New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

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

Medicaid Program
Department of Health

Report 2017-S-74 January 2019

Executive Summary

Purpose

To determine whether Medicaid made improper fee-for-service (FFS) payments for certain services covered by mainstream managed care plans. Our audit covered the period January 1, 2013 to April 30, 2018.

Background

The Department of Health (Department) pays Medicaid providers using the FFS or managed care method. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays providers directly for services rendered to Medicaid recipients. Under the managed care method, the Department pays managed care plans a monthly premium for each Medicaid recipient enrolled in managed care, and the managed care plans pay providers for services rendered to their members. The Medicaid program should not pay claims on a FFS basis when the services are covered by managed care.

The State's Medicaid program offers different types of managed care. Most recipients are enrolled in mainstream managed care plans (Plans), which provide comprehensive medical services ranging from hospital inpatient care to physician and dental services. Accordingly, Plans are responsible for providing most medical services to enrollees. Generally, Plans are also required to pay for medical services for newborns whose mothers are Plan enrollees. However, some services are excluded (carved out) from the Plans' benefit packages and paid separately through FFS. Medicaid FFS claims are subject to various payment controls through the eMedNY system. For example, eMedNY edits determine whether recipients are enrolled in Plans and will deny FFS claim payments unless the services are carved out from the recipient's Plan benefit package. The carved-out services are controlled by the scope of benefits information maintained in eMedNY.

Key Findings

- Medicaid made over $36 million in improper FFS payments for inpatient, practitioner, and dental services that should have been covered by Plans.
- Many of the improper payments identified were for newborn-related medical services. Generally, a child born to a mother enrolled in a Plan should be enrolled in the mother's Plan from the month of birth. Improper payments occur when newborns are not enrolled in the Plans timely, and hospitals inappropriately bill Medicaid FFS for the services.
- The Department has not taken effective steps to ensure Plans promptly report enrollee pregnancies to the entities responsible for managed care enrollment of newborns.
- The Department does not track or penalize lateness when hospitals do not report live births within five business days to the Department.
- The Department does not have a process to routinely or timely identify and recover all improper FFS payments that result from retroactive updates to a recipient's Plan eligibility (including retroactive enrollments of newborns into their mothers' Plans), or retroactive updates to the scope of benefits information in eMedNY.

Key Recommendations

- Review the $36 million in FFS claim payments and recover overpayments, as appropriate.
- Work with the entities responsible for managed care enrollment to help ensure timely enrollments of newborns.
- Develop a process for timely identification and recovery of improper FFS Medicaid payments for managed care services resulting from retroactive managed care enrollments and retroactive updates to the scope of benefits information in eMedNY.

Other Related Audit/Report of Interest

Department of Health: Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care (2014-S-5)

State of New York
Office of the State Comptroller

Division of State Government Accountability

January 10, 2019

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by doing so, providing accountability for 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 *Improper Fee-for-Service Payments for Services Covered by Managed Care*. 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,

Office of the State Comptroller
Division of State Government Accountability

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This report is also available on our website at: www.osc.state.ny.us

Background

Medicaid is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Medicaid is administered in New York by the State Department of Health (Department). For the State fiscal year ended March 31, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3 percent.

The Department uses two methods to pay health care providers for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays providers directly for eligible services rendered to Medicaid recipients. Under the managed care method, the Department makes monthly premium payments to managed care plans for Medicaid recipients enrolled in their plans. In return, managed care plans arrange for the provision of health care services and reimburse providers for services provided to their enrollees.

The State's Medicaid program offers different types of managed care. Most recipients are enrolled in mainstream managed care plans (Plans), which provide comprehensive medical services ranging from hospital inpatient care and physician services to dental and pharmacy benefits. Individuals are enrolled in managed care in multiple ways, including through Local Departments of Social Services (LDSSs) and, as of January 2014, the New York State of Health (NYSOH, the State's online health insurance marketplace). Since 2010, the Department has also contracted with Maximus Inc. (Maximus) to develop and operate a statewide enrollment center for public health insurance programs, including Medicaid. Currently, Maximus handles managed care enrollments in most counties of New York (including New York City).

