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# Ensuring Integrity in New York State Medicaid



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## Executive Summary

Medicaid provides health insurance coverage to more than 6 million New Yorkers and is projected to cost a total of \$62 billion from federal, State and local sources in State Fiscal Year 2016. Recent reforms have injected billions in new federal funds into New York's economy and are changing the Medicaid program to one in which contracted managed-care organizations (MCOs) play a much more significant role. In this context, maintaining accountability and strengthening program integrity remain critical.

The Office of the State Comptroller (OSC) conducts independent, cost-effective Medicaid audits that safeguard resources for the program. From January 2011 through February 2015, OSC released 73 audit reports, which identified \$513 million in improper payments or potential revenue, and questioned an additional \$361 million in transactions that would require agency actions to reduce costs or recover funds.

Audits found recurring deficiencies in eMedNY, New York's Medicaid Management Information System (MMIS). Certain flawed functioning and inadequate system controls caused at least \$190 million of the improper payments identified in the audits. The Department of Health (DOH), which administers Medicaid, was slow to modify eMedNY, at times taking as long as three years to resolve issues raised by auditors. These problems will persist until DOH improves or replaces eMedNY.

In the audits, which cover various timeframes, DOH failed to obtain approximately \$170 million in drug rebates and discounts. DOH made \$169 million in improper payments for services provided to enrollees covered by both Medicare and Medicaid. Overpayments also resulted from eMedNY's failure to deduct patient cost-sharing amounts from nursing-home payments (\$47 million); duplicate payments by MCOs and fee-for-service Medicaid (\$18 million); and the issuance of multiple client identification numbers (\$17 million).

OSC audits highlight the need for more effective oversight of MCOs. As the State expects to transition the majority of Medicaid spending, services, and enrollees to managed care by 2016, it is essential that OSC have ready access to the MCOs' financial and program data in order to perform its mandated financial oversight functions. This oversight helps to control spending in Medicaid and reduce fraud, waste, and abuse.

## Protecting a Vital Program for New Yorkers

Medicaid is a costly yet vital program. The New York State Medicaid program is a federal, State and locally funded program. In State Fiscal Year 2016, the Division of the Budget projects expenditures will reach \$62 billion. State funding for the Medicaid program is projected to total \$22.4 billion that year. Medicaid performs an essential public health function by insuring nearly 6.4 million New Yorkers, enabling them to access health care that would otherwise be unaffordable.

Medicaid spending also generates positive economic impacts for the State and local communities, as the money is used to provide goods and services, make purchases, and support salaries. For instance, in calendar year 2009, Medicaid accounted for nearly 30 percent of third-party payer revenue to New York's hospitals. An estimated 125,000 providers participate in New York's fee-for-service Medicaid, and almost 90,000 providers participate in New York's managed-care Medicaid. In New York, approximately 50 managed-care organizations (MCOs) offer at least 80 different plans.

## Federal Support for Medicaid

Medicaid has grown, in part, as a result of the 2010 federal Affordable Care Act (ACA), which expanded coverage and reduced the State share of Medicaid costs. The ACA raised Medicaid income limits to 138 percent of the federal poverty level (FPL), which expanded Medicaid eligibility to many non-elderly, non-disabled people, and could add 320,000 new enrollees between 2013 and 2022, according to the Kaiser Commission on Medicaid and the Uninsured. As of 2014, the federal government pays 100 percent of the costs for these new enrollees, with the federal share scaling down to 90 percent by 2020. The ACA also enabled New York to end its Family Health Plus program, another source of savings for the State.

Federal approval of an amendment to New York's Medicaid Plan may add up to \$6.42 billion in Delivery System Reform Incentive Payments (DSRIP) to New York's health care market. New York plans to use its DSRIP funds to reduce avoidable hospital use by 25 percent and improve measures and health outcomes for the State's Medicaid population. New York also intends to implement managed-care payment reform as a way to sustain delivery system transformation.

With the expanded federal role in Medicaid came a renewed federal emphasis on strengthening program integrity functions to fight fraud, waste and abuse. The federal government has prioritized education and training for states and providers, and is promoting data quality and analytics as essential for accountability and desired program outcomes.

## New York's Medicaid Oversight

In New York, several State entities perform critical statewide program integrity functions. The Department of Health (DOH) administers the Medicaid program, implements federal and State laws, establishes regulations and controls on coverage, spending, and utilization, and develops quality standards and objectives. The Office of the Medicaid Inspector General (OMIG) prevents and detects fraud and abuse by auditing and investigating the Medicaid program and preparing federally mandated reports. The Attorney General's Medicaid Fraud Control Unit (MFCU) investigates and prosecutes individuals and companies responsible for improper or fraudulent billing schemes. County District Attorneys also perform the same functions at the county level.

