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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

May 10, 2004

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: MMIS Provider Enrollment
Report 2003-S-5

Dear Dr. Novello:

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 audited the applicable controls at the Department of Health (Department) for ensuring that only eligible providers are rendering services to Medicaid recipients. Our audit covered the period January 1, 2002 through August 21, 2003.

A. Background

The Department administers the State's Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the federal Social Security Act to provide medical assistance to needy people. The Department's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS) and eMedNY, both of which are computerized payment and information reporting systems, to process Medicaid claims and pay providers for medical services they render to eligible Medicaid recipients. In New York, the federal, State and local governments jointly fund the Medicaid program.

The Department's Bureau of Medical Review and Payment and Enrollment (Bureau) are responsible for enrolling Medicaid providers. Department regulations specify that enrolled Medicaid providers of medical services must hold a proper and currently valid license, registration or certification issued by the State Education Department's (SED) Office of Professions. To maintain a license to practice in New York State, SED guidelines require licensees to re-register every three years; providers who are physicians or physician's assistants must re-register every two years. The re-registration process requires licensees to disclose any convictions, pending charges and/or disciplinary actions, and to state whether they have met all relevant continuing education requirements. Any practitioner who willfully refuses to register is subject to penalty, such as license

suspension or revocation. Department regulations also require that Medicaid providers submit a statement with their enrollment application that lists names and addresses of all persons who have an ownership interest in, or control of, the disclosing entity (e.g., the provider's professional practice), and whether the providers' employees or agents have been convicted of a criminal offense. Regulations require this information be provided with the application and every year thereafter.

The Bureau strives to ensure Medicaid payments are made only to properly qualified providers. To obtain this assurance, the Bureau obtains information from SED and other agencies (such as the Department of Transportation, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services) to verify that providers hold proper credentials. For example, the Bureau regularly receives updated information from SED that identifies newly licensed and re-registered providers.

The Bureau enrolls two types of providers: fee-based providers (e.g., physicians, pharmacists, medical appliance dealers and nursing services), who are paid a predetermined amount for each service rendered; and rate-based providers (e.g., nursing homes, home health agencies, clinics and hospitals) that are paid a specific Medicaid rate intended to cover all the services and procedures they deliver to a recipient. For the period January 1, 2002 through December 31, 2002, Medicaid paid 47,000 providers of both types a total of about $32 billion. Approximately $228 million of this amount was paid to 2,579 out-of-state providers.

B. Audit Scope, Objectives and Methodology

We audited applicable Department controls for enrolling Medicaid providers for the period January 1, 2002 through August 21, 2003. The objectives of our performance audit were to determine whether the Department enrolls only qualified providers in the Medicaid program and whether the Department ensures that the providers maintain their Medicaid eligibility.

To accomplish our objectives, we interviewed Department officials and reviewed applicable sections of federal and State laws and regulations. We reviewed provider enrollment applications to determine whether the Department followed existing guidelines and regulations when enrolling Medicaid providers. We also matched the Department's list of active Medicaid providers to licensing information received from SED to determine whether the Department took appropriate action to ensure Medicaid paid only currently enrolled and properly licensed providers. In addition, we used payment and provider information from MMIS and eMedNY to ascertain whether providers received or referred claims after their registration expired. Further, we determined whether a sample of 50 out-of-state providers met the requirements for enrollment in New York State's Medicaid program. Finally, we selected a random sample of 100 fee-based providers and 35 rate-based providers to test Department practices for enrolling Medicaid providers.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess Department operations within our audit scope. Further, these standards require that we understand the Department's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence-supporting transactions recorded in the accounting and operating records and applying such other auditing procedures, as we consider necessary in the circumstances. An audit

also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our efforts on those procedures and operations identified through our preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use our finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing procedures and operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

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, several of which are performed by the Division of State Services. 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 who 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 management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

Department regulations require providers to have a valid license, registration or certification to participate in the Medicaid program. However, in testing the Department's list of active Medicaid providers, we found that Medicaid had paid unlicensed and deceased providers for medical services because the Bureau does not effectively verify the status of enrollees' licenses. We also found the Department's application review process does not ensure applicants submit all the documentation required by relevant law and regulations. As a result of these weaknesses, Medicaid paid providers who did not have valid medical licenses. The absence of a current medical license makes such providers ineligible to participate in the Medicaid program, and raises questions about providers' fitness to deliver care to Medicaid patients.