LDSSs use the State's Welfare Management System (WMS) to update individuals' enrollment information, which is ultimately communicated to the Department's eMedNY claims processing and payment system. NYSOH communicates with eMedNY and other systems to coordinate the enrollment activities associated with NYSOH-enrolled individuals.

Plans are responsible for providing most medical services to their enrollees; however, some services are excluded (carved out) from the Plans' benefit packages and paid separately by Medicaid FFS. The Medicaid program should not pay claims on a FFS basis for services covered by Plans. Medicaid FFS claims are subject to various eMedNY payment controls that, for example, determine whether recipients are enrolled in Plans and will deny FFS claim payments unless the services are carved out from the recipient's Plan benefit package. The carved-out services are controlled by the scope of benefits information maintained in eMedNY. During the audit period, the Medicaid program paid about $7 billion in FFS payments for inpatient, practitioner, and dental claims on behalf of recipients enrolled in Plans.

Audit Findings and Recommendations

During the audit period, the Department made over $36 million in improper Medicaid FFS payments for services that should have been covered by a recipient's Plan, as follows:

- 5,615 inpatient claims totaling $35,098,173;
- 5,387 practitioner claims totaling $791,837; and
- 2,789 dental claims totaling $129,384.

The majority of the improper payments occurred because the managed care enrollment information was not updated timely in the Medicaid eligibility files used to process Medicaid claims, particularly for newborns. Generally, Plans are required to pay for medical services for newborns whose mothers are Plan enrollees. However, when newborns are not enrolled in a mother's Plan prior to birth, the newborn's managed care enrollment may be delayed, resulting in hospitals improperly billing Medicaid FFS for the newborn's medical services.

The Department needs to develop controls to ensure Medicaid FFS does not pay hospitals for newborn medical services when the mother is enrolled in a Plan. Such controls should include assessing eMedNY edits to deny improper FFS payments for newborns of mothers enrolled in Plans. The Department should also take steps to improve the timeliness of Plan reporting of member pregnancies and hospital notification of live births, both of which can help reduce newborn Plan enrollment delays. Furthermore, in cases where a recipient is retroactively enrolled in a Plan and Medicaid makes premium payments to the Plan for the retroactive period, the Department should examine the propriety of all FFS payments made during the retroactive period.

Improper FFS Payments for Services Covered by Managed Care

Late managed care enrollments as well as delays in adding FFS carved-out benefits to eMedNY contribute to improper FFS payments for managed care services. Our audit identified over $36 million in improper inpatient, practitioner, and dental FFS payments resulting from such factors.

Our analysis of the improper inpatient claims for the period January 1, 2013 through June 30, 2017 revealed the primary cause was a delay in updating managed care enrollments (see Table 1), particularly for newborns. Of the 5,005 improper claims resulting from retroactive enrollments, we found 3,919 claims totaling over $22.3 million were on behalf of 3,726 newborns (or 84 percent of the 4,433 retroactively enrolled recipients).

Table 1 – Reasons for Improper FFS Payments

Reason	Number of Claims	Medicaid Payments	Number of Recipients
Retroactive managed care enrollments	5,005	$30,133,650	4,433
Retroactive updates to the scope of benefits information in eMedNY	325	1,562,776	308
Other	337	3,290,581	249
(Less) Claims reported in more than one category due to more than one reason	(318)	(1,528,225)	(303)
Totals	**5,349**	**$33,458,782**	**4,687**

Enrollment of Newborns Into Managed Care

The Medicaid Managed Care Model Contract (Contract) states that a child born to a woman who is eligible for and receiving Medicaid at the time of the birth (with certain exclusions) shall be enrolled in the mother's Plan, effective from the first day of the child's birth month. Plans, hospitals, the Department, and LDSSs (or NYSOH) each have a role in the timely enrollment of newborns into their mothers' Plans. Newborn enrollment delays can cause improper Medicaid FFS payments.

Newborn Enrollment Process

Chapter 412 of the Laws of 1999 added Section 366-g of the Social Services Law, which specifies requirements for the timely authorization of Medicaid for eligible newborns. The law mandates that the Department enroll infants born to women receiving Medicaid into the Medicaid program, assign a client identification number (CIN), and issue an active identification card as soon as possible, but no more than ten business days from the Department's receipt of notification of the birth from the hospital. Since 2001, this process has been performed through automated computer systems, including WMS. Further, when LDSSs or NYSOH receive information about a member's pregnancy from a medical provider, an expectant mother, or Plan, the unborn child must be added to the mother's case immediately upon notification, assigned a CIN (known as an Unborn CIN), and issued a Medicaid card.