The Office of the State Comptroller (OSC) plays an independent role in ensuring the Medicaid program's integrity through auditing. OSC's responsibility and authority to audit Medicaid are articulated in Article V, Section 1 of New York State's Constitution and Article II, Section 8 of New York State's Finance Law.

OSC Medicaid auditors have long used data analytics to identify risks and solve costly problems. Because of that approach, OSC produces audit findings that impact the work of the other State oversight entities, facilitate recurring financial recoveries by those entities, lead to criminal investigations and prosecutions, identify ineligible providers and enrollees, and strengthen program management.

## OSC Medicaid Auditing

OSC audits include reviews of Medicaid claims and monthly capitation payments (contractually established payments based on plan enrollment, regional cost variations, and certain health-related risk factors) by DOH to MCOs. These claims and payments are contained in eMedNY, New York's Medicaid Management Information System (MMIS), which processes more than 2 million Medicaid transactions daily.

OSC's Medicaid audit work accesses eMedNY and the Medicaid Data Warehouse, which stores historical claims and cost, service, and utilization data. Auditors analyze, test, and verify data reported on claims and determine whether the services provided are appropriate, payments are correct, and providers and beneficiaries are eligible to participate. They also test whether eMedNY functions as expected and recommend modifications to the system (referred to as "edits") to detect, prevent, and correct improper payments.

OSC conducts two types of claims audits: "pre-audits" (referred to as weekly pre-audits) look at claims before they are released for payment by eMedNY, and "post-audits" examine claims paid by eMedNY. OSC also audits encounter data submitted by MCOs, which includes information on enrollees' medical services, such as visits to a clinic or purchases of medical equipment.

OSC audits Medicaid-related contracts and programs to examine whether objectives are being met, and when necessary, conducts fraud audits. Regular "follow-up" audits examine whether initial audit recommendations were implemented and determine the status of funds recovered at the time of the follow-up.

## Safeguarding Medicaid Resources

From January 2011 through February 2015, OSC issued 73 Medicaid audit reports covering various timeframes that identified \$513 million in incorrect payments and potential revenue, and \$361 million in questionable transactions that largely require DOH to take action to realize any financial benefit. Major findings by source are listed in the table below and discussed in more detail later in this report.

### Dollar Value of Findings in Audits Released January 2011 – February 2015

<b>Incorrect Payments and Potential Revenue</b>	<b>Amount</b>
Drug Rebates and Discounts	\$171,492,301
Dual Eligible Claims	\$168,785,679
Nursing Home Claims	\$46,792,454
Hospital Billings	\$18,634,078
Managed-Care Organizations and Fee-for-Service Payments	\$17,761,852
Multiple Client Identification Numbers	\$17,344,047
Low Birth Weight Babies	\$14,586,679
Provider Errors on Claims	\$14,247,895
Other	\$43,840,580
<b>Subtotal</b>	<b>\$513,485,565</b>
<b>Questionable Transactions</b>	<b>\$360,687,581</b>
<b>Total Findings</b>	<b>\$874,173,146</b>

Source: Office of the State Comptroller, Division of State Government Accountability

Recoveries based on OSC audit findings are the responsibility of DOH and OMIG. While these agencies can respond quickly to OSC audit findings and recommendations, they can also take a few years to initiate a response.

For instance, at least \$190 million in findings ensued from flaws in eMedNY's functioning. These incorrect payments happened because eMedNY made errors interpreting codes on claims. Also, additional incorrect payments resulted from a lack of controls in eMedNY to detect errors in claims, maintain required service and reimbursement limits, and properly identify Medicaid providers and drug manufacturers. DOH is often slow to implement needed modifications recommended by auditors that would have stopped improper payments from continuing. For example, in September 2009, auditors recommended that DOH develop a test process to identify potentially problematic Medicaid claims for services to newborns and to prevent overpayments on such claims. DOH began to develop new eMedNY edits in March 2011. DOH also took nearly three years to make changes in eMedNY to increase its collection of drug rebates and discounts, as detailed below. Audit findings about eMedNY are significant because they can help prevent future improper payments and produce recurring budgetary savings.

## Drug Rebates and Discounts

The federal Medicaid Drug Rebate Program allows states to recover a portion of their prescription drug costs by obtaining rebates from manufacturers. DOH identifies which manufacturers are responsible for paying the rebate by using the National Drug Code (NDC), which should be indicated on claims submitted to Medicaid. Federal regulations required the use of NDCs on certain pharmacy claims (e.g., physician-administered drugs) beginning January 2008.

