New York State Comptroller
THOMAS P. DiNAPOLI

Department of Health

Medicaid Program – Oversight of Electronic Transmitter Identification Numbers

September 2026 | Report 2024-S-34
Prepared by the Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health provided adequate oversight of electronic transmitter identification numbers used for Medicaid billings. This audit examined fee-for-service claims from January 2020 through December 2024.

About the Program

The Department of Health (DOH) administers the Medicaid program in New York State. An electronic transmitter identification number (ETIN) is a unique identifier used to submit fee-for-service (FFS) claims to Medicaid for medical services rendered to members. Claims are submitted by providers or by service bureaus that provide claim processing or claim submission services for or on behalf of providers. State regulations require service bureaus to be enrolled in the Medicaid program, and federal regulations require providers (regardless of provider type) to revalidate their Medicaid enrollment at least every 5 years.

Medicaid policy requires all entities that submit claims to Medicaid to have an active, certified ETIN affiliation on file before submitting claims. In addition to their own ETINs, providers must recertify annually any ETIN affiliations they have with service bureaus that submit claims on their behalf. ETIN information and certification documents are stored in eMedNY, DOH's Medicaid claim processing and payment system.

The Office of the Medicaid Inspector General (OMIG)—which conducts and coordinates investigations, detections, audits, and reviews of Medicaid providers and members to ensure compliance with laws and regulations—maintains a list of restricted providers or entities that are excluded from the Medicaid program to prevent Medicaid payments for care, services, or supplies furnished, ordered, or prescribed by providers on the list.

Key Findings

We found that DOH has not implemented adequate controls to ensure that ETIN affiliations meet requirements. As a result, eMedNY processed nearly 10.8 million claims submitted with 783 ETINs that were not affiliated with the billing providers on the date of service. While eMedNY has controls in place to detect and prevent payment for certain claims submitted using expired ETIN affiliations, pharmacy claims are not included in the edit logic. Consequently, 720 ETINs with expired affiliations were used to submit claims for pharmacy services. The remaining 63 ETINs were used to submit non-pharmacy claims where some affiliations were expired as of the date of service and other affiliations did not exist. These deficiencies reduce visibility in the claim submission process, creating uncertainty about whether claim submitters that may have been previously authorized are still authorized to submit claims.

Additionally, we reviewed the Medicaid enrollment statuses of 242 service bureaus whose ETINs appeared on claims during the audit period. We found that 84 of these service bureaus (35%) had Medicaid IDs that remained inactive throughout the audit period. An additional three service bureaus had no Medicaid ID at all. DOH did not develop controls to detect the use of ETINs belonging to claim submitters that are excluded from the Medicaid program. For example, one service bureau submitted 30,415 claims totaling $1.4 million after OMIG excluded it from the Medicaid program. Without appropriate controls to ensure that only service bureaus with active Medicaid IDs in good standing are involved in claim submissions, there is a risk that service bureaus that should be prevented from submitting claims may still be able to do so.

Key Recommendations

- Ensure the status of the 720 ETINs related to pharmacy claim submissions and the 63 ETINs related to non-pharmacy claim submissions that were either expired or had never been affiliated with the billing providers are updated appropriately.
- Improve DOH oversight and monitoring to ensure the appropriate use of ETINs for claim submissions.
- Review the claim submissions containing the ETIN affiliated with the claim submitter that was terminated from participating in the Medicaid program and take appropriate action.

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

September 25, 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 *Oversight of Electronic Transmitter Identification Numbers*. This 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

Term	Description	Identifier
DOH	Department of Health	*Auditee*
eMedNY	Medicaid claims processing and payment system	*System*
ETIN	Electronic transmitter identification number	*Key Term*
FFS	Fee for service	*Key Term*
MDW	Medicaid Data Warehouse	*System*
NYCRR	New York Codes, Rules and Regulations	*Regulation*
OMIG	Office of the Medicaid Inspector General	*Agency*

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. During the State fiscal year ended March 31, 2026, New York's Medicaid program had approximately 6.8 million members per month and Medicaid claim costs totaled about $99.7 billion (comprising $52.1 billion in fee-for-service [FFS] health care payments and $47.6 billion in managed care premium payments). The federal government funded about 56.1% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.9%.