1. Verification of Provider License and Disclosure Information

Department regulations specify that providers of medical services must hold a proper and currently valid license, registration or certification to be enrolled in the Medicaid program. However, when we reviewed Department control procedures intended to ensure Medicaid providers continue to meet enrollment requirements, we found these procedures were not adequate to detect unlicensed practitioners. Thus, we found the Department had paid some providers who had inactive or expired licenses (including some providers who were deceased), and other providers from out of state that did not meet Department enrollment criteria. Because it does not effectively verify the status of provider licenses, the Department paid at least $950,000 to providers with expired licenses

and at least $1.5 million for prescriptions written by providers with expired licenses in the 2002 calendar year.

To test whether the Department effectively verifies provider licenses, we obtained license information for the 101,700 fee-based providers identified as active in the Department's Medicaid files on MMIS and eMedNY, and matched this data to current license information we received from SED. As of June 26, 2003, the date we performed the match, we found that 7,680 of these 101,700 Medicaid providers had inactive or expired professional license registrations. Since the SED information identified providers with expired licenses, but not the date their licenses expired, we then tested to determine how long providers without a current license had been allowed to participate in the program. To do this, we identified the ending registration date for a randomly selected sample of 100 of the above 7,680 fee-based providers. We found that 83 of these 100 providers were enrolled in Medicaid for more than one year after their license had expired; in 12 of these cases, the provider's license had been expired for more than 10 years.

We also determined that some of these 7,680 providers received Medicaid payments for services they performed with expired licenses. We identified 325 providers with expired licenses who received $2.4 million in Medicaid payments during calendar year 2002. To find out whether these 325 providers had billed for services after their licenses had expired, we obtained ending registration date information from SED for the 50 providers in this group who had submitted the highest bills to Medicaid. These 50 providers' Medicaid claims totaled approximately $2.0 million for calendar year 2002. We found that 18 of the 50 providers received Medicaid payments totaling $950,000 (14,282 claims) for services they performed after their licenses had expired.

Similarly, we found that 2,941 of the 7,680 providers with expired licenses had prescribed over $14.3 million in medications. We obtained ending registration date information from SED for the 50 highest prescribing providers in this group, and found that 12 of these 50 providers had prescribed over 25,000 prescriptions, totaling more than $1.5 million, after their licenses had expired.

The licensing and re-registration information SED sends to the Department also identifies deceased providers, and their dates of death. Using this information, we examined the 7,680 providers with expired licenses and found 27 deceased providers who were listed as actively enrolled in the Medicaid program. According to available records, these 27 providers had died between 1988 and 2000. One provider, who died in July 1995, had received nearly $124,000 in Medicaid payments under his Medicaid identification number since the date of his death. Another provider, who died in December 1997, was recorded as the ordering physician for 659 Medicaid claims totaling over $104,000.

We also determined that the Department paid Medicaid claims from some out-of-state providers who did not meet Department enrollment criteria. The Department requires out-of-state providers to have current licenses and to be enrolled as Medicaid providers in their home states. In calendar year 2002, Medicaid paid approximately $228 million to 2,579 out-of-state providers. Of these 2,579 out-of-state providers, 113 providers received at least $1,000 in Medicaid payments. We judgmentally selected 50 of the 113 providers, which were selected based on the dollar value of services rendered and the location of the providers. We identified three providers whose home state licenses had expired. The Department paid one provider, whose license to practice medicine in

Massachusetts expired in July 1997, nearly $3,600 in 2002 for services rendered in Massachusetts; the second provider, whose license to practice in Pennsylvania expired in December 1998, received nearly $4,500 in 2002 for services rendered in Pennsylvania. The third provider, whose license to practice in Vermont expired in November 2002, did not receive any Medicaid payments after the expiration date.