When an Unborn CIN is created for an infant to be born to a woman enrolled in a Plan, the managed care enrollment data for the newborn is added prior to the birth. Once the newborn's demographic information is updated after the birth, managed care enrollment becomes active simultaneously with Medicaid eligibility. Hospitals should submit claims for the newborn's birth-related medical services to the Plan for payment. If hospitals submit the newborn-related claims to FFS Medicaid, eMedNY will deny payment due to the newborn's managed care enrollment.

We found that newborns are sometimes added to their mother's Plan after birth, and the delays lead to improper FFS payments. We found delays occur because Plans do not always notify LDSSs or NYSOH about expectant mothers' pregnancies. Additionally, hospitals do not always report

live births within five business days to the Department, as required. Further, in the counties in which Maximus handles the enrollment process, delays can occur because Maximus cannot enroll newborns retroactively. Rather, Maximus must coordinate with LDSSs and the LDSSs must manually correct the effective enrollment date, retroactively enrolling the newborns to the first day of the birth month. As a result of the various delays, managed care enrollment may not be updated until one to two months (and possibly later) after the birth date.

The following cases outline the timing of two newborn enrollments into managed care and the financial impact created by delays:

- An Unborn CIN was created for Newborn A, and the managed care enrollment became active simultaneously with Medicaid eligibility – a process that prevents improper FFS payments. As a result, no FFS payments were made for the newborn-related medical services.
- No Unborn CIN was created prior to Newborn B's birth on August 5, 2016. The newborn's CIN was created after the birth date, and the managed care effective date was set to October 1, 2016 (almost two months after birth). On October 20, the LDSS manually updated the managed care eligibility retroactively to August 1, 2016 (the first day of the birth month). The hospital billed Medicaid FFS for the newborn medical services prior to the LDSS update, and the Department improperly paid the hospital $16,941. The Department also paid the Plan two months of premiums ($401 for August and September), yet the Plan did not pay the hospital bill ($16,941) as it should have.

Regardless of when a newborn's managed care eligibility is updated, the mother's Plan is responsible for all costs of Medicaid-covered services related to the newborn. According to Department policy, hospitals must not bill Medicaid FFS for these services.

Plan Reporting of Enrollee Pregnancies

According to the Contract, Plans must notify NYSOH or LDSSs within five days of learning of a Plan enrollee's pregnancy. NYSOH or the LDSS will then enroll an Unborn CIN in the mother's Plan. After the birth, the Medicaid eligibility of the Unborn CIN will be updated to reflect the date of birth and other demographic information, allowing for timely managed care enrollment.

To assess Plans' handling of member pregnancy notifications, we visited two LDSS offices: NYC Human Resources Administration (HRA), which handles all the five boroughs of New York City; and Rockland County (Rockland). Rockland officials stated they generally do not receive pregnancy notifications from Plans, and HRA officials stated they receive very few. HRA officials believe one of the primary reasons Plans do not report these pregnancies is that Plans have no incentive to do so (i.e., when newborn enrollments into Plans are delayed, the Department not only pays hospitals on a FFS basis for newborn services, but also pays Plans retroactive premiums for the months covering those newborn services).

We tested, for further review, the Plan with the highest number of associated newborn FFS claims in our audit findings. We identified pregnancy-related services (such as ultrasound imaging) paid

by the Plan on behalf of 644 members we determined were mothers of newborns. We found that Plan payments for these pregnancy-related services on behalf of 501 members occurred at least two months prior to the birth. However, no Unborn CINs were created. Of the 501 members, 138 were enrolled in Rockland, but according to Rockland officials, none of the 138 pregnancies were reported to them. We found Medicaid made $2.2 million in improper FFS payments for services on behalf of newborns related to the 501 members.