The Department of Health (DOH) administers the Medicaid program in New York State. DOH uses eMedNY, a computerized system for claim processing, to receive and review claims and make FFS payments directly to the Medicaid providers for services rendered to eligible members. As part of the claim review process, the eMedNY system uses various automated controls, called edits, to determine whether claims are eligible for reimbursement. The eMedNY system also maintains forms and notices issued to providers to ensure appropriate and consistent screening of providers and improve program integrity (e.g., ensure the provider's information on file is complete and up to date).

Generally, a provider can submit claims to the eMedNY system or have a third party, such as a service bureau, submit the claims on their behalf. The New York Codes, Rules and Regulations (NYCRR) define a service bureau as "any person who provides claims processing or claims submission services for or on behalf of a provider, including a business agent, billing service, or accounting firm." State regulations require service bureaus to be enrolled in the Medicaid program and federal regulations require providers (regardless of provider type) to revalidate their Medicaid enrollment at least every 5 years.

An electronic transmitter identification number (ETIN) is a unique identifier used to submit FFS claims electronically to Medicaid. The provider is responsible for determining who should submit claims on its behalf. All claim submitters (i.e., providers and service bureaus) must have an active ETIN affiliation on file with eMedNY before submitting claims, even when the claim submitter is the provider that performed the service. Claim submitters obtain an ETIN by submitting an ETIN application. Providers separately must submit a notarized certification statement to DOH that indicates who can submit claims on their behalf and initiates the active ETIN affiliation. By signing the certification statement, the provider attests that they are enrolled in and authorized to participate in the Medicaid program and that all claim data to be submitted by them or the affiliated third party is accurate and complete.

Once the ETIN application and certification statement are submitted and approved by DOH, eMedNY generates and assigns the ETIN, linking it to the provider's Medicaid ID. If the provider needs to create a new ETIN affiliation, they must complete and notarize a certification statement

for each affiliation. The Exhibit at the end of this report provides an overview of the claim submission roles and responsibilities.

In addition to setting up and assigning ETINs to providers, DOH oversees claim submitters' use and management of ETINs. Providers are responsible for submitting annual notarized ETIN certifications to DOH to keep ETIN affiliations active. As part of DOH's monitoring process, it identifies expiring ETIN affiliations and sends a reminder letter to the claim submitters about 45 days before the certification period ends and again about 15 days later if DOH has not received the updated ETIN certification statement. DOH officials stated the ETIN affiliation is recertified only when a new certification statement is received.

In addition, the annual ETIN certification statement requires providers to attest that they are enrolled in and authorized to participate in the Medicaid program. During the audit period, 18,913 ETINs appeared on claims.

Audit Findings and Recommendations

We identified weaknesses in DOH's procedures and system controls that diminished its oversight of ETINs. As a result, eMedNY processed nearly 10.8 million claims associated with 783 ETINs that were not affiliated with the billing providers on the date of service. Although DOH provides guidance on the ETIN certification process, it has not established sufficient controls to ensure compliance by providers and claim submitters. For example, while DOH has processes to inform providers of ETIN requirements—including notifications about recertification of ETIN affiliations—it does not monitor to ensure provider compliance.

Additionally, we found that, although DOH implemented pre-adjudication claim edits to detect and prevent payment for certain claims submitted with expired ETIN affiliations, pharmacy claims were excluded from the edit logic. As a result, 720 of the expired ETIN affiliations we identified were used to submit claims for pharmacy services. The remaining 63 ETINs were used to submit non-pharmacy claims where some affiliations were expired as of the date of service and other affiliations did not exist. DOH does not monitor to ensure that only ETINs with active affiliations are used when submitting claims. In fact, over 80% of the pharmacy claims submitted with expired ETIN affiliations were made more than 1 year after the ETIN affiliation had expired.

Furthermore, DOH did not ensure that claim submitters had active Medicaid IDs when the ETINs were used for those submissions. We identified 84 ETINs belonging to service bureaus that were used to submit claims despite the service bureaus' Medicaid IDs being inactive. An additional three service bureaus had no Medicaid IDs at all. Moreover, one ETIN affiliated with a service bureau that had been excluded from participating in Medicaid appeared on paid claims totaling $1.4 million. DOH officials acknowledged that the presence and status of Medicaid IDs are not enforced through system edits.