The federal 340B Drug Pricing Program requires drug manufacturers to discount the price of medications sold to eligible health care providers, including some physician-administered drugs delivered by doctors to their patients in their health care facilities. Providers are required to bill Medicaid for the discounted cost of the drugs.

Two OSC audits found that nearly \$50 million in rebates and discounts were not obtained because DOH did not program eMedNY properly to enable rebate collection; eMedNY improperly paid claims it should have denied; DOH did not ensure proper billing for 340B drugs; and DOH delayed implementing auditors' recommendations, by nearly three years, to expand the rebate program to apply to more than two Medicaid claim categories (there are 15 categories).

In 2010, the ACA expanded the Medicaid Drug Rebate Program to cover medications dispensed to MCO plan members. MCOs submit encounter claims to eMedNY that must include the NDC; otherwise, eMedNY should deny the claims and MCOs should resubmit corrected claims. OSC auditors found that DOH did not collect \$119.3 million in available rebates from October 1, 2011 through June 30, 2014 as a result of ineffective policies and processes and untapped rebate opportunities.

For example, DOH lacked controls to ensure that MCOs' rejected encounter claims are successfully resubmitted so that all rebates can be collected. Auditors estimated that 1 million rejected encounter claims were never successfully resubmitted by MCOs, accounting for \$69 million of the uncollected rebates. DOH did not seek rebates on drug encounter claims from all categories of Medicaid services, resulting in uncollected rebates totaling \$26 million. DOH did not always obtain NDCs from claims, even though the NDCs were necessary to identify the manufacturers that owed rebates, and some claims

were either missing or reported invalid ones, resulting in \$24.3 million in uncollected rebates. Some of these problems stemmed from inadequate controls in eMedNY, which DOH agreed to modify. In total, auditors found that DOH did not obtain approximately \$170 million in drug rebates and discounts that could have offset spending on Medicaid. In addition, auditors found drug costs were overbilled on some claims.

## Payments for Dual-Eligible Enrollees

New York has approximately 800,000 residents who are enrolled in both Medicare and Medicaid. In 2007, “dual eligibles” comprised 15 percent of New York’s total Medicaid enrollment and accounted for 45 percent of New York’s Medicaid spending, according to DOH. OSC audits issued from January 2011 through February 2015 identified \$169 million in overpayments associated with dual-eligible claims; major sources are highlighted below.

### Managed-Care Premiums

For the three years ending in May 31, 2010, DOH made 271,000 unnecessary managed-care premium payments totaling \$111 million for 45,000 dual eligibles who were not actually entitled to enroll in Medicaid managed care. This wasteful spending resulted from delays in posting Medicare data to eMedNY and in removing enrollees from Medicaid managed-care plans. Under Care Management for All, a federally approved State initiative to improve health outcomes, safety, and care quality and reduce costs, since 2012, the State has been moving most dual-eligible enrollees into specialized managed-care plans, which are paid capitated rates, or “health homes” that coordinate care and are paid using the fee-for-service methodology.

### Crossover Payments

In December 2009, New York State implemented a new payment system for most dual-eligible claims, known as the “crossover” system, which was intended to avoid improper Medicaid payments for services provided to dual-eligible enrollees. This functionality was more difficult to achieve than anticipated by DOH contractors, and the system’s performance was sometimes lacking, as found by OSC auditors. In addition, providers were still allowed to submit dual-eligible claims directly to Medicaid, potentially including claims denied by Medicare, which could result in Medicaid overpayments.

Auditors identified overpayments totaling \$26 million because eMedNY incorrectly interpreted certain crossover claim adjustment codes and did not properly apply Medicaid reimbursement limits (\$10 million); and providers were able to bypass controls set by the crossover system and to submit their claims directly to Medicaid (\$16 million).

### Payment of Excessive Medicare Costs

Between March 1, 2006 and February 28, 2011, New York made 71,355 excessive payments totaling nearly \$5.5 million for Medicare enrollees who were eligible for Medicaid to pay for their Medicare premiums, deductibles, and coinsurance. The overpayments resulted from eMedNY system controls that did not function properly or reflect DOH regulations.

## Primary Payer Designation

Medicaid enrollees can have other insurance coverage, such as Medicare, military coverage, or even private insurance; however, Medicare is most common. When health care providers submit Medicaid claims that do not correctly identify the primary payer, eMedNY in some cases cannot detect this provider error, which can result in overpayments. In a limited review of certain claims, auditors identified \$6 million in such overpayments for 384 claims, and recovered \$5 million.

## Nursing Home Claims

Medicaid enrollees who reside in nursing homes must share the cost of their care with Medicaid. The amount that a Medicaid-covered nursing-home resident must contribute is referred to as Net Available Monthly Income (NAMI). Local social services districts are responsible for determining current NAMI amounts for nursing-home residents in their domain and for updating eMedNY with that information.