As a result of these audit tests, we conclude the Department does not take adequate steps to ensure only providers with current licenses are enrolled in the Medicaid program. Although the Department currently receives updates from SED that show current licensing data, the Bureau does not use this data effectively to disenroll providers whose licenses have expired. Medicaid payments to unlicensed providers are inappropriate, and payments to deceased providers are payments of potentially fraudulent claims. Further, since the lack of a current license raises questions about a provider's fitness as a medical professional, paying such providers to deliver treatment could jeopardize the health of Medicaid patients.

We also found the Department has not enforced its regulation requiring enrolled providers to annually disclose names and addresses of parties with an ownership interest in their professional practices. Department officials contend that providers should have to update this information only when there is a change in ownership interest; in their opinion, affirmative reporting is of marginal utility to the Department and unduly burdensome for providers. Officials stated they plan to amend this regulation to modify the reporting requirement. However, we believe ownership changes may be unreported now because the Department does not enforce its regulation. The Department has also noted providers' lack of compliance with this reporting requirement in past re-enrollment efforts, along with other compliance issues. Some of these providers were ultimately terminated from the Medicaid program.

2. Review of Qualified Provider Enrollment Applications

Department regulations specify requirements for enrollment as a Medicaid provider. However, we found that Bureau procedures do not identify all the documentation applicants must submit or provide Bureau staff with adequate guidance about reviewing applications for completeness and accuracy. As a result, there is increased risk the Bureau may enroll providers who do not meet its minimum requirements for program participation.

Department policies require that providers submit certain types of documentation with their applications to demonstrate conformance with Department regulations. The documentation that is required depends, in part, on provider type (fee-based or rate-based). For example, the documentation fee-based providers must submit includes a Medicare Approval Letter; a balance sheet for the provider's business entity; and, for durable medical equipment (DME) providers, evidence that the Bureau completed a required site visit prior to enrollment. Bureau staff should also document their verification of applicants' disclosure of any illegal acts and/or professional restrictions, and their research to identify applicants who are already actively enrolled or are subject to Department sanction.

To determine whether the Bureau adequately reviews applications for completeness and accuracy before enrolling providers in the Medicaid program, we selected a random sample of 100

fee-based provider applications from among the 8,975 applications the Bureau received during calendar year 2002. Our test found the following exceptions:

- 1 provider did not include the Medicare Approval Letter;
- 1 provider did not include a balance sheet;
- 1 out-of-state provider who sought enrollment for only one date of service (June 20, 2002) was still enrolled as of June 15, 2003;
- 3 DME providers did not receive Bureau site visits prior to enrollment; and
- 66 provider enrollment files did not contain evidence that Department staff had verified provider enrollment status or existing sanctions; in 2 of these 66 instances, there was no evidence showing Department staff had appropriately addressed disclosures of illegal acts and/or professional restrictions.

Because the Bureau review process did not identify instances of missing documents or take appropriate action to investigate provider disclosures, the Bureau may have enrolled providers who do not meet its participation criteria. Further, the Bureau should not have allowed the out-of-state provider to have continuing participation status, since the Bureau cannot easily verify that such providers are properly licensed.

To restrict access to controlled substances to authorized medical providers, the federal Drug Enforcement Agency (DEA) requires manufacturers, distributors and dispensers of controlled substances to register with the DEA for the purpose of obtaining a DEA certificate and a federal identification number. Providers who meet these criteria should submit evidence of their DEA certificate, including federal identification number, with their application for Medicaid participation, or explain why they do not require a DEA certificate. To determine whether the Department ensures compliance with this federal requirement, we randomly selected a sample of 35 rate-based provider applications from among the 716 applications the Bureau received during calendar year 2002. Our test showed that 22 of the 35 sampled applicants did not submit DEA certificates or explanations with their applications; in addition, 3 of the 22 providers did not indicate a federal employer identification number. The Bureau did not adequately document what staff had done to determine whether the providers were required to produce this certificate. Bureau officials stated they would not hold up an enrollment for lack of a DEA certificate or an explanation of why it was not required. Subsequent Bureau research indicated 19 of the 22 applicants did not need a DEA certificate, but could not readily determine whether the remaining 3 providers needed certificates. Department officials stated that, in the future, they would require the DEA certificate or an explanation from the provider as to why it is not applicable.