The control deficiencies we identified reduce visibility into the claim submission process, creating uncertainty about whether claim submitters who may have been previously authorized are still authorized to submit claims. We recommend that DOH strengthen its oversight and monitoring to ensure the appropriate use of ETINs for claim submissions, including by addressing expired ETIN affiliations and ensuring that claim submitters have an active Medicaid ID.

Pharmacy Claims

During the audit, we identified 720 expired ETIN affiliations used in nearly 10.8 million pharmacy claim submissions totaling about $1.4 billion in payments. Of this, almost $1.3 billion was for claims with service dates after the providers' ETIN affiliations expired. These claims were submitted across 708 ETINs. The remaining $71.7 million in payments was associated with claims linked to 12 ETINs belonging to service bureaus that had expired affiliations with the 72 pharmacies that received payments on those claims. See the following table for details.

FFS Pharmacy Claims Submitted Without Active ETIN Certifications

Finding Category	Number of Claims	Total Payments	Number of ETINs With Expired Affiliations	Number of Pharmacies
Claims Submitted by Entities (Other Than Service Bureaus)	9,953,739	$1,295,754,148	708	712
Claims Submitted by Service Bureaus	818,663	$71,707,077	12	72
Totals	**10,772,402**	**$1,367,461,225**	**720**	**784**

Note: One pharmacy is counted twice because it appears in both categories of findings.

According to DOH officials, the eMedNY system lacked an edit to verify active ETIN affiliations on pharmacy claims because the delivery of medications to members is a critical service. Consequently, a high volume of pharmacy claims was submitted to eMedNY, processed, and paid using ETINs with expired affiliations. Although an edit was not implemented, DOH had access to data that could have been used to identify and monitor the frequency of claim submissions made using ETINs with expired affiliations, but DOH did not use the data to review ETIN use. Consequently, when expired ETIN affiliations are still in use, DOH lacks assurance that the claim submitters that were previously authorized by the provider remain authorized to submit claims on behalf of that provider.

Non-Compliance With ETIN Requirements

We selected a sample of 50 ETINs from the 708 ETINs in the table above to determine whether the pharmacies using these ETINs had alternative ETIN affiliations certified as active in the eMedNY system. We found 26 of the 50 ETINs were affiliated with pharmacies that had separate active ETIN affiliations that could have been used to submit the claims. The remaining 24 pharmacies did not have any other ETIN affiliations.

We also found that 12 of the 50 pharmacies (24%) did not have an ETIN certification statement on file in the eMedNY system. DOH granted the 12 pharmacies conditional enrollment periods, typically 4 months, to complete the necessary forms and certify their ETINs. However, there was no evidence that the pharmacies completed the requested forms as they continued to use the ETINs after the 4-month period had elapsed. The remaining 38 pharmacies had ETIN certification statements on file but did not recertify their ETIN affiliations as required.

We also reviewed documentation in the eMedNY system for 10 of the 50 sampled ETINs to understand DOH's process for following up with pharmacies that have not recertified their ETIN affiliations (including cases where the affiliation is with themselves). In all 10 cases, DOH notified the pharmacies of the need to recertify; however, we found no correspondence in DOH's records

indicating that the 10 pharmacies acted on DOH's ETIN recertification notifications. Additionally, there was no evidence that DOH informed any of the 10 pharmacies that their ETIN affiliations had expired, as reflected in eMedNY. DOH's guidelines for Medicaid providers state that ETINs must be up to date and active to access electronic transactions, such as claim submissions, within eMedNY, and that delaying ETIN certification could result in billing disruptions and other issues. However, there is no evidence that DOH followed its own guidelines or took any action to address pharmacies' non-compliance, as providers continued to use expired ETIN affiliations.

ETIN Use and Management

We visited three pharmacies that received payments for claims submitted with ETINs belonging to service bureaus whose affiliations with the pharmacies had expired. According to officials at each pharmacy, they do not use service bureaus. Instead, officials explained that they entered claim information into their claim processing systems and submitted the claims directly to eMedNY. When we asked why the pharmacies didn't use their own certified ETINs, an owner of one of the pharmacies said the service bureau ETIN worked when they submitted claims, so there was no reason to stop using it. Officials at two of the pharmacies also stated that DOH did not reach out to them regarding the use of ETINs with expired affiliations, nor did they receive recent guidance from DOH regarding ETIN use.

