Department of Health

Medicaid Program: Claims Processing Activity October 1, 2024 Through March 31, 2025

Report 2024-S-26 | March 2026

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 October 2024 through March 2025, and certain findings included claims with dates of service as far back as January 2022 or as recent as April 2025.

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 March 31, 2025, eMedNY processed over 328 million Medicaid claims, resulting in payments to providers of over $46 billion. The claims are processed and paid in weekly cycles, which averaged about 12.6 million claims and $1.8 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 $13.8 million in improper Medicaid payments, as follows:

- $6.4 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.
- $4.1 million was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that members had.
- $2.4 million was paid for fee-for-service inpatient claims that should have been paid by managed care.
- $742,804 was paid for managed care newborn birth and maternity claims that contained inaccurate information, such as low newborn birth weight, which caused increased payments.
- $252,777 was paid for inpatient, clinic, referred ambulatory, and eye care claims that did not comply with Medicaid policies.

As a result of the audit, more than $3.4 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 providers from the Medicaid program and was reviewing the ownership status of the remaining provider.

Key Recommendations

- We made eight 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

March 19, 2026

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 October 1, 2024 Through March 31, 2025*. The audit was performed pursuant to the State Comptroller's authority under 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 4

Background 5

Audit Findings and Recommendations 7

Improper Managed Care Premium Payments for Members With Comprehensive Third-Party Health Insurance 7

Recommendation 8

Other Insurance on Medicaid Claims 8

Recommendations 9

Improper Fee-for-Service Payments for Inpatient Services Covered by Managed Care 9

Recommendation 9

Incorrect Maternity and Newborn Birth Claims Involving Managed Care 10

Recommendation 11

Improper Payments for Inpatient, Clinic, Referred Ambulatory, and Eye Care Claims 11

Recommendation 12

Status of Providers Who Violate Program Requirements 12

Recommendations 12

Audit Objective, Scope, and Methodology 13

Statutory Requirements 14

Authority 14

Reporting Requirements 14

Exhibit 15

Agency Comments 16

Contributors to Report 21

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. During the State fiscal year ended March 31, 2025, New York's Medicaid program had approximately 8.4 million members and Medicaid claim costs totaled about $93 billion. The federal government funded about 55.7% of New York's Medicaid claim costs, and the State and the localities (the City of New York and other counties) funded the remaining 44.3%.

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 March 31, 2025, eMedNY processed over 328 million Medicaid claims, resulting in payments to providers of over $46 billion. The claims are processed and paid in weekly cycles, which averaged about 12.6 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 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 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 March 31, 2025, 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 $13.8 million in improper payments pertaining to: MCO premiums for enrollees with concurrent comprehensive third-party health insurance; claims billed with incorrect information related to other insurance that members had; 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; and inpatient, clinic, referred ambulatory, and eye care claims that did not comply with Medicaid policies.

At the time the audit fieldwork concluded, over $3.4 million of the improper payments had been recovered. DOH officials need to take additional actions to review the remaining inappropriate payments totaling over $10.4 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 was reviewing the ownership status of the remaining provider.

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 almost $6.4 million between October 2024 and March 2025 (see the following table).

Enrollment Type	Number of Claims	Premium Amount
NYSOH	4,649	$1,728,268
Non-NYSOH	8,979	4,646,811
Totals	**13,628**	**$6,375,079**

According to DOH procedures, disenrolling managed care enrollees through the 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 completed timely. For example, one managed care enrollee's comprehensive third-party insurance was updated in eMedNY in April 2024. Although the managed care enrollment should have been terminated beginning May 1, 2024, this member's managed care enrollment continued through the audit period (March 2025). As a result, Medicaid made six improper premium payments totaling $12,266 on behalf of this member during the audit period.

Recommendation

1. Review the almost $6.4 million in overpayments, disenroll the members from managed care plans, 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, healthcare providers must verify whether members had other insurance coverage on the dates services were provided. If a member had other insurance, that insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer, typically covering the member's cost-sharing responsibilities, including deductibles, coinsurance, and copayments. If the member or the medical service is not covered by any other insurance, Medicaid is the primary insurer.