Timely enrollment of Unborn CINs into managed care may not be possible in all instances, such as when the mother also receives retroactive enrollment. However, we found that members (i.e., mothers) were generally enrolled in a Plan on the service dates of pregnancy-related services. Therefore, Plans should have notified NYSOH or the LDSS of the pregnancies to establish Unborn CINs. Although information about a member's pregnancy may come from various sources, including medical providers or expectant mothers, the Department should work with Plans to develop a proactive approach to identifying pregnant Plan members to allow for the proper creation of Unborn CINs and prevention of improper FFS payments.

Billing for Newborn-Related Medical Services

The Contract states that Plans are responsible for providing services to a newborn and paying the hospital or birthing center bill if the mother is an enrollee of the Plan at the time of birth, even if the newborn is not yet on the monthly roster listing enrollees whose benefits are to be covered by the Plan (note: the Department compiles and distributes a monthly roster to each Plan listing every Medicaid recipient who is eligible for enrollment in the Plan for the upcoming month). According to the NYS Medicaid Program Inpatient Manual Policy Guidelines, providers must bill the Plan, not Medicaid FFS, for a newborn's hospital stay. Hospitals are to determine the newborn's managed care status by checking the mother's status in the electronic Medicaid eligibility verification system and, if either the baby or mother is enrolled and the Plan covers the service to be provided, hospitals should contact the Plan before rendering service (except in an emergency).

We contacted one hospital about seven improper FFS inpatient claims for newborns who were related to the previously noted 138 mothers with pregnancy-related services. Hospital officials informed us they did not attempt to bill the Plan prior to billing Medicaid FFS because the newborns' managed care enrollment did not yet exist. However, as stated previously, hospitals are to determine the managed care enrollment status of both the baby and the mother. If the mother is enrolled in a Plan, the hospital should contact the Plan to allow for proper billing.

We contacted officials from four Plans to determine how they process claims for newborns not yet on their rosters. Two Plans stated they do not allow services to be billed for newborns until they are officially on their roster. However, without the creation of an Unborn CIN, the newborn may not be listed on the Plan roster for months. The other two Plans stated they create temporary IDs for newborns once birth occurs, allowing the hospitals to bill for the newborn services under those IDs. Despite this, we identified improper FFS claims on behalf of newborns in both of those Plans.

We calculated the number of days it took to enroll newborns into managed care using an

enrollment effective date of the first day of their birth month. Of the 3,726 newborns in our audit findings population for the period January 1, 2013 through June 30, 2017, it took over three months to update the effective date for 2,145 newborns (56 percent). Table 2 illustrates that hospitals improperly billed FFS instead of the Plan, even when updates occurred within a month of birth.

The Department should remind hospitals that they must contact and bill the Plans (not Medicaid FFS) for newborn-related medical services when the mother is enrolled in a Plan but the newborn's managed care enrollment does not yet exist. The Department also needs to work with Plans to ensure they have the ability to issue timely payments to hospitals for medical services for all Plan-eligible newborns, including those not yet enrolled. This would minimize improperly billed FFS claims.

Table 2 – Timing of Enrollment and Corresponding Improper Payments

Timing of Newborn Enrollment	Number of Claims	Medicaid Payments	Number of Newborns
Within 30 days	763	$2,470,738	758
31 to 60 days	441	1,889,090	430
61 to 90 days	414	2,830,932	393
Over 90 days	2,301	15,168,234	2,145
Totals	**3,919**	**$22,358,994**	**3,726**

Hospital Reporting of Births to the Department

A Medicaid statute requires hospitals to report every live birth within five business days to the Department. Hospitals may face a penalty of up to $3,500 for each birth they fail to report within that time frame. The Department uses the automated Statewide Perinatal Data System (SPDS) over the Health Commerce System network to receive information electronically from hospitals and to update Medicaid information for newborns. However, the Department currently does not have a process to monitor hospital compliance with this reporting requirement. When live births are not reported promptly, newborns' enrollment into the Medicaid program is delayed, which, in turn, can delay enrollment into managed care.