We surveyed 26 other pharmacies that had paid claims submitted using ETINs belonging to service bureaus that were not actively affiliated with the pharmacy. Of the 26, 16 pharmacies responded to our outreach. Twelve of these pharmacies also said they don't use service bureaus, and four further said that DOH did not reach out to inform them of the issue, so it was never corrected. After our survey, some of these pharmacies stated they took the initiative to work with their software vendors to start using their active ETINs.

We calculated the number of days between the ETIN affiliations' expiration dates and the service dates for the nearly 10.8 million pharmacy claims in the table. We determined that over 80% of the claims (more than 8.6 million) had service dates more than 1 year after the ETINs' expiration dates. This indicates a lack of monitoring by DOH and non-compliance by claim submitters. In addition, the absence of system edits to identify and flag pharmacy claims with expired ETINs further diminishes DOH's ability to promptly identify these claims and take corrective action.

Non-Pharmacy Claims

Non-pharmacy claims include those for medical services other than pharmacy, such as diagnostic, eye care, or laboratory services. DOH implemented pre-adjudication claim edits to verify that the ETINs used on the claims are appropriate.

For example, one edit requires the ETIN and provider combination on a claim to be valid on the date of service. Another edit denies a claim if there is no active ETIN affiliation with at least one of the following types of providers, checked in this order: the supervising provider/assistant surgeon, the rendering provider, and the billing provider. If the rendering provider's ETIN is present on the claim and passes the affiliation check, the billing provider's ETIN affiliation does not need to pass the check.

We inquired with DOH officials why certain types of providers are prioritized in this check over others; however, they were unable to provide an explanation. Additionally, this edit uses the date of service to determine whether the ETIN affiliation is active. It is important to note that for non-pharmacy claims, the date of service can often precede the invoice date of the claim. Without a proper explanation or written policy, it is unclear whether these controls align with DOH's objective to ensure that claim submitters have appropriate affiliations.

We reviewed non-pharmacy claims within the audit period to determine whether the ETINs on the claims had certified affiliations with the billing providers on the dates of service. We found that ETINs generally had active affiliations with the billing providers. However, we identified 4,932 claims totaling $393,604 in payments submitted using 63 ETINs that were either never affiliated with the provider or were for service dates after the ETINs' affiliations had expired.

Medicaid Enrollment Status of Claim Submitters

State regulations require providers and service bureaus to enroll in the Medicaid program. In addition, federal regulations require providers (regardless of provider type) to revalidate their Medicaid enrollment at least every 5 years. During the audit period, 18,913 ETINs appeared on claims, of which 11,863 belonged to providers, 242 belonged to service bureaus, and 68 belonged to entities that serve in both provider and service bureau roles. We could not determine whether the remaining 6,740 ETINs were providers, service bureaus, or both because of data constraints such as entity name conflicts.

Excluded Service Bureau

The Office of the Medicaid Inspector General (OMIG), which conducts and coordinates investigations, detections, audits, and reviews of Medicaid providers and members to ensure compliance with laws and regulations, maintains a list of restricted entities that are excluded from the Medicaid program in order to prevent Medicaid payments for care, services, or supplies furnished, ordered, or prescribed by these entities.

According to guidelines from OMIG, an entity excluded from the Medicaid program cannot be involved in any activity relating to furnishing medical care, services, or supplies to recipients of medical assistance for which claims are submitted to the program, or relating to claiming or receiving payment for medical care, services, or supplies during the period of exclusion. Exclusions can occur for a variety of reasons, including failure to follow official rules and regulations, false claims, false statements, and bribes and kickbacks. Because access to the Medicaid program is restricted, ETINs for excluded entities should not appear on claims during the restriction period.

We reviewed Medicaid enrollment statuses for all claim submitters during the audit period to determine whether their ETINs appeared on claims while they were excluded from the Medicaid program. In many cases, claim submitters were placed on the exclusion list because their Medicaid IDs were inactive and not revalidated. We found one service bureau whose Medicaid enrollment was terminated in 2015, but whose ETIN continued to appear on pharmacy claims during the audit period. The only affiliation associated with this service bureau's ETIN had

expired in November 2009. Despite the termination, the service bureau's ETIN appeared on 30,415 claims totaling $1.4 million from 52 providers during the audit period.