We determined that the Department has not adhered to proper application review procedures for provider application procedures by testing a sample of 100 applications every month, as officials agreed to do in their response to the 2001 Single Audit. We determined that, for all of 2002, Bureau staff reviewed only 42 enrollment applications that were submitted during November 2002, instead of the 1,200 applications they agreed to test. Our work in this area revealed that enrollment procedures are not always sufficiently documented, which contributed to the findings we identified.

The Department should implement this prior audit recommendation to exert better control over the enrollment of Medicaid providers.

Recommendations

1. *Ensure active Medicaid providers comply with all requirements for continued enrollment in the Medicaid program, and address the instances of provider noncompliance identified in this report. At a minimum, Department actions should include:*

    - *developing policies and procedures to ensure that providers with expired professional license registrations and deceased providers are detected and their enrollment is terminated in a timely manner;*
    - *reviewing the list of providers with expired licenses, as reported in this audit, and terminating the enrollment of all providers whose licenses are not current;*
    - *recovering any Medicaid payments that may have been inappropriate;*
    - *determining who submitted claims using deceased providers Medicaid identification numbers; and*
    - *ensuring out-of-state providers comply with all requirements for enrollment in the Medicaid program.*

2. *Enforce regulations requiring providers to update their Disclosure of Ownership and Control Interest Statement annually.*

3. *To obtain complete and accurate information about providers who apply for Medicaid enrollment, develop formal written application review procedures for Bureau staff to follow, and monitor compliance with these procedures. These procedures should include:*

    - *an application-processing checklist by provider type, dated and initialed by the reviewer and supervisor, that identifies all the required documentation that is collected, and all required procedures that are completed prior to processing;*
    - *updated written criteria for performing on-site reviews of DME providers;*
    - *review for compliance with DEA requirements for rate-based providers; and*
    - *monthly audit of 100 fee-based applications to ensure review procedures are followed.*

We provided draft copies of this report to Department officials for their review and comment. We considered their comments in preparing this report. Department officials generally agreed with recommendations numbers one and three. However, they disagree with recommendation number two, stating that the current regulation is ineffective and that they intend to eliminate this requirement. A complete copy of the Department's response is included as Appendix A. Appendix B contains State Comptroller's Notes, which address matters of disagreement included in the Department's response.

Within 90 days after 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 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 therefor.

Major contributors to the report include Ken Shulman, William Clynes, Ed Durocher, Terry Smith, Bob Elliott, Casey O'Connor and Nancy Varley.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Steven E. Sossei
Audit Director

cc: Robert Barnes

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 27, 2004

Kevin M. McClune
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2003-S-5) entitled "MMIS Provider Enrollment."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2003-S-5 Entitled
"MMIS Provider Enrollment"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) draft audit report (2003-S-5) entitled "MMIS Provider Enrollment."

General Comments

18 NYCRR 504 does not require the Department to verify the ongoing status of a license. Under 18 NYCRR 504.3, by enrolling in the Medicaid program, an applicant agrees to comply with all the rules and regulations of the Medicaid program, one of which is maintaining a valid license registration. Responsibility for keeping an active license registration resides with the provider. Once the Medicaid Provider Enrollment Unit becomes aware that a provider's license registration has lapsed, they disenroll the provider. Information related to the status of these licenses/registrations is obtained from the State Education Department (SED) license file.

* *Note 1*

The rate-based providers' licensing information is not on the automated computer file sent to the Department of Health from the SED. This licensing information is currently received via paper from the appropriate licensing approval agencies and is manually loaded to the license area of the Medicaid provider file. In some cases the provider's category of service does not require an actual license; instead, the provider must enter into a contract, receive an approval or sign a provider agreement with the licensing agency, the approval authority or an individual county. The various rate-based provider licensing approval agencies include, but are not limited to, the following: Department of Health (DOH), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Alcoholism and Substance Abuse Services (OASAS), county Department of Social Services, Federal Centers for Medicare & Medicaid Services (CMS) and out-of-state licensing agencies.