### Failure to Deduct Patients' Cost-Sharing Amounts

NAMI was not always deducted by eMedNY from Medicaid payments when a nursing home excluded billing for the first day of the month on its monthly claim. Some nursing homes appeared to be aware of this glitch and chose to exploit it. DOH could not fully explain why this occurred, or why certain nursing homes routinely billed with this omission. According to DOH, the flaw was a legacy from the predecessor MMIS. Auditors identified \$34.5 million in NAMI improperly retained by 700 nursing homes from January 2007 through August 2010, a result of eMedNY's flawed processing. Ultimately, a consultant hired by OMIG recovered \$30 million and expected to recover another \$16 million at the time of the follow-up audit.

Nearly two years later, auditors found that DOH still had not modified eMedNY to correctly deduct NAMI. A consultant hired by DOH noted that in 2007, the average time for DOH to complete a modification to eMedNY was 752 days.

### Late Cost-Sharing Updates by Local Social Services Districts

Local social services districts are required to update NAMI data in eMedNY in a timely manner, but they often do not. Auditors found 334 NAMI changes for 96 residents that were late, including 108 posted late by six months and 111 posted late by one year or more. As a result, eMedNY overpaid nursing homes by \$7.5 million. A follow-up audit and some weekly pre-audits identified \$4.8 million in overpayments related primarily to NAMI and other nursing home issues. Auditors previously raised this issue in an audit released in February 2001, but the problem is likely to persist for years to come without a more focused effort by DOH to correct the problem.

## Duplication in Managed-Care and Fee-for-Service

Prior to 2011, New York required many, but not all, of its Medicaid beneficiaries to enroll in managed care. Auditors found that New York paid fee-for-service claims for services provided to managed-care plan members whose health care costs should have been paid by their MCOs, which received capitation payments from DOH to do so. Auditors also found that New York paid premiums for the same person

enrolled twice in the same managed-care plan or in different managed-care plans. Auditors found that New York made nearly \$18 million in such duplicate payments.

The largest of these findings included a review of five years of claims, submitted from July 1, 2005 through June 30, 2010, which found that New York made 105,767 improper payments for premiums to MCOs, totaling \$15.6 million. The payments were made on behalf of 14,899 people who were then ineligible for managed care and who were covered by Medicaid under other arrangements. Most of these individuals also had multiple client identification numbers, which increased the improper payments to MCOs.

## Multiple Client Identification Numbers

Lack of controls on the issuance of Medicaid identification numbers has been a recurring problem for the State going back many years with a significant associated cost. OSC audits issued prior to 2011 identified \$98 million in potentially improper Medicaid spending because enrollees were issued multiple identification numbers (referred to as “Client Identification Numbers” or “CINs”), leading to duplicate payments to providers or unnecessary capitation payments to MCOs. The MFCU and OMIG recovered \$7.7 million, but DOH did not improve its controls over the years, as detailed in one example below.

Between June 2007 and May 2010, New York paid \$17.3 million in unnecessary Medicaid expenses because 9,848 recipients were enrolled with multiple identification numbers. Of that amount, \$13 million in fee-for-service payments went to hospitals and clinics for 5,141 recipients who were members of managed-care plans, which should have paid for the care they received. Also, managed-care plans received \$2.6 million in duplicate premium payments because local districts enrolled 3,526 people in two different plans using different CINs for each person. Local districts enrolled 2,264 people in the same managed-care plan twice, using different CINs, and then made duplicative monthly premium payments to the plan. OMIG recovered \$4.4 million of such inappropriate payments, and as of May 31, 2014, expected to recover another \$2.4 million.

### Poor Controls on Client Identification Numbers

The federal government concurred that New York State lacked adequate controls on the issuance of CINs to Medicaid enrollees in a report issued January 2014. In response, DOH noted that New York State of Health (NYSOH), the State’s health coverage marketplace established in accordance with the ACA, would eliminate or minimize the creation of multiple CINs for enrolled individuals since NYSOH was expected to gradually include all Medicaid enrollees and eventually all human services programs, such that one system would generate CINs.

## Incorrect Hospital Billing

Generally, Medicaid pays inpatient claims using two reimbursement methods: Diagnosis Related Groups (DRG) and DRG-exempt per diem rates. The DRG methodology is intended to better reflect the variable costs of care for individual patients. DOH periodically modifies the methodology to better align reimbursement, patient needs, and the cost of care.

Auditors identified nearly \$19 million in overpayments to hospitals due to incorrect billings. Hospital stays were billed and paid at higher acute-care rates even though patients received less intensive services, resulting in nearly \$15 million in overpayments. Inappropriate claims also ensued from the use of a service bureau that improperly adjusted and resubmitted a hospital's claims (\$2.4 million in recovered and prevented overpayments). Hospitals also inappropriately billed \$1.4 million for ancillary services provided during patients' hospital stays.

