NEW YORK STATE | Department of Health

KATHY HOCHUL
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Executive Deputy Commissioner

September 1, 2026

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

Dear Christopher Morris:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2024-S-26 entitled, "Claims Processing Activity October 1, 2024 Through March 31, 2025."

Please feel free to contact the Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Johanne E Morne

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

Enclosures

cc: Melissa Fiore
DOH Audit

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2024-S-26 entitled, "Claims Processing Activity October 1, 2024 Through March 31, 2025."

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2024-S-26 entitled, "Claims Processing Activity October 1, 2024 Through March 31, 2025." 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.

Audit Recommendation Responses:

Recommendation #1

Review the almost $6.4 million in overpayments, disenroll the members from managed care plans, and make recoveries, as appropriate.

Response #1

The Department continues to review data that is sent in the Third-Party Disenrollment process and is actively working with internal and external stakeholders. As this process continues, the Department will work to improve the accuracy and timeliness of the data received in order to facilitate more accurate and timely processing of the monthly list of data for New York Medicaid Choice (NYMC).

The Department reviewed cases identified by OSC which were not included in the NYMC lists and as of July 2024, the Department instituted a more refined filtering methodology which has improved accuracy. The Department is confident this refined process will result in not only timelier, but more accurate, processing of the monthly data.

In an effort to refine the process mentioned above, the Department is continuously monitoring and reviewing the process. While the process is improving, we have recently identified an issue with Third-Party Health Insurance (TPHI) members that are also in receipt of Medicare being filtered out of the prospective TPHI disenrollment report. We are currently working on finding a resolution to this issue. The Department has ongoing efforts to enhance the accuracy of data and the efficiency of processing. As a result, process improvements have been identified and will continue to be implemented.

In May 2026, the Department requested the OSC audit query, which was provided, to help identify any populations that may have been incorrectly filtered from the current Department query. The analysis and enhancement of processes for this step are ongoing as the Department examines the OSC query.

In June 2026, the Department revised the report and the email requests sent to the Local Departments of Social Services (LDSS) regarding their requirement to process retroactive terminations and the associated recoupment of capitation payments due to Third-Party enrollment. The Department hopes that the update clarifies the request of the Department to the LDSS and helps the LDSS in their review. This update should lead to a more accurate

accounting of third-party retroactive disenrollments and recoupment of paid capitation payments for the retroactive months. The Department will continue in collaboration with the LDSS on retroactive disenrollments.
The Department is optimistic that the recent modifications will promote both timeliness and accuracy in processing the third-party disenrollment process, both prospectively and retroactively.

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 (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. To date, OMIG has recovered more than $316,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on prior claims processing activity audits.

Recommendation #2

Formally advise the providers identified in this report to accurately report Medicare payment information and to include all Claim Adjustment Reason Codes on claims, as appropriate.

Response #2

The Department formally notified providers that all claims must include the appropriate Claim Adjustment Reason Codes (CARCs) received from prior payers, and that Medicare should be billed before submitting claims to Medicaid, as specified in program guidelines.

In addition, the Department included a Medicaid Update article in the December 2025 issue, entitled "Reminder: Coordination of Benefits Billing Protocols for Providers; New York State Medicaid is the Payer of Last Resort", reminding providers that Medicaid is the payer of last resort, and they must bill any/all applicable insurance before submitting any claims to NYS Medicaid for reimbursement. The article can be found in Volume 41-Number 12: https://www.health.ny.gov/health_care/medicaid/program/update/2025/no12_2025-12.htm#COB.

Recommendation #3

Review the nearly $2.8 million ($1,817,935 + $948,399) in overpayments and make recoveries, as appropriate.

Response #3

(OMIG) 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 when to start the audit process. OMIG will pursue recovery of 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 #4

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

Response #4

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 when to start the audit process. OMIG will pursue recovery of 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 #5

Review the $79,068 in overpayments and make recoveries, as appropriate.

Response #5

OMIG continuously performs audits of supplemental maternity capitation payments to MCOs. 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, 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. To date, OMIG has recovered more than $240,000 in overpayments made in 2020 through 2023 that were identified as potential overpayments by OSC on prior claims processing activity audits.

Recommendation #6

Review the $27,794 in overpayments and make recoveries, as appropriate.

Response #6

OMIG is performing analysis on the OSC-identified inpatient, clinic, and referred ambulatory 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 when to start the audit process. OMIG will pursue recovery of 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 #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 or referral to other sanctioning bodies.

Response #7

Of the 14 OSC-referred providers, OMIG had already identified eight of the providers prior to receiving the referral from OSC and completed a review and determined to exclude all eight of them. Of the remaining six providers: three were excluded, and OMIG could not take action against the last three providers because their professional misconduct was not directly related to the furnishing or billing of medical care services or supplies. 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.

Recommendation #8

Determine the status of the remaining provider related to their future participation in the Medicaid program.

Response #8

The change of ownership for the organization was processed and completed. No fraud, waste, or abuse was found related to the new owners, and the new owners have been added to the enrollment file. The owner previously in question was removed.