

Department of Health

Medicaid Program: Claims Processing Activity October 1, 2022 Through March 31, 2023

Report 2022-S-36 | October 2023

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 October 2022 through March 2023, and certain claims going back to June 2022.

About the Program

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the 6-month period ended March 31, 2023, eMedNY processed over 233 million claims, resulting in payments to providers of nearly \$45 billion. The claims are processed and paid in weekly cycles, which averaged about 9 million claims and \$1.7 billion in payments to providers.

Key Findings

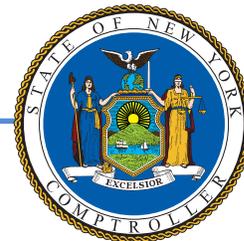
The audit identified over \$20.6 million in improper Medicaid payments, as follows:

- \$12.2 million was paid for managed care premiums on behalf of Medicaid recipients who had other concurrent comprehensive third-party health insurance;
- \$5.6 million was paid for claims that were billed with incorrect information pertaining to other health insurance coverage that recipients had, or where Medicaid was incorrectly designated as the primary payer instead of another insurer;
- \$1.3 million was paid for newborn birth and maternity claims that contained inaccurate information, such as the newborn's birth weight;
- \$1.2 million was paid for pharmacy, practitioner, inpatient, managed care capitation, and clinic claims that did not comply with Medicaid policies; and
- \$256,777 was paid for fee-for-service inpatient claims that should have been paid by managed care.

As a result of the audit, about \$7.4 million of the improper payments was recovered. We also identified three Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. In response to the findings, the Department removed two of the providers from the Medicaid program and the remaining provider was still under review.

Key Recommendations

- We made six recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claims processing controls.



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

October 25, 2023

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, 2022 Through March 31, 2023*. 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

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Glossary of Terms

Term	Description	Identifier
Department	Department of Health	<i>Auditee</i>
eMedNY	The Department's Medicaid claims processing and payment system	<i>System</i>
FFS	Fee-for-service	<i>Key Term</i>
GME	Graduate Medical Education	<i>Key Term</i>
Local District	Local Department of Social Services	<i>Key Term</i>
MCO	Managed care organization	<i>Key Term</i>
NYSOH	NY State of Health	<i>System</i>
TPHI	Third-party health insurance	<i>Key Term</i>

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 (Local Districts) or the NY State of Health (NYSOH), the State's online health plan marketplace. For the State fiscal year ended March 31, 2023, New York's Medicaid program had approximately 8.4 million recipients and Medicaid claim costs totaled about \$80.2 billion. The federal government funded about 56.9% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.1%.

The Department of Health's (Department's) Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the 6-month period ended March 31, 2023, eMedNY processed over 233 million claims, resulting in payments to providers of nearly \$45 billion. The claims are processed and paid in weekly cycles, which averaged about 9 million claims and \$1.7 billion in payments to providers.

The Medicaid program pays health care providers through the fee-for-service (FFS) method or through managed care. Under FFS, the Department makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, the Department pays managed care organizations (MCOs) a monthly premium for each Medicaid recipient enrolled in the MCOs. The MCOs are then responsible for ensuring recipients have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services provided to recipients and are required to submit encounter claims to inform the Department 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 recipient, 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 Department 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, 2023, 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 \$20.6 million in improper payments pertaining to: MCO premiums for enrollees with concurrent comprehensive third-party health insurance (TPHI); claims with incorrect information regarding other health insurance coverage that recipients had; newborn birth and maternity claims that contained inaccurate information; pharmacy, practitioner, inpatient, managed care capitation, and clinic claims that did not comply with Medicaid policies; and FFS claims for inpatient services that should have been covered by each recipient's MCO.

At the time the audit fieldwork concluded, about \$7.4 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments totaling about \$13.2 million and recover funds, as warranted.

We also identified three 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 Department officials of the providers and, by the end of the audit fieldwork, the Department had removed two of them from the Medicaid program and the remaining provider was still under the Office of the Medicaid Inspector General's review.

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

Medicaid recipients may have additional sources of coverage for health care services (i.e., TPHI). The Department's policy is to exclude Medicaid recipients from enrollment in mainstream managed care when they also have concurrent comprehensive TPHI (TPHI is considered comprehensive if it covers certain types of services, among them: hospital care, physician services, pharmacy, and hospice care). These recipients should, instead, be enrolled in Medicaid FFS.

In response to the coronavirus disease 2019 state of emergency, declared under Executive Order 202 on March 7, 2020, the Department paused disenrollment of recipients with comprehensive TPHI from managed care for the period March 30, 2020 through February 27, 2021. However, we found problems with the disenrollment process after the pause ended that led to improper managed care premium payments of over \$12.2 million between October 2022 and March 2023 (see the following table).