We contacted the three hospitals that corresponded to the most delayed newborn managed care enrollments in our findings population and judgmentally selected 57 newborn inpatient claims to review the reporting of births. Claims were selected based on the highest dollar amount paid, and were limited to newborns whose managed care eligibility was updated at least 90 days after the date of birth. Officials from two hospitals stated they reported births in a timely manner. However, the hospitals do not keep any copy of the information from the SPDS and we were unable to confirm the dates that the births were entered. The third hospital did not notify the Department within five days of birth in 13 of 17 cases (76 percent), with delays ranging from 11 to 32 days. Currently, the Department does not track or penalize lateness. Department officials stated they stopped using the database to monitor hospitals' compliance with this requirement

in 2015 when the staff person with exclusive knowledge of the database was no longer available to maintain it. The Department is pursuing options for creating a new database.

The longer it takes to properly enroll newborns into managed care, the longer improper FFS claims can be paid by Medicaid. Thus, it is important that the Department monitor hospital compliance with this requirement.

Adjustments and Recoveries of Improper FFS Claims

As stated, in addition to the payment of medical services on a FFS basis, the Department pays Plans retroactive premiums for the months covering those services. Yet the Department and the Office of the Medicaid Inspector General do not have a process to routinely or timely identify and recover all improper Medicaid FFS payments for services covered by managed care.

We note that, in addition to the monthly premium payments, Plans receive supplemental payments for the costs associated with newborn medical care. Specifically, Plans receive a one-time Supplemental Newborn Capitation Payment (commonly referred to as a "kick payment") for the inpatient birthing costs of each newborn enrolled. The additional kick payments are intended to cover the higher cost of newborn care.

We analyzed claims for newborns in our findings population for the period January 1, 2013 through June 30, 2017, and found that Medicaid also made kick payments to Plans totaling $3,045,639 on behalf of 796 newborns (or 21 percent of 3,726 newborns – see Table 2). These 796 newborns were associated with 857 improper FFS claims totaling $7,261,899 of the $22,358,994 in improper newborn-related FFS claims. Because the Department paid Plans kick payments (in addition to monthly premiums) for these services, the Department should start recoupment efforts for these claims. Recoupment of the remaining improper FFS payments related to newborn medical services (over $15 million) may require the Department to make kick payments to the Plans. In addition to the kick payments, Graduate Medical Education (GME) payments (supplemental payments made to teaching hospitals that are already built into the FFS reimbursement rate) may also be required.

Also, it is important that the Department develop a process to identify and promptly recoup FFS payments not related to newborn services that are covered by managed care. For example, in 2017, a recipient received retroactive managed care coverage for 2015 and 2016. Medicaid paid $17,582 in managed care premiums to the recipient's Plan for the retroactive period. However, Medicaid also made FFS payments totaling $380,154 for services rendered and billed prior to the managed care enrollment update.

It is important that the propriety of all Medicaid FFS payments made during recipients' retroactive managed care coverage be examined and improper Medicaid FFS payments be recovered.

Recommendations

1. Review the $36 million in improper Medicaid FFS payments we identified and make recoveries, as appropriate.

2. Work with Maximus and the LDSSs to ensure newborn managed care eligibility is updated promptly, retroactive to the month of birth.

3. Coordinate with the entities responsible for managed care enrollments to prevent inappropriate FFS payments, particularly for newborn enrollees. Steps should include, but not be limited to:

   - Working with Plans to identify pregnant enrollees and to ensure Plans promptly notify LDSSs and NYSOH of pregnancies to allow for the timely creation of Unborn CINs;
   - Reminding hospitals that they must contact Plans and not bill Medicaid FFS for newborn-related medical services when the mother is enrolled in a Plan but the newborn's managed care does not exist; and
   - Ensuring Plans correct their procedures and processes to make timely payments to hospitals for newborns not yet enrolled in mothers' Plans, including when newborns are not on the monthly rosters.

4. Remind hospitals to report every live birth to the Department within five business days and monitor the timing of their reporting, assessing penalties, if warranted.

5. Develop a process to routinely identify and recover improper Medicaid FFS payments for managed care services resulting from retroactive updates to recipients' managed care eligibility and scope of benefits information in eMedNY.

6. Assess the feasibility of implementing eMedNY edits to deny improper FFS payments for newborns of mothers enrolled in Plans.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper FFS payments for inpatient, practitioner, and dental services covered by mainstream managed care plans. The audit covered the period from January 1, 2013 through April 30, 2018.