Auditors also questioned the revised DRG reimbursement method, called the All Patient Refined Diagnosis Related Groups, because it may have resulted in excessive payments for claims for care to patients who died during the first day of their hospital stay. New York paid nearly \$51 million for 1,833 such claims between December 2009 and September 2012, although the hospitals' charges totaled \$22.6 million. In July 2014, DOH informed providers that it would research a new short-stay policy as a result of the OSC audit.

## Low Birth Weight Newborns

When newborns covered by Medicaid are below a certain weight, Medicaid reimburses their care at a higher rate than it pays for normal-weight newborns. MCOs receive a monthly premium for each newborn and supplemental payments to cover the costs of the newborn's special needs medical care. Since April 1, 2012, MCOs have received a Supplemental Low Birth Weight Newborn Capitation Payment for each newborn weighing less than 1,200 grams, or 2.64 pounds, at birth. Such payments range from \$68,355 to \$105,108 per newborn and far exceed standard payments, which can range from \$2,277 to \$6,651 per newborn. OSC weekly pre-audits have repeatedly uncovered overpayments for services for newborns because of birth weight reporting errors by providers and MCOs, incorrect patient status codes and other coding errors on claims.

OSC also conducted a comprehensive audit of low birth weight claims paid from April 1, 2012 through June 1, 2014 that identified \$13.9 million in improper payments. On 77 claims, the birth weight was equal to or greater than 1,200 grams (\$7.4 million in overpayments). Another 48 claims were submitted late, more than one year after the newborn's birth date (\$4.7 million). Flaws in one hospital's billing system truncated the correct birth weights and caused improper payments for 50 neonatal claims (\$4.8 million). Also, eMedNY could not verify the ages of recipients on low birth weight newborn claims and paid \$173,288 on two such claims for patients who were 57 and 58 years old.

Effective March 28, 2013, eMedNY was set to deny supplemental payments when the reported birth weight exceeded 1,200 grams, but auditors noticed that the edit did not function properly. As a result of the audit work, on November 6, 2014, DOH revised the edit to restrict supplemental payments on claims for newborns weighing less than 1,200 grams. DOH also implemented controls to require that most claims for supplemental payments be submitted within one year of birth.

## Provider Errors on Claims

When providers make errors on claims that eMedNY cannot detect, overpayments often occur. OSC audits uncovered \$14 million in provider errors, including: incorrect codes used on claims; incorrect coinsurance, copayments, and deductibles; errors on dates of service; data-entry errors; and incorrect reimbursement rates. Incorrect reimbursement rate codes on claims for inpatient care, hemodialysis and other services, along with data-entry errors generated more than \$6 million in overpayments.

## Provider Monitoring

Weekly pre-audits identified 138 providers who had previously been charged with or convicted of crimes that violate Medicaid laws and regulations. For instance, a provider in default on an education loan was excluded from Medicaid until the default was resolved. Other providers were convicted of tax fraud or submitting false claims for reimbursement to Medicare or Medicaid. Another provider was indicted on charges of fraud and falsification of records for allegedly signing off on 40,000 radiology reports without actually having reviewed the reports. One doctor was convicted of reckless involuntary manslaughter in another state for using an unauthorized treatment for Lyme disease that caused a patient's death. Auditors advised DOH to review these providers' eligibility to participate in Medicaid and to terminate their participation as warranted.

Auditors found that DOH is not always aware of provider convictions in part because courts do not always publish their adjudications. OMIG must request and review court documents to ascertain the nature of the crime committed. DOH must then evaluate each case to determine whether exclusion from Medicaid is justified. For instance, DOH determined that the providers convicted of tax evasion could not legally be excluded from Medicaid. At the time of OSC's audits, DOH had terminated 71 providers (of the 138 identified by auditors) from participating in Medicaid.

### Recurring Weaknesses in Provider Monitoring

In a 2014 program integrity review, the federal Centers for Medicare and Medicaid Services (CMS) noted that for years New York lacked adequate safeguards for ensuring that payments are not made to excluded individuals or entities. CMS also noted that while New York may delegate provider enrollment or credentialing functions to MCOs, the State is still responsible for ensuring that excluded parties do not receive Medicaid funds. CMS has prioritized keeping unethical providers out of Medicaid as a means to reduce fraud, waste, and abuse. According to CMS, this approach also protects enrollees, who could be harmed by substandard care from these providers.