Enrollment Type	Number of Claims	Premium Amount
NYSOH	9,669	\$4,358,916
Non-NYSOH	11,796	7,859,261
Totals	21,465	\$12,218,177

According to Department 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 TPHI is identified). Additionally, a monthly query is used to identify non-NYSOH-enrolled members (members enrolled in Medicaid by Local Districts) for disenrollment. We found instances where the disenrollment processes were not done timely. For example, one managed care enrollee’s comprehensive TPHI was updated in eMedNY via NYSOH in August 2022. Although the managed care enrollment should have been terminated beginning September 1, 2022, this recipient’s managed care enrollment continued through the audit period. As a result, Medicaid made six improper premium payments totaling \$3,095 on behalf of this recipient during the audit period. Department officials stated they are monitoring the current process that automatically disenrolls members with TPHI from managed care to identify and correct any problems.

Recommendation

1. Review the over \$12.2 million in overpayments, make recoveries, and disenroll the members from managed care, as appropriate.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have additional health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, health care providers must verify whether recipients had other insurance coverage on the date services were provided. If a recipient 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 recipient’s normal financial obligation, such as coinsurance. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer.

Errors in the amount claimed for copayment or in the designation of the primary payer may result in improper Medicaid payments. We identified overpayments to two providers totaling \$5,187,559 on 35 claims that resulted from excessive charges for copayment amounts for recipients covered by other insurance. One hospital billed 34 of the 35 improper claims. We contacted the hospital, and officials stated that a billing issue caused the charged amount to be incorrectly reported as a copayment. As a result of our outreach, hospital officials stated that all Medicaid cases going forward would be manually reviewed prior to billing. At the conclusion of our audit fieldwork, all 35 claims from both providers had been adjusted, resulting in Medicaid savings of \$5,187,559. We also identified overpayments totaling \$405,325 on four claims where Medicaid paid as the primary payer for services that should have been covered by the recipient’s other insurance. We contacted the providers and all four claims were adjusted, saving Medicaid \$405,325.

Recommendation

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

Incorrect Newborn Birth and Maternity 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 every 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. Further, 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 the supplemental payments to the MCOs, there is also a FFS Graduate Medical Education (GME) claim that hospitals receive 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 34 claims, resulting in overpayments totaling \$1,296,093. By the end of the audit fieldwork, the providers had adjusted all 34 claims, resulting in Medicaid savings of \$1,296,093.

Supplemental Low Birth Weight Newborn Capitation Payments

We identified \$1,048,901 in overpayments for nine Supplemental Low Birth Weight Newborn Capitation claims. The overpayments occurred because hospitals reported inaccurate birth weights to MCOs, and MCOs reported inaccurate birth weight information on the claims. For example, an MCO submitted a Supplemental Low Birth Weight Newborn Capitation claim that erroneously reported a birth weight of 324 grams (less than 1 pound). We reviewed the corresponding GME claim and noted the hospital had also reported a birth weight of 324 grams on the newborn's inpatient GME claim. However, we noticed the newborn was discharged home after only 3 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 \$114,941. At the time our fieldwork concluded, all nine Supplemental Low Birth Weight Newborn Capitation claims had been corrected, for a savings of \$1,048,901. Additionally, in response to these audit findings, the Department issued billing guidance in the June 2023 Medicaid Update, reminding hospitals to accurately report newborn birth weights on inpatient claims.

Supplemental Maternity Capitation Payments

We identified 25 claims totaling \$247,192 for improper Supplemental Maternity Capitation Payments to MCOs between June 2022 and February 2023. 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 payments. According to the MCOs we contacted, the payments occurred because of billing errors. At the end of our fieldwork, the MCOs had adjusted all 25 claims, saving Medicaid \$247,192.

Recommendation

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

Improper Payments for Pharmacy, Practitioner, Inpatient, Managed Care Capitation, and Clinic Claims

We identified \$1,248,885 in overpayments on 22 pharmacy claims, 13 practitioner claims, four inpatient claims, four managed care capitation claims, and one clinic claim that resulted from errors in billing. At the time our fieldwork concluded, nine claims had been adjusted, saving Medicaid \$370,232. However, corrective actions were still required to address the remaining 35 claims with overpayments totaling \$878,653.

The overpayments occurred under the following scenarios:

- 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 six claims from five providers who did not respond to our records request. As a result, we consider the services unsupported. Medicaid paid \$732,818 for the unsupported claims, and this amount should be followed up on for recovery.
- Providers are responsible for submitting claims with correct information. We identified \$512,277 in overpayments on 25 claims resulting from provider errors. For example, one pharmacy was paid \$97,284 for six claims for a prescription brand name drug when the prescription allowed for generic substitution. We contacted the pharmacy and it adjusted all six claims, saving Medicaid \$81,697. In total, at the end of our fieldwork, providers had adjusted nine claims, saving Medicaid \$370,232. However, Medicaid paid \$142,045 for the remaining 16 unadjusted claims, which should be followed up on for recovery.
- Certain practitioner-administered drugs must be billed to Medicaid at their acquisition cost. We identified \$3,790 in overpayments on 13 claims where the

providers billed more than the acquisition costs for practitioner-administered drugs. All 13 claims needed to be adjusted.