With respect to comments in Section C.1. page 5, the Department disagrees with the contention that ownership updates would prevent ordering from parties using sanctioned or deceased provider information because ownership changes have no affect on ordering by someone using another's provider number. Additionally, it is unlikely that a practitioner group would report a sanctioned provider in their membership. Therefore, the Department believes that elimination of this requirement, and concentration on more focused, cost effective and efficient methods of provider credentialing is the proper strategy.

* *Notes 2, 3*

General Comments (continued):

Section C.2. page 5, notes exceptions relative to a provider not including a balance sheet and three DME providers that did not receive on-site inspections prior to enrollment.

Large and reputable entities may not need balance sheets, nor is an on-site inspection always needed, if the company is known to the Medicaid program. (NYCRR 504.1 states that the Medicaid program will contract with applicants who can demonstrate their ability to provide high quality care.) On-site inspections are not required and are considered only one of many tools used in an enrollment review. In addition, two of the three DME providers identified were for ownership changes not subject to on-site inspections.

With regard to the 66 provider enrollment files not containing evidence that staff had verified status or existing sanctions (i.e. marked "A/S"), 64 were clear of any sanctions or possible duplication of provider identification numbers and have been documented accordingly. Of the remaining two:

- The pharmacist that indicated on the enrollment application that his license had been revoked, suspended or restricted was enrolled without staff conducting the appropriate follow-up procedures at time of enrollment. Subsequently, a letter was sent to the New Hampshire Board of Pharmacy requesting information on the pharmacist in question. According to the board, the pharmacist was reprimanded with probation that ended in 1986. Since the pharmacist had no additional disciplinary actions taken against his license, the provider was not disenrolled.

- The reason for not addressing the issue of a DME provider that did not disclose a previous illegal action on his application was because this was previously addressed in 1993 when the provider first enrolled. This provider received a new number due to additional locators. The Quality Review & Appeals Unit did not need to re-review the past history, as stated on the history transaction sheet in the file.

The following comments are provided in response to OSC's specific recommendations.

Recommendation #1

Ensure active Medicaid providers comply with all requirements for continued enrollment in the Medicaid program, and address the instances of provider noncompliance identified in this report. At a minimum, Department actions should include:

i. developing policies and procedures to ensure that providers with expired professional license registrations and deceased providers are detected and their enrollment is terminated in a timely manner;

ii. reviewing the list of providers with expired licenses, as reported in the audit, and terminating the enrollment of all providers whose licenses are not current;

iii. recovering any Medicaid payments that may have been inappropriate;

Recommendation #1 (continued):

iv. determining who submitted claims using deceased providers Medicaid identification numbers; and

v. ensuring out-of-state providers comply with all requirements for enrollment in the Medicaid program.

Response #1:

i. The Department has relied on a systems interface with the SED for updated license registration data to terminate providers that are known to have an inactive license. As previously stated, maintaining an active license for continued enrollment is a provider responsibility. While this system historically has experienced problems, policies and procedures have been developed in eMedNY Phase II Joint Application Design (JAD) sessions to ensure that deceased providers and/or providers with expired licenses and registrations are detected and disenrolled in a timely manner. This will entail use of a fully automated system for this function, and will address the fact that current resources do not allow for the manual reviewing and updating of over 100,000 licensed practitioners in the Medicaid program.

ii. OSC's sample of 100 providers with expired license registrations was immediately addressed. The providers with expired licenses were changed to an inactive status in the Medicaid program.

iii. any identified payments made to these providers will be referred to Office of Medicaid Management's (OMM) Audit Unit for review and recovery, as appropriate.

iv. use of Medicaid identification numbers of two deceased providers will be referred to OMM's Audit Unit for review and action, as appropriate.

v. to ensure that all providers, in-state as well as out-of-state, comply with all requirements for enrollment in the Medicaid program, a checklist has been developed for fee-for-service providers. This checklist is used by both reviewers and supervisors. Checklists are being developed for the rate-based providers.

Recommendation #2:

Enforce regulations requiring providers to update their Disclosure of Ownership and Control Interest Statement annually.

