NEW YORK STATE | Department of Health

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Executive Deputy Commissioner

June 4, 2025

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

Dear Andrea Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2023-S-18 entitled, "Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers."

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

Sincerely,

Johanne E. Morne

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

Enclosures

cc: Alyssa DeRosa
Melissa Fiore
DOH Audit

# Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2023-S-18 entitled, "Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2023-S-18 entitled, "Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers." Included in the Department's response is the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

**General Comments:**

OSC Use of A Judgmental Sample

OSC used a judgmental sample to select which payments they would review, which means the auditors selected the payments based on their professional judgement, opinion, and knowledge. As a result, the selected sample and any OSC findings or conclusions are not representative of the entire population.

**State Comptroller's Comment** – DOH's statement is misleading. The audit findings, totaling about $117 million, were based on our analysis of the following total Medicaid payments: clinic, inpatient, practitioner, laboratory, and durable medical equipment encounter claims for services provided between July 1, 2018 and May 31, 2023 to restricted recipients who had designated Restriction Program providers on file, yet the restricted services were not furnished or referred by the designated Restriction Program providers (we then removed emergency claims and claims for services related to methadone treatment from our population; additionally, clinic and practitioner claim types were not included from March 2020 through October 2020 due to OMIG guidance for the COVID-19 public health emergency). Accordingly, this DOH data showed recipients with a designated Restriction Program provider on file didn't receive restricted services directly by designated Restriction Program providers or through a designated provider's referral, which totaled about $117 million in services.

Separately, the audit sample, in this case a judgmental sample, was used for many purposes, including but not limited to gaining an understanding of the issues and testing the reliability of DOH's data, which allowed us to conclude the data was sufficiently reliable for our audit purposes. We remind DOH that we sampled the top eight highest-paid MCOs, which represented a substantial 80% of the total MCO claim payments analyzed by the audit (we also found 93% of the sampled claims were not processed and paid in accordance with Restriction Program requirements). Readers of this report should know that judgmental samples are routinely used and widely acceptable to reach audit conclusions. As previously stated, the audit sampled a variety of categories of claims, medical services, and procedures to capture a holistic view of the payments. Also, as mentioned in the audit report, the sample review was supplemented with reviews of policies and procedures; interviews with various DOH, OMIG, and MCO officials; assessments of internal controls; and data analysis to reach audit conclusions and make the recommendations.

**Audit Recommendation Responses:**

**Recommendation #1**

Review the identified $117 million in encounter claim payments on behalf of restricted recipients and determine whether any recoveries should be made or any penalties assessed.

**Response #1**

OMIG continues to perform analysis on the OSC-identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG is preparing to issue draft audit reports to Managed Care Organizations (MCOs) that appear not to have met the requirements of the Recipient Restriction Program based on review of their reported encounters. Where inappropriate Medicaid overpayments are validated, OMIG will conduct audits to recover these payments, enforce program requirements, and assess penalties if appropriate. The impacted MCOs will maintain their due process protections to challenge audit findings or enforcement actions.

Based on Medicaid program policy, emergency services and methadone maintenance treatment program services are exempt from restriction. OMIG's preliminary analysis determined that 6,504 encounters totaling $38,544,231 are considered appropriate due to the following reasons:

- Encounters with Nature of Admission code Emergency or Urgent
- Encounters that have Methadone Maintenance Treatment Program Rate Codes

**State Comptroller's Comment** – OMIG's statement is incorrect. As stated previously in the first State Comptroller's Comment and also in the "Audit Scope, Objective, and Methodology" section on page 11 of the audit report, emergency claims and claims related to methadone treatment were identified and removed from the audit population based on the feedback from DOH, OMIG, and MCO officials provided to the audit team. Furthermore, urgent services are generally subject to Restriction Program rules according to State regulations and information received from OMIG during the audit.

Additionally, as of March 2025, OMIG determined that more than $11.7 million in encounters have been voided or adjusted to zero or are no longer recoverable due to the 6-year lookback provision in regulation.

**Recommendation #2**

Take steps to ensure MCOs consistently and appropriately enforce the State's Restriction Program policies and regulations, including but not limited to monitoring encounter claims and determining whether any recoveries should be made or any penalties assessed. Prioritize engagement with the MCOs identified in the audit that did not fully apply Restriction Program controls and ensure corrective actions are taken.

**Response #2**

OMIG is considering amendments to its regulations and Appendix Q of the Medicaid Managed Care Model Contract to better monitor and enforce the MCOs' Recipient Restriction Program. These amendments were noted in OMIG's 2025 Regulatory Agenda, published in the NY State Register on January 29, 2025. The amendments will provide OMIG the opportunity to be more engaged in the oversight of Recipient Restriction Program in Managed Care, leading to

improved communication, collaboration, and training.

OMIG has verified MCO Recipient Restriction Program contacts, to ensure that the monthly restriction roster is being sent and reviewed by the appropriate personnel within the MCOs so that appropriate care management for restricted recipients is being performed. OMIG will enhance monitoring of MCOs Recipient Restriction Program, by reviewing reported encounter data.

MCOs are responsible for developing policies and procedures to enforce Recipient Restriction Program requirements. MCOs are contractually required to have effective mechanisms for monitoring and identifying when restricted recipients attempt to access restricted services from providers other than their designated providers. Such mechanisms are subject to audit and review by OMIG, and where MCOs are found to be not in compliance with their contractual obligations, recoveries will be made or other actions taken, where appropriate.

OMIG has established guidelines, frequently educated MCOs on these guidelines and their contractual requirements, and identified and informed the MCOs where procedural improvements are necessary. OMIG will continue to review MCO compliance with Medicaid rules regulations, and contractual obligations. OMIG continues to work to improve processes to monitor MCO encounter claims for compliance with Recipient Restriction Program and to determine whether recovery of overpayments would be appropriate.