DOH officials told us that OMIG does not regularly conduct reviews or audits that would identify ETINs belonging to excluded entities. As a result, the ETIN of the excluded service bureau continued to be used to submit claims during the exclusion periods. We urge DOH and OMIG to address the control weaknesses identified to ensure affiliations with ETINs belonging to excluded entities are canceled and prevented from further use.

Service Bureaus With Inactive Medicaid IDs

We reviewed the Medicaid enrollment status of the 12 service bureaus whose ETINs appeared on the 818,663 claims (as shown in the table) but were not affiliated with the pharmacies on the dates of service to determine whether they had active Medicaid IDs. We found that six had inactive Medicaid IDs, three had active Medicaid IDs, and three had no Medicaid IDs. In most cases, the service bureaus did not respond to DOH's Medicaid ID revalidation reminders. DOH officials explained that the three service bureaus that lacked Medicaid IDs did so because they were established in eMedNY before the current enrollment requirements took effect. Nonetheless, DOH should ensure that all claim submitters have active Medicaid IDs at the time of claim submission.

We reviewed the remaining 230 (242-12) service bureaus for which we obtained Medicaid IDs to determine how many had inactive Medicaid IDs. We found that 78 (34%) had Medicaid IDs that remained inactive throughout the audit period. We reviewed data in the Medicaid Data Warehouse (MDW) for 78 service bureaus and found that 57 (73%) did not respond to DOH's notices to revalidate their Medicaid IDs. The remaining service bureaus had inactive statuses for various reasons, such as ownership changes or duplicate Medicaid IDs on file. While we identified a total of 84 (78+6) service bureaus that submitted claims despite having inactive Medicaid IDs, DOH officials stated that the presence and status of a claim submitter's Medicaid ID are not enforced through eMedNY system edits.

Without appropriate controls to ensure that only service bureaus with active Medicaid IDs in good standing are involved in claim submissions, there is a risk that service bureaus that should be prevented from submitting claims may still be able to do so.

Recommendations

1. Ensure the status of the 720 ETINs related to pharmacy claim submissions and the 63 ETINs related to non-pharmacy claim submissions that were either expired or had never been affiliated with the billing providers are updated appropriately.
2. Improve DOH oversight and monitoring to ensure the appropriate use of ETINs for claim submissions, including addressing expired ETIN affiliations and ensuring claim submitters have an active Medicaid ID.
3. Document the rationale for existing pre-adjudicated claim edits, including the prioritization of certain providers.

4. Review the claim submissions containing the ETIN affiliated with the claim submitter that was terminated from participating in the Medicaid program and take appropriate action.

Audit Objective, Scope, and Methodology

The objective of the audit was to determine whether DOH provided adequate oversight of ETINs used for Medicaid billings. This audit examined FFS claims from January 2020 through December 2024.

To accomplish our audit objective and assess related internal controls, we interviewed DOH officials and gathered information from DOH and providers. We examined DOH's relevant policies and procedures as well as applicable federal and State rules and regulations. We used the MDW and the eMedNY system to identify claims where the ETINs were not actively affiliated with the billing providers, the ETINs belonged to claim submitters with inactive or missing Medicaid IDs, and the ETINs belonged to claim submitters excluded from the Medicaid program.

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

- A judgmental sample of 50 ETINs with the highest total FFS pharmacy claim payments of $697.7 million, selected from a population of 708 ETINs on FFS pharmacy claims totaling almost $1.3 billion, to determine whether pharmacies had alternative active ETINs on file.
    - We also selected the top 10 ETINs with claims totaling $377.1 million from the sampled 50 ETINs to assess controls over information and communication from DOH to providers regarding their ETIN recertifications.
- Two judgmental samples from a population of 72 pharmacies where a service bureau submitted FFS pharmacy claims, totaling $71.7 million, when there was no active ETIN certification.
    - A judgmental sample of three pharmacies with claims totaling $12.2 million to interview and gather information on the claim submission process. We selected these providers based on high total claim payments from submitted claims that had ETINs belonging to two service bureaus associated with high total claim payments in the risk population.
    - A judgmental sample of 26 pharmacies were contacted to get information about claim submissions. These pharmacies had claims totaling $44.1 million and were judgmentally selected based on high payments on claims where the pharmacies were not actively affiliated with the service bureau ETIN on the claims. Of the 26 pharmacies, only 16 responded to our outreach.