Response #2:

The Department has found the current requirement to update Disclosure forms to be of marginal utility. The Department plans to amend this regulation by eliminating this ineffective and burdensome requirement as priorities permit.

* ***Note 2***

Recommendation #3:

To obtain complete and accurate information about providers who apply for Medicaid enrollment, develop formal written application review procedures for Bureau staff to follow, and monitor compliance with these procedures. These procedures should include:

i. an application–processing checklist by provider type, dated and initialed by the reviewer and supervisor, that identifies all the required documentation that is collected, and all required procedures that are completed prior to processing.

ii. updated written criteria for performing on-site reviews of DME providers.

iii. review for compliance with DEA requirements for rate-based providers.

iv. monthly audit of 100 fee-based applications to ensure review procedures are followed.

Response #3:

i. Checklists have been developed for practitioners and business entities and have been in use since October 1, 2003.

   OMM's Rate-Based Provider Unit already has formal written procedures. The Unit previously had an application-processing checklist for each provider type, but gradually changed to using the fields on the cover letter as the area to indicate the necessary, required information. This evolved since many providers did not read the checklist. Checklists are being reintroduced, in conjunction with the use of the cover letter and the implementation of eMedNY.

ii. There is no regulatory requirement for on-site reviews. However, if an on-site review is conducted, the reviewer completes a written questionnaire, an example of which was given to the OSC audit team.

iii. Many of the rate-based providers do not require a Drug Enforcement Agency (DEA) certificate, due to their enrollment category of service and the type of services they render. Of the 22 providers in the sample, 19 do not require a DEA certificate, due to their enrollment category of service. Of the three providers remaining, the policy has been to not delay the enrollment process, because the DEA certificate was not attached. This procedure was followed, due to the fact that during the certification process, the responsible office or agency inspects the provider and reviews all of the provider's credentials. If a DEA certificate is necessary, the provider must obtain one in order to be certified. In addition, the DEA monitors providers to ensure that all appropriate providers have current, valid certificates. In addition, many of the rate-based providers may be eligible to have a certificate but decide to contract pharmacy services to a community or chain pharmacy. Therefore, the providers would not need a DEA certificate. As a further control, OMM has started to request that the providers

* *Note 4*

* See State Comptroller's Notes, page 15

Response #3
iii. (continued):

either send in the copy of the certificate or submit an explanation stating why the certificate is not applicable.

iv. Staff has been assigned and have been conducting the internal audits of 100 applications monthly since September 2003.

State Comptroller's Notes

1. We agree that providers are ultimately responsible for maintaining an active license registration. However, the Department regulations establish a policy to provide all Medicaid recipients with high-quality health care. In pursuing this goal, the Department will contract with only those providers who can demonstrate that they can offer the needed medical services and supplies. We maintain that the Department needs to strengthen procedures to ensure that Medicaid providers continue to meet enrollment requirements subsequent to their initial enrollment as a provider. As documented in our report, we determined that 7,680 of the 101,700 Medicaid providers had inactive or expired professional licenses. We found 325 of these unlicensed providers received $2.4 million in Medicaid payments during calendar year 2002 and 2,941 of these providers prescribed over $14.3 million in medications. As such, we recommend that the Department take actions to ensure that active Medicaid providers comply with all requirements for continued enrollment in the Medicaid program.

2. We acknowledge that the Department plans to take action to amend the Disclosure of Ownership and Control Interest reporting requirement. Nevertheless, we maintain that there is a benefit to collecting information of this nature and agree with the Department's position that the collection of this information should be done in a cost effective and efficient manner. As stated in our report, companies that change owners may be unreported because the Department does not enforce its regulations. Until such time as the regulations are changed, we recommend that the Department collect this information.

3. Certain matters presented in the draft audit report were revised or deleted in this final audit report based on the agency response.

4. Department policies require a site visit prior to a durable medical equipment (DME) provider's Medicaid enrollment. We identified three DME providers who did not receive a site visit and as such we recommend that the Department take action to improve their oversight in this area. Additionally, Department policy requires that staff obtain a balance sheet before approving DME providers for Medicaid. In one instance we found that the Department did not obtain a balance sheet before approving the DME provider, as required by the Department's policy.