Medicare must communicate the reason for remaining balances not covered by Medicare on the Explanation of Benefits using universal Claim Adjustment Reason Codes. Providers are then required to report these codes to eMedNY, which uses them to determine if the billed service is eligible for payment and to calculate the correct payment amount.

Errors in coordinating Medicaid coverage with other insurance, such as providers inappropriately identifying Medicaid as the primary insurer, can result in improper Medicaid payments. We identified overpayments totaling $2,129,843 for 17 claims with service dates between June 2023 and January 2025, where Medicaid was incorrectly designated as the primary payer when Medicare was actually primary. Sixteen of these claims, totaling overpayments of $2,103,319, involved a single provider that failed to properly bill Medicare before submitting the claim to Medicaid, due to administrative and system errors. At the time of our review, adjustments or voids had been submitted for five claims, saving Medicaid $311,908. Actions were still needed to correct the remaining 12 claims, totaling overpayments of $1,817,935.

We also identified overpayments totaling $1,938,327 on 22 claims with service dates between January 2022 and April 2025, resulting from excessive cost-sharing charges

for members covered by other insurance. For example, we determined six claims were overpaid by $933,552 because one provider did not submit the proper Claim Adjustment Reason Code information from the Medicare Explanation of Benefits. Had the provider reported the correct information, eMedNY would not have paid these claims. At the end of fieldwork, five of these claims were adjusted, saving Medicaid $989,928. However, actions were still needed to address the remaining 17 claims, totaling $948,399.

Recommendations

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.
3. Review the nearly $2.8 million ($1,817,935 + $948,399) in overpayments 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 member's managed care plan for covered services and should not bill DOH directly for payment under the fee-for-service method. We identified 111 overpayments, totaling $2,370,849, for inpatient claims with service dates between January 2023 and December 2024, where fee-for-service payments were made for members enrolled in a managed care plan that should have paid for the services. Of these overpayments, 87 were due to retroactive managed care coverage, including 55 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 24 overpayments occurred due to providers incorrectly billing fee-for-service when the member had managed care coverage, or due to inaccurate eMedNY eligibility information. We contacted the providers for each of the claims and 64 were adjusted, saving Medicaid $1,211,186. However, the remaining 47 claims, totaling $1,159,663, still need to be adjusted.

Recommendation

4. Review the nearly $1.2 million 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.

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 18 claims that resulted in overpayments totaling $742,804. By the end of fieldwork, providers had adjusted 12 claims, resulting in Medicaid savings of $663,736. However, actions are still needed to address the remaining six claims, totaling $79,068.

Supplemental Low Birth Weight Newborn Capitation Payments

We identified $580,517 in overpayments for five Supplemental Low Birth Weight Newborn Capitation claims. The overpayments occurred 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 500 grams. We requested and reviewed the corresponding medical records and found the hospital reported a weight of 3,192 grams. We contacted the MCO and notified it of the discrepancy. The MCO admitted its error and adjusted the claim, saving Medicaid $123,658. The MCO also stated that it was going to review its internal billing process to ensure accurate billing going forward. By the time our fieldwork concluded, all five Supplemental Low Birth Weight Newborn Capitation claims had been corrected for a cost savings of $580,517.

Supplemental Maternity Capitation Payments

We identified 13 claims totaling $162,287 for improper Supplemental Maternity Capitation Payments to MCOs made during the audit period. In each case, there was 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, MCOs had adjusted seven of the claims, saving Medicaid $83,219. However, the remaining six claims, totaling $79,068, still needed to be adjusted.

Recommendation

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

Improper Payments for Inpatient, Clinic, Referred Ambulatory, and Eye Care Claims

We identified $252,777 in overpayments on four referred ambulatory, two inpatient claims, 11 clinic claims, and five eye care claims that resulted from errors in billing. At the time our fieldwork concluded, three claims had been adjusted, saving Medicaid $224,983. However, corrective actions are still required to address the remaining 19 claims with overpayments totaling $27,794.