### Monitoring Fee-for-Service and Managed Care Providers

DOH officials have indicated that the new Medicaid Administrative Services system they plan to procure as a replacement for eMedNY will have enhanced provider credentialing functionality that complies with ACA standards. It will feature software that conducts profiles based on electronic matching with millions of records in State, federal, or private databases, including licenses, registrations, certifications, and criminal records.

According to DOH, the automated data matching will also be supported by telephone verifications to ensure that the most current information is accessible. DOH intends to conduct monitoring of registered fee-for-service providers and will not maintain data on MCO network-only providers (who will make up the majority of health care providers in Medicaid). MCOs can also access the new software to review provider credentialing, if their providers are also registered with fee-for-service Medicaid. Otherwise, MCOs self-report provider information to a DOH database, the Provider Network Data System, which DOH uses to evaluate provider networks. As a result, OSC's provider monitoring will continue to assist in ensuring that New York complies with federal law and regulations and pays only eligible providers.

## Enrollee Eligibility

OSC audits also examined whether enrollees who received services paid through Medicaid were eligible for the program. During fieldwork for those audits, local social services districts were responsible for ensuring that enrollment information was current and for removing people who were no longer eligible. Auditors found incorrect payments made for services and premiums on behalf of deceased people and other states' residents (who were enrolled in their home states' Medicaid programs), and overpayments resulting from out-of-date information or errors on claims not detected by eMedNY. Lax oversight of eligibility is significant, recurring, and leads to wasteful spending.

During a period of four years, auditors found that local social services districts did not perform eligibility determinations as required for more than 85,000 people in the Medicare buy-in program, whose Medicare premiums cost Medicaid \$85.9 million. Auditors determined that at least \$21.1 million of the \$85.9 million should never have been paid (the appropriateness of the remaining \$64.8 million would require more detailed eligibility determinations by the local districts). Among those determined ineligible for these benefits were 532 deceased individuals, whose premiums cost \$1.9 million. In another instance, Medicaid coverage for one person ended in February 1996, but New York continued to pay the individual's Medicare premiums for 15 years until auditors pointed this out to the local district.

## Accountability in Medicaid Managed Care

In 1998, managed care accounted for just 8 percent of New York State Medicaid expenditures. By 2013, managed care's share of Medicaid expenditures rose to 50 percent. New York's goal to shift almost all services and enrollees to managed care by 2016 could increase managed care's share of New York's Medicaid expenditures to 90 percent or higher. Claims management will be decentralized, with most claims processed in MCOs' proprietary systems instead of eMedNY. Provider credentialing and review will largely be conducted by MCOs.

Despite this operational shift, the State remains legally responsible for ensuring that MCOs comply with State and federal Medicaid regulations, according to the terms of New York's federally approved Medicaid plan. For example, State oversight of MCOs must ensure that: enrollees receive needed services; MCOs comply with requirements for program quality and financial viability; only eligible providers participate in Medicaid; and MCOs report accurate and timely encounter and financial data.

DOH's oversight of MCOs includes examinations of their quarterly and annual financial reports, fulfillment of contractual obligations, program quality, achievement, and encounter data. Federal law requires MCOs to report encounter data to states, and requires states to report this data to the federal government or be denied federal Medicaid matching funds. DOH uses encounter data for utilization and access monitoring, financial analysis, setting capitation rates, and quality and performance monitoring.

Oversight of MCOs by DOH enables the agency to set capitation rates and program policies, and to comply with federal regulations, but these efforts mostly take place out of public view. OSC's independent auditing with publicly released findings can strengthen accountability and transparency in the financial oversight of MCOs' Medicaid-funded operations, by assuring the public that the cost of Medicaid managed care is justified and in compliance with State and federal laws and regulations.

OSC audit findings already indicate that MCOs make errors in their claims processing and fail to comply fully with State and federal regulations. In response to the projected growth of managed care, OSC has been examining encounter data and financial data reported by MCOs to determine whether DOH's capitation payments to MCOs are justified and to control the cost of managed care.

## Fiscal Impact of OSC Medicaid Audits

In addition to identifying \$513 million in improper payments and untapped revenue opportunities, OSC identified \$361 million in questionable transactions that will require DOH and OMIG to review and take actions to prevent overpayments or recover costs, including: improving oversight of eligibility for Medicare buy-in coverage (more than \$80 million), as noted previously; implementing better controls on payments to foster-care agencies (\$83 million); and limiting Medicare Part C coinsurance payments to Medicaid's maximum service fee (\$69 million). The total benefit to be realized by implementing audit recommendations would be much higher than the amounts reported in OSC audits, as the recommended changes would have a recurring budgetary impact long into the future.