To accomplish our audit objective and assess relevant internal controls, we interviewed Department officials to confirm our understanding of applicable Medicaid policies and processes. Additionally, we interviewed officials from HRA and Rockland. We also reached out to certain hospitals and Plans to assess the cause of our findings. We obtained and analyzed FFS claims, recipients' managed care enrollment data, and scope of benefit data from the Medicaid Data Warehouse. Details of our methodology, along with individual claim information, were provided to the Department.

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. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

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.

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 the report. In their response, Department officials concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner 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.

Contributors to This Report

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Vision

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To improve government operations by conducting independent audits, reviews, and evaluations of New York State and New York City taxpayer-financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 20, 2018

Ms. 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 Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2017-S-74 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Care."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2017-S-74 entitled, Improper Fee-for-Service Payments for Services Covered by Managed Care

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2017-S-74 entitled, "Improper Fee-for-Service Payments for Services Covered by Managed Care."

Recommendation #1:

Review the $36 million in improper Medicaid FFS payments we identified and make recoveries, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) verified more than $500,000 in voided payments and recovered more than $65,000. The OMIG will continue to review the remaining identified payments and determine an appropriate course of action.

Recommendation #2:

Work with Maximus and the LDSSs to ensure newborn managed care eligibility is updated promptly, retroactive to the month of birth.

Response #2:

The automated enrollment process in New York State of Health was turned on in October 2017 for Upstate districts and in March 2018 for New York City. Newborns are being enrolled in managed care back to the month of birth timelier because it is no longer a manual process. Maximus cannot retroactively enroll newborns; however, the Department will work with Local Departments of Social Services (LDSS) to ensure newborns who have coverage on Welfare Management System get enrolled in a managed care plan back to the month of birth without delay.

Recommendation #3:

Coordinate with the entities responsible for managed care enrollments to prevent inappropriate FFS payments, particularly for newborn enrollees. Steps should include, but not be limited to:

- Working with Plans to identify pregnant enrollees and to ensure Plans promptly notify LDSSs and NYSOH of pregnancies to allow for the timely creation of Unborn CINs;
- Reminding hospitals that they must contact Plans and not bill Medicaid FFS for newborn-related medical services when the mother is enrolled in a Plan but the newborn's managed care does not exist; and
- Ensuring Plans correct their procedures and processes to make timely payments to hospitals for newborns not yet enrolled in mothers' Plans, including when newborns are not on the monthly rosters.

Response #3:

The Department will a send notice to the LDSSs reminding them of their roles and responsibilities in ensuring the prompt enrollment of unborn and newborns into the Medicaid system.

The Department will send a letter to hospitals reminding them not to bill FFS for newborn-related medical services when the mother is enrolled in a managed care plan at the time of birth.

The Department will send a notice to the plans reminding them of their responsibility to provide prompt notification regarding known pregnancies and to ensure coverage of medically necessary benefit package services for those newborns whose mother is enrolled in the plan on the newborn's date of birth, including coverage in the absence of an effectuated enrollment for the newborn.

Recommendation #4:

Remind hospitals to report every live birth to the Department within five business days and monitor the timing of their reporting, assessing penalties, if warranted.

Response #4:

The Department will send a letter to hospitals reminding them of the requirement to report every live birth within five business days of birth. To monitor hospitals' compliance with reporting requirements, a database needs to be created. Therefore, the Department has begun working with the New York State Office of Information Technology Services to create a new database. Preliminary steps have been taken to explore the best approach.

Recommendation #5:

Develop a process to routinely identify and recover improper Medicaid FFS payments for managed care services resulting from retroactive updates to recipients' managed care eligibility and scope of benefits information in eMedNY.

Response #5:

The Department will collaborate with OMIG to explore the feasibility of routinely identifying and recovering improper Medicaid FFS payments for managed care services resulting from retroactive updates to recipients' managed care eligibility and scope of benefits information in eMedNY.

Recommendation #6:

Assess the feasibility of implementing eMedNY edits to deny improper FFS payments for newborns of mothers enrolled in Plans.

Response #6:

The Department will assess the feasibility of edits in eMedNY to prevent payment of FFS claims for newborns who are awaiting enrollment into the mother's managed care plan.