, six claims totaling $7,291 still needed to be adjusted.
- We identified two providers that each submitted two Medicaid claims for one service resulting in $5,317 in overpayments. In each case, the provider submitted two claims for the same member, date of service, and procedure.

We contacted both providers during the audit and the providers were unable to determine why a second (duplicate) claim was billed. By the end of our fieldwork, both claims still needed to be adjusted.

Recommendation

4. Review the $220,794 in overpayments and make recoveries, as appropriate.

Other Insurance on Medicaid Claims

Many Medicaid members also have additional health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, health care providers must verify whether members had other insurance coverage on the dates that services were provided. If a member 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 member's normal financial obligations, including deductibles, coinsurance, and copayments. If the member 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 $50,283 for seven claims in which Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. We contacted the provider and advised them that the members had other insurance coverage at the time the services were provided. As a result, the provider adjusted four claims, saving Medicaid $30,648. Three claims totaling $19,635 still needed to be adjusted.

We also identified overpayments of $3,623 on two claims that resulted from excessive charges for copayments for members covered by other insurance. We contacted the providers and one provider adjusted its claim, saving Medicaid $1,700. However, the second provider still needed to adjust the other claim totaling $1,923.

Recommendations

5. Remind the providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid.
6. Review the $21,558 in overpayments and make recoveries, as appropriate.

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 that should be excluded from the Medicaid program, or fails to impose proper sanctions, the provider remains active to treat Medicaid members, perhaps placing members at risk of poor-quality care while the provider continues to receive Medicaid payments.

We identified 14 Medicaid providers, including individuals and organizations with individual owners, 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 14 providers had an active status in the Medicaid program. We advised DOH officials of the 14 providers and, by the end of the audit fieldwork, DOH had removed 13 of them from the Medicaid program and referred one to the Office of the New York State Attorney General.

Recommendation

7. 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 2024 through September 2024, 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 2,010 claims totaling approximately $170 million selected based on dollar amount and on areas identified as risk on prior audits;
- A random sample of 78 pharmacy claims totaling approximately $2.9 million; and
- All claims that did not follow payment rules pertaining to comprehensive third-party 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, 2024 through September 30, 2024.

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 the report. In their response, DOH officials concurred 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	16,087	16,087
Various claim types	2,010	137
Randomly selected pharmacy claims	78	0
Totals	**18,175**	**16,224**

Agency Comments

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 2, 2025

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

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2024-S-5 entitled, "Medicaid Program: Claims Processing Activity April 1, 2024 Through September 30, 2024."

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
Jennifer Danz
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Gentile
Michael Atwood
Michael Lewandowski
OHIP Audit
DOH Audit

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2024-S-5 entitled, "Medicaid Program: Claims Processing Activity April 1, 2024 Through September 30, 2024"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2024-S-5 entitled, "Medicaid Program: Claims Processing Activity April 1, 2024 Through September 30, 2024." 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.

General Comments:

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

Status of Providers Who Violate Program Requirements (page 12, last paragraph):

"We identified 14 Medicaid providers, including individuals and organizations with individual owners, 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 14 providers had an active status in the Medicaid program. We advised DOH officials of the 14 providers and, by the end of the audit fieldwork, DOH had removed 13 of them from the Medicaid program and referred one to the Office of the New York State Attorney General."

Department's Comment

OMIG requests OSC to consider the following language instead:

> "We identified 14 Medicaid providers, of which eight providers were already identified by OMIG for review and subsequent action, including individuals and organizations with individual owners, 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 14 providers had an active status in the Medicaid program. We advised DOH/OMIG officials of the 14 providers and, by the end of the audit fieldwork, DOH/OMIG had removed 13 of them from the Medicaid program and referred one to the Office of the New York State Attorney General."

Audit Recommendation Responses:

Recommendation #1

Review the $8.3 million in overpayments, disenroll the members from managed care plans, and make recoveries, as appropriate.

Response #1

OMIG works extensively and has multiple projects designed to ensure that Medicaid is the payor of last resort. OMIG is performing analysis on the OSC-identified third party insurance claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse 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. OMIG will recover any identified and remaining overpayments. 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 $354,058 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 Medicaid Data Warehouse 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. OMIG will recover any identified and remaining overpayments. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $121,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on prior claims processing activity audits.

Recommendation #3

Formally advise the MCOs and hospitals identified in this audit to accurately report newborn claim information when billing Medicaid to ensure appropriate payment.

Response #3

The Department sent out a blast email reminder on March 26, 2025, to formally advise all Managed Care Organizations to accurately report newborn claim information when billing Medicaid to ensure appropriate payment. The Department will continue to send out semi-annual reminders to formally advise the Managed Care Organizations to accurately report newborn and maternity claim information when billing Medicaid to ensure appropriate payment.

The Department will issue a Medicaid Update reminding providers to accurately report newborn information on inpatient claims.

Recommendation #4

Review the $220,794 in overpayments and make recoveries, as appropriate.

Response #4

OMIG is performing analysis on the OSC-identified inpatient, clinic, and referred ambulatory claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse 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. OMIG will recover any identified and remaining overpayments. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $461,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on prior claims processing activity audits.

Recommendation #5

Remind the providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid.

Response #5

The Department will be issuing another Medicaid Update in June 2025, reminding providers to accurately bill all applicable third parties that may be liable when billing Medicaid to ensure appropriate payment.

The Department has been sending out a blast email to all Managed Care Organizations bi-annually reminding them of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid. The most recent blast email was sent to Managed Care Organizations on July 2, 2024. The Department will be sending out another blast email to all the Managed Care Organizations in the second quarter of 2025.

Recommendation #6

Review the $21,558 in overpayments and make recoveries, as appropriate.

Response #6

OMIG works extensively and has multiple projects designed to ensure that Medicaid is the payor of last resort OMIG is performing analysis on the OSC-identified other insurance claims. OMIG will perform its own extraction of data from the Medicaid Data Warehouse 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. OMIG will recover any identified and remaining overpayments. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. To date, OMIG has recovered more than $136,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on prior claims processing activity audits.

Recommendation #7

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 #7

Of the 14 OSC-referred providers, OMIG had identified eight of the providers prior to receiving the referral, performed a review and excluded seven of them. 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*
Daniel Rossi - *Audit Supervisor*
Lindsey Winter - *Examiner-in-Charge*
Justine Maloy - *Examiner-in-Charge*
Rachelle Goodine - *Examiner-in-Charge*
Dawn Daubney, RN - *Registered Nurse (Medical Care)*
Jamala Benjamin-Hurdle - *Senior Examiner*
Benjamin Buyer - *Senior Examiner*
Julissa Guzman - *Senior Examiner*
Fiorella Seminario - *Senior Examiner*
Jeffrey Babcock - *Staff Examiner*
Alexander Francis - *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