We relied on data from eMedNY and the MDW, which, based on work performed by OSC, is sufficiently reliable for the purposes of this audit.

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 of ETINs used for Medicaid billings.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. Their comments were considered in preparing this report and are attached in their entirety at the end of the report. In their response, DOH officials concurred with the audit recommendations and indicated actions they have taken or will take to address them. Our response to one DOH comment is embedded within DOH's response as a State Comptroller's Comment.

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

Claim Submission Roles and Responsibilities

Steps required to be performed by billing, rendering, and supervising providers, and service bureaus in order to submit claims to Medicaid.	Billing, Rendering, and Supervising Providers	Service Bureaus
1 Enroll as a Medicaid provider	✓	✓
2 Submit ETIN application and notarized ETIN certification statement to obtain their own ETIN	✓	✓
3 eMedNY generates and assigns ETINs	✓	✓
4 Responsible for identifying and certifying who can submit claims on their behalf	✓	✗
5 Perform medical services	✓	✗
6 Submit claims to Medicaid	✓	✓

Note: Service Bureaus submit claims to Medicaid on behalf of providers.

DOH Response and State Comptroller's Comment

NEW YORK STATE | Department of Health

KATHY HOCHUL
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JAMES V. McDONALD, MD, MPH
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JOHANNE E. MORNE, MS
Executive Deputy Commissioner

August 20, 2026

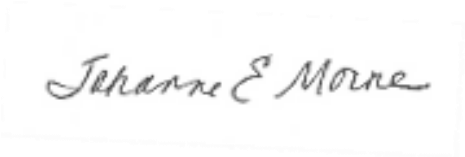
Christopher Morris, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Christopher Morris:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2024-S-34 entitled, "Oversight of Electronic Transmitter Identification Numbers".

Thank you for the opportunity to comment.

Sincerely,



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

Enclosure

cc: Melissa Fiore
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2024-S-34 entitled, "Oversight of Electronic Transmitter Identification Numbers"

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-34 entitled, "Oversight of Electronic Transmitter Identification Numbers." 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

Ensure the status of the 720 ETINs related to pharmacy claim submissions and the 63 ETINs related to non-pharmacy claim submissions that were either expired or had never been affiliated with the billing providers are updated appropriately.

Response #1

The Department is actively exploring the best approach to address this recommendation.

Recommendation #2

Improve DOH oversight and monitoring to ensure the appropriate use of ETINs for claim submissions, including addressing expired ETIN affiliations and ensuring claim submitters have an active Medicaid ID.

Response #2

The Department needs to develop a process to address the findings in this recommendation. Internal discussions are needed to ascertain which area(s) of the Department can work with the Fiscal Agent to ensure claims are submitted appropriately.

Recommendation #3

Document the rationale for existing pre-adjudicated claim edits, including the prioritization of certain providers.

Response #3

The audit reports states that OSC "inquired with the Department officials why certain types of providers are prioritized in this check over others; however, they were unable to

provide an explanation." OSC asked the Department (March 2026) about the rationale for existing edits – specifically, why the edit logic for institutional claims checks only for billing provider, not rendering or supervising providers. The Department responded, explaining why these other provider checks are not relevant for institutional claims given the nature of what they cover. The Department was unaware that OSC did not consider this response sufficient or that there was remaining concern with the edits' designs. The Department will review its documentation of these edits to assess if further documentation is needed.

State Comptroller's Comment – DOH officials clarified that the order of provider checks is not relevant to institutional claims; however, they did not provide an explanation for the order of provider checks related to professional and dental claims, which had also been requested. Additionally, DOH's Division of Operations and Systems was unable to provide formal documentation, such as a policy, in response to our initial inquiry about the order of provider checks in the pre-adjudication edit logic. We acknowledge DOH's commitment to review its edit documentation.

Recommendation #4

Review the claim submissions containing the ETIN affiliated with the claim submitter that was terminated from participating in the Medicaid program and take appropriate action.

Response #4

The Department accepts this recommendation. After the Department reviews the OSC-identified claim submissions, any claims identified as inappropriate will be referred to OMIG. OMIG will review the referred claims and take appropriate action as necessary.

Contact

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Prepared by the Division of State Government Accountability

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