OSC Medicaid audits return real savings to taxpayers. At the time of OSC's follow-up audits, significant recoveries included nearly \$82 million from dual-eligible claims; \$48 million from audits of cost-sharing funds in nursing homes and other errors on nursing-home claims; nearly \$13 million from dental claims; over \$6 million from provider errors on claims; nearly \$9 million from supplemental payments for low birth weight newborns; \$8 million in hospital claims; and nearly \$7 million from multiple client identification numbers, among others.

The financial benefits provided by OSC audits are often recurring, largely because the eMedNY edits and management actions implemented as a result of the audits often prevent future overpayments. Recoveries are the legal responsibility of DOH and OMIG. These agencies do not publicly report on actions they take after responding to OSC follow-up audits unless the agency's 30-day response discusses future action.

OMIG employees and contractors generally perform the recovery work recommended by OSC. OMIG has adopted routine or periodic audits in its annual work plan to monitor issues identified in OSC audits. OMIG has also made recoveries that can be attributed to the groundwork laid by OSC auditors. For example, OMIG reviewed OSC audit findings pertaining to dual-eligible claims. As a result, OMIG and its contractor modified their review of such claims, which returned an additional \$22.3 million to Medicaid.

When Medicaid audits involve fraud, auditors work with the Comptroller's Division of Investigation, which refers cases to federal, State, and local prosecutors. For example, on August 13, 2012, Comptroller Thomas DiNapoli and Attorney General Eric Schneiderman announced the guilty plea of Brooklyn dentist Lawrence Bruckner. Among other charges, Dr. Bruckner paid recruiters to solicit homeless Medicaid patients with cash and billed taxpayers under his son's name for services the son never provided. Dr. Bruckner paid \$700,000 in restitution and was sentenced to one to three years in prison.

## Conclusion:

# Strengthen Integrity in New York State Medicaid

As the majority of Medicaid spending continues to migrate to MCOs, increased oversight of these entities and better access to their data by OSC and other State oversight agencies will help strengthen program integrity. The Comptroller recommends that New York consider the following actions to enhance the State's financial oversight of MCOs in Medicaid:

1. Set standards to ensure that MCOs' systems controls detect, prevent, and correct errors in MCO provider payments.
2. Strengthen standards for MCOs regarding provider credentialing, review, and verification, and timely reporting of this information to the State.
3. Implement previously issued OSC recommendations, which address processing of MCO claims, in the new Medicaid Administrative Services system.
4. Strengthen the enforcement of timeliness and quality standards, and provider identification requirements for encounter data from MCOs.
5. Apply financial penalties when MCOs do not comply with Department of Health requirements.

## Appendix

<b>Report</b>	<b>Medicaid Audits</b>	<b>Date Issued</b>
2009-S-71	Claims Processing Activity 10/1/09 – 3/31/10	1/6/2011
2010-F-33	Inappropriate Payments for Dental Services to Patients with Dentures	1/20/2011
2010-F-43	Inappropriate Claims for Newborn Services	3/17/2011
2010-F-46	Reimbursement of Synagis	4/7/2011
2010-F-47	Inappropriate Payments for Vision Care Services Claimed by Dr. Horowitz	4/14/2011
2010-F-42	Payments for Diabetic Testing Supplies	4/14/2011
2011-F-4	Controls Over eMedNY Edit Changes	8/9/2011
2010-S-15	Claims Processing Activity 4/1/10 – 9/30/10	8/22/2011
2011-F-11	Overpayments of Coinsurance Fees for Medicare Beneficiaries	9/15/2011
2010-S-17	Underreporting of Net Available Monthly Income for Nursing Homes	9/28/2011
2011-S-8	Overpayments to Cabrini Medical Center	4/3/2012
2010-S-65	Claims Processing Activity 10/1/10 – 3/31/11	4/18/2012
2010-S-75	Unnecessary Managed Care Payments for Recipients with Medicare	4/18/2012
2010-S-73	Overpayments of Claims for Selected Professional Services	4/20/2012
2010-S-50	Overpayments for Services Also Covered by Medicare Part B	6/20/2012
2010-S-29	Recipients with Multiple Identification Numbers	7/24/2012
2010-S-66	Improper Managed Care Payments for Certain Medicaid Recipients	7/24/2012
2010-S-72	Rebates and Discounts on Physician-Administered Drugs	7/24/2012
2011-F-15	Recipients with Multiple Identification Numbers	8/13/2012
2012-F-9	Payments to Providers for Services to Recipients with Medicare Part C	9/6/2012
2010-S-47	Unnecessary Payments for Children at Voluntary Agencies	9/19/2012
2012-F-10	Improper Payments for Misclassified Patient Discharges	9/19/2012
2011-S-33	Overpayments for Medicare Part C Coinsurance Charges	9/26/2012
2012-F-8	Claims Processing Activity 4/1/09 – 9/30/09	9/26/2012
2010-S-76	Improper Payments Related to the Medicare Buy-In Program	10/26/2012
2012-F-11	Overpayments for Hospital Readmissions	10/26/2012
2012-F-27	Payments for Dental Consultations	11/27/2012
2011-S-28	Overpayments of Certain Medicare Crossover Claims	1/10/2013