The overpayments occurred under the following scenarios:

- Providers are responsible for submitting claims with accurate information. We identified one hospital that reported an inaccurate birth weight on a neonatal claim and received $133,103. We contacted the hospital and it corrected the claim, saving Medicaid $121,995.
- We identified one hospital that incorrectly billed an outpatient service as inpatient and received $105,141. Generally, outpatient services are medical procedures that can be performed in the same day, and are less expensive than inpatient treatments because they are less involved and do not require a patient's continued presence in a facility. We contacted the provider and they adjusted the claim, saving Medicaid $101,876.
- 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 nine clinic claims from three providers and five eye care claims from three providers who did not respond to our records request. As a result, we consider these services unsupported. Medicaid paid $19,044 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 four claims for practitioner-administered drugs billed by two hospitals at amounts higher than the acquisition cost, resulting in overpayments of $7,332. By the time our fieldwork ended, all four claims still needed to be adjusted.
- We identified two providers who submitted duplicate Medicaid claims resulting in inappropriate payments of $2,530. In each case, the provider submitted two claims for the same member, date of service, and procedures. We contacted both providers during the audit, and they were unable to determine or provide documentation to support the additional billing. By the end of our fieldwork, one provider voided a claim, saving Medicaid $1,112, but the other provider still needed to adjust their duplicate claim, totaling $1,418.

Recommendation

6. Review the $27,794 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 who 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 individual owners of organizations, who were charged with or found guilty of crimes that violated laws or regulations of a health care program, or who were otherwise barred from participating in the Medicaid program. All 14 providers had an active status in Medicaid. We advised DOH officials of the 14 providers and by the time our audit fieldwork ended, DOH had removed 13 of them from the Medicaid program and was reviewing the ownership status of the remaining provider.

Additionally, we determined that DOH lacked a formal process to refer individuals charged with certain crimes to the appropriate disciplinary authority, such as the State Education Department or the Office of Professional Medical Conduct. Based on the results of our audit, DOH took immediate action to develop a formal referral process and DOH officials provided evidence in September 2025 that this new process had already been implemented.

Recommendations

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

Audit Objective, Scope, 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 October 2024 through March 2025, and as noted in the body of the report, certain findings included claims with dates of service as far back as January 2022 or as recent as April 2025.

To accomplish our 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 provide conclusions on our audit objectives and to test internal controls and compliance. We selected judgmental and random samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the populations even for the random samples. Our samples, which are discussed in detail in the body of our report, include:

- A judgmental sample of 2,214 claims totaling approximately $162 million selected based on dollar amount and on areas identified as risk on prior audits.
- A random sample of 78 pharmacy claims totaling approximately $3.5 million.
- 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 purpose 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 the 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 October 1, 2024 through March 31, 2025.

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	13,628	13,628
Various claim types	2,214	190
Randomly selected pharmacy claims	78	0
Totals	**15,920**	**13,818**

Agency Comments

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

January 14, 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:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2024-S-26 entitled, "Medicaid Program: Claims Processing Activity October 1, 2024 Through March 31, 2025."

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 Lewandowski
OHIP Audit
DOH Audit

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2024-S-26 entitled, "Medicaid Program: 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) Draft Audit Report 2024-S-26 entitled, "Medicaid Program: 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. While the process is continuing to improve, 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. The Department is currently working on finding a resolution to this issue.

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 (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. 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 $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 received from prior payers, and that Medicare should be billed before submitting claims to Medicaid, as specified in program guidelines.

In addition, the Department is issuing a reminder Medicaid Update article, titled *"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.

Recommendation #3

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

Response #3

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 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 $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 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 $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 Managed Care Organizations. 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 performed 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 provider submitted documentation for the Change of Ownership (CHOW), and it is currently under review. The enrollment file remains open, pending a determination on enrollment under the CHOW.

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 Director*
Daniel Rossi - *Audit Supervisor*
Caitlin Colacino - *Examiner-in-Charge*
Lindsey Winter - *Examiner-in-Charge*
Dawn Daubney, RN - *Registered Nurse (Medical Care)*
Jamala Benjamin-Hurdle - *Senior Examiner*
Julissa Guzman - *Senior Examiner*
Jennifer Kirby - *Senior Examiner*
Fiorella Seminario - *Senior Examiner*
Mahnoor Ali - *Staff Examiner*
Alexander Francis - *Staff Examiner*
James Male - *Staff Examiner*
Daniel Rosenberg - *Staff Examiner*
Jacob Stevens - *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