Recommendation

4. Review the \$878,653 (\$732,818 + \$142,045 + \$3,790) in overpayments and make recoveries, as appropriate.

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

We identified 23 overpayments, totaling \$256,777, for inpatient claims with service dates between September 2022 and October 2022 where FFS payments were made for recipients enrolled in managed care plans that should have paid for the services. Of these overpayments, 21 were due to retroactive managed care coverage, including two for newborns. For instance, a child born to a mother enrolled in a managed care plan should be enrolled in the mother's plan from the child's date of birth. However, the Department does not have a process in place to timely identify and recover improper FFS payments resulting from retroactive updates to a recipient'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 two overpayments occurred due to providers incorrectly billing FFS when the recipient had managed care coverage. We contacted the providers for each of the claims we identified and 12 were adjusted, saving Medicaid \$148,623. However, the remaining 11 claims totaling \$108,154 still needed to be adjusted.

Recommendation

5. Review the \$108,154 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, the Department 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 the Department 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 patients, perhaps placing recipients at risk of poor-quality care while the provider continues to receive Medicaid payments.

We identified three Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations of a health care program. All three providers had an active status in the Medicaid program. We advised Department officials of the three providers. By the end of audit fieldwork, the Department had removed two

of them from the Medicaid program, and the remaining provider was still under the Office of the Medicaid Inspector General's review.

Recommendation

- 6.** 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 the Department'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 October 2022 through March 2023, and certain claims going back to June 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 the Department and reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Based on our audit work, we believe the data obtained was sufficiently reliable for the purposes of this audit. We judgmentally sampled 1,975 claims, totaling over \$146 million, and reviewed them for accuracy and appropriateness. We used a risk-based approach to judgmentally sample different claim types, including selecting the highest-dollar claims and claims identified as a risk area on prior audits. We also selected a random sample of 78 pharmacy claims, totaling over \$1.1 million, and reviewed them for accuracy and appropriateness. We selected 100% of the claims that did not follow payment rules pertaining to comprehensive TPHI coverage. A summary of the sampled claims is presented in the Exhibit. The results of our samples cannot be projected to the population.

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 may 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 the Department's oversight and administration of Medicaid claims processing activity from October 1, 2022 through March 31, 2023.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials agreed with the audit recommendations and indicated that certain actions have been and will be taken to address them.

Within 180 days of the 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 TPHI	21,465	21,465
Various claim types	1,975	137
Randomly selected pharmacy claims	78	3
Totals	23,518	21,605

Agency Comments



KATHY HOCHUL
Governor

**Department
of Health**

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

October 6, 2023

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

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2022-S-36 entitled, "Medicaid Program: Claims Processing Activity October 1, 2022 Through March 31, 2023."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Andrea Martin
James Dematteo
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**Department of Health Comments to
Draft Audit Report 2022-S-36 entitled, “Medicaid Program: Claims
Processing Activity October 1, 2022 Through March 31, 2023” by the
Office of the State Comptroller**

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2022-S-36 entitled, “Medicaid Program: Claims Processing Activity October 1, 2022 Through March 31, 2023” by the Office of the State Comptroller (OSC).

General Comment

The audit concluded on the top of page 6 that “eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers.”

Recommendation #1:

Review the over \$12.2 million in overpayments, make recoveries, and disenroll the members from managed care, as appropriate.

Response #1:

The Office of The Medicaid Inspector General (OMIG) continuously performs audits of Medicaid payments on behalf of recipients with third party health insurance (TPHI). 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.

Recommendation #2:

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

Response #2:

The Department published a Medicaid Update article in the July 2023 issue, titled “*Reminder to Provider: New York State Medicaid Requires Coordination of Benefits*”, which addresses the OSC recommendation. The article can be found in Volume 39-Number 12: https://www.health.ny.gov/health_care/medicaid/program/update/2023/no12_2023-07.htm#benefits

Recommendation #3:

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

Response #3:

The Department issued a reminder to MCO's on July 21, 2023 formally advising all MCOs to accurately report newborn claim information when billing Medicaid to ensure appropriate payment (copy attached). The Department is issuing a reminder to formally advise all MCOs to accurately report maternity claim information when billing Medicaid to ensure appropriate payment. This communication to MCOs is currently pending review and approval. The Department will continue to send out semi-annual reminders to formally advise the MCOs to accurately report newborn and maternity claim information when billing Medicaid to ensure appropriate payment.

The Department published a Medicaid Update article in the June 2023 issue, titled "*Billing Guidance for Reporting Newborn Birth Weights*", which addresses the OSC recommendation. The article can be found in Volume 39-Number 11:

https://www.health.ny.gov/health_care/medicaid/program/update/2023/no11_2023-06.htm#newborn

Recommendation #4:

Review the \$878,653 (\$732,818 + \$142,045 + \$3,790) in overpayments and make recoveries, as appropriate.

Response #4:

OMIG continuously performs audits of practitioner, clinic, and pharmacy 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 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. From previously identified OSC overpayments, OMIG has recovered more than \$500,000 for the scope period of 2018 through 2021 related to audits in this area.

Recommendation #5:

Review the \$108,154 in overpayments and make recoveries, as appropriate.

Response #5:

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 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.

From previously identified OSC overpayments, OMIG has recovered more than \$32,000 for the scope period of 2018 through 2021 related to audits in this area.

Recommendation #6:

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 #6:

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

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