<b>Report</b>	<b>Medicaid Audits</b>	<b>Date Issued</b>
2011-S-9	Claims Processing Activity 4/1/11 – 9 /30/11	1/10/2013
2012-F-26	Overpayments for Out-of-State Ambulatory Surgery Services	1/10/2013
2012-F-28	Payments for Nursing Home Bed Reserve Days	1/10/2013
2012-F-25	Overpayments for Non-Emergency Out-of-State Inpatient Services	3/11/2013
2011-S-29	Claims Submitted by Accordis for the Health and Hospitals Corporation	3/12/2013
2010-S-64	Suspicious and Fraudulent Payments to Affiliated Brooklyn Dentists	4/4/2013
2012-F-30	Payments for Excessive Dental Services	4/10/2013
2012-F-29	Excessive Payments for Services to Recipients Receiving Medicare	4/26/2013
2011-S-39	Claims Processing Activity 10/1/11 – 3/31/12	7/9/2013
2012-S-27	Overpayments for Services Also Covered by Medicare Part B	7/9/2013
2012-S-52	Improper Payments to a Dentist	7/15/2013
2010-S-30	Overpayments of Hospital Claims for Lengthy Acute Care Admissions	7/25/2013
2012-S-11	Fraudulent and Improper Claims Submitted by Davis Ethical Pharmacy	8/13/2013
2012-S-5	Payments for Death-Related One-Day Inpatient Admissions	8/15/2013
2013-F-11	Underreporting of Net Available Monthly Income for Nursing Homes	8/16/2013
2011-S-43	Overpayments of Ambulatory Patient Group Claims	8/20/2013
2013-F-1	Enhanced Medicaid Payments to Home Health Care Service Providers	9/5/2013
2013-F-2	Collection of Accounts Receivable	9/5/2013
2013-F-14	Overpayments of Claims for Selected Professional Services	9/23/2013
2012-S-24	Claims Processing Activity 4/1/12 – 9/30/12	10/9/2013
2013-F-15	Unnecessary Managed Care Payments for Recipients with Medicare	11/1/2013
2013-F-19	Overpayments to Cabrini Medical Center	11/7/2013
2013-F-21	Claims Processing Activity 10/1/08 – 3/31/09	12/12/2013
2013-F-26	Overpayments for Medicare Part C Coinsurance Charges	12/12/2013
2013-F-23	Rebates and Discounts on Physician-Administered Drugs	3/6/2014
2013-F-30	Overpayments for Services Also Covered by Medicare Part B	3/6/2014
2012-S-162	Coordination of Veterans' Health Care Benefits	3/19/2014
2012-S-160	Ancillary Services Provided During Hospital Inpatient Admissions	4/3/2014
2013-F-16	Payments for Medicare Part A Beneficiaries	4/4/2014
2012-S-133	Medicaid Payments Made Pursuant to Medicare Part C	5/9/2014

<b>Report</b>	<b>Medicaid Audits</b>	<b>Date Issued</b>
2012-S-131	Claims Processing Activity 10/1/12 – 3/31/13	5/22/2014
2014-F-1	Recipients with Multiple Identification Numbers	8/6/2014
2012-S-163	Multiple Same-Day Procedures on Ambulatory Patient Group Claims	8/12/2014
2013-S-57	Overpayments for Low Birth Weight Newborns	10/2/2014
2014-F-5	Unnecessary Payments for Children at Voluntary Agencies	10/23/2014
2013-S-51	Excessive Payments to Federally Qualified Health Centers	11/18/2014
2014-F-12	Improper Payments Related to the Medicare Buy-In Program	11/18/2014
2013-S-15	Improper Payments to a Physical Therapist	12/15/2014
2014-F-17	Overpayments of Certain Medicare Crossover Claims	12/22/2014
2014-S-5	Fee-for-Service Pharmacy Payments Covered by Managed Care	1/05/2015
2013-S-35	Overpayments for Medicare Part C Claims	1/16/2015
2014-F-7	Improper Managed Care Payments for Certain Medicaid Recipients	1/20/2015
2013-S-12	Claims Processing Activity 4/1/13 – 9/30/13	2/05/2015
2014-S-41	Payments for Controlled Substances that Exceed Dispensing Units	2/06/2015
2013-S-59	Medicaid Drug Rebate Program Under Managed Care	2/18/2015

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