THOMAS P. DiNAPOLI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

September 6, 2019

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

Re: Managed Care Organizations:
Payments to Ineligible Providers
Report 2019-F-2

Dear Dr. Zucker:

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 have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report *Managed Care Organizations: Payments to Ineligible Providers* (Report 2016-S-59).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs.

Medicaid Managed Care Organizations (MCOs) must report accurate and timely encounter claims (claims from health care providers that MCOs paid) to the Department. Prior to September 2015, MCOs submitted encounter claims to the Department's eMedNY claims processing system. Generally, the Medicaid provider ID and National Provider Identifier (NPI), a unique identifier issued by the federal government to health care providers, were submitted on the encounter claim to identify the provider that rendered the service. However, many encounter claims lacked an NPI and were submitted using one of seven generic Medicaid provider IDs (based on service type). The Department had no means to identify the providers on these claims. As of September 2015, as part of the Department's implementation of its All-Payer Database, a new Encounter Intake System (EIS) began accepting encounter claims from Medicaid MCOs. Within the EIS, the system logic expects the claim's billing provider to be identified by its NPI or a secondary identifier, such as the health care provider's Medicaid provider ID, thus improving the Department's

ability to identify providers rendering care to Medicaid recipients.

Medicaid providers who violate statutory or regulatory requirements related to the Medicaid or Medicare programs or who have engaged in other unacceptable insurance practices face possible sanctions, such as exclusion or termination from the Medicaid program. The State's Office of the Medicaid Inspector General (OMIG) and the U.S. Department of Health and Human Services' Office of Inspector General (OIG), for instance, have the authority to exclude individuals and entities found to be in violation of statutory or regulatory requirements. Providers that are excluded or terminated from Medicaid are not eligible to receive payments from MCOs for services rendered to Medicaid recipients.

Under the Medicaid Managed Care Model Contract (Model Contract), MCOs are responsible for determining the exclusion status of providers, reporting payments made to ineligible providers, and recovering improper payments. OMIG, OIG, and the Department's Office of Professional Medical Conduct (OPMC), among other authorities, maintain lists of ineligible providers, which can be used by MCOs to prevent improper payments. Additionally, Centers for Medicare & Medicaid Services (CMS) guidelines state that a deactivated NPI should not be used to submit encounter claims, as they will result in improper payments. Since 2007, CMS has disseminated NPI data, including deactivated NPIs, via the Internet for MCOs to verify the NPI activation status of providers in their networks.

MCOs are also required to submit provider network data quarterly to the Department's Provider Network Data System (PNDS), and the Department evaluates that data to identify any MCO network providers that have been identified as ineligible by federal and State authorities or otherwise deemed inactive. From these analyses, the Department produces quarterly Sanction Provider Reports. As part of its oversight activities, the Department's Bureau of Managed Care Certification and Surveillance (BMCCS) sends notifications, along with a list of the sanctioned providers, to the MCOs.

The 21st Century Cures Act, enacted by the U.S. Congress in 2016, required all managed care network providers to enroll in the State's Medicaid program by January 1, 2018. Providers not enrolled by that date were to be removed from the Medicaid program. During the enrollment process, the Department checks the status of network providers against State and federal databases, including the databases of excluded providers maintained by OMIG and OIG. The Department updates the list of active Medicaid providers as well as a list of pending providers' enrollment and publishes these lists bimonthly on Open Data NY, a public database of State policies, programs, and tools.

We issued our initial audit report on February 26, 2018. The audit objective was to determine whether the Department and MCOs had adequate processes in place to prevent payments to ineligible providers and whether improper payments were made to ineligible providers. Our audit covered the period January 1, 2012 to December 31, 2016.

Our initial audit found that the Department launched efforts to improve its ability to detect and prevent payments by MCOs to ineligible providers. However, we also identified certain weaknesses in Department and MCO processes that, if improved, could increase

their ability to detect and prevent improper payments to ineligible providers. During the audit period, we determined MCOs improperly paid $50.3 million: $37.6 million for 379,761 claims paid to ineligible health care providers and $12.7 million for 198,515 claims paid to pharmacies where the prescribing physician was excluded from the Medicaid program or otherwise ineligible for Medicaid payments. We also identified 22.5 million MCO encounter claims (totaling over $2 billion) that lacked the provider identification information needed to assess the appropriateness of payments.

The objective of our follow-up review was to assess the extent of implementation, as of July 10, 2019, of the eight recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made progress in addressing the problems we identified in the initial audit report; however, additional action is needed. Of the initial report's eight audit recommendations, two were implemented, five were partially implemented, and one was not implemented.

Follow-Up Observations

Recommendation 1

Review the MCO payments to ineligible providers that we identified, and instruct the MCOs to recover improper payments where appropriate. Ensure the MCOs timely recover the inappropriate payments and properly account for the recoveries on their Medicaid Managed Care Operating Reports (MMCORs).

Status – Partially Implemented

Agency Action – Our initial audit found that MCOs made $50.3 million in payments to providers who were excluded from the Medicaid program or were otherwise ineligible to receive Medicaid payments. At the conclusion of our initial audit, we provided the Department with the claim details supporting our findings.

In April 2019, after we initiated our follow-up review, the Department distributed the findings data to the MCOs for review. The Department is in the process of compiling the responses from the MCOs and plans to forward the information to OMIG for review and to ensure the MCOs report the recoveries on their MMCORs. We note that, of the $50.3 million in audit findings, $7.2 million of the improper payments (14 percent) represented dates of services between January 1, 2012 and June 30, 2013. Due to federal look-back provisions, these payments may no longer be recoverable. We encourage the Department to take prompt action to avoid any loss of recoveries.

Recommendation 2

Obtain the missing provider IDs on the encounter claims we identified that lacked this information. Take the appropriate steps to assess the propriety of these claims and recover any improper payments.

Status – Partially Implemented

Agency Action – Our initial audit identified 22.5 million MCO encounter claims that lacked the provider IDs needed to assess the propriety of payments. Department officials stated they obtained the provider IDs for 19.3 million encounter claims and, in March 2018, sent the information to OMIG to facilitate its review of the appropriateness of these payments. OMIG is still working on this review and was unable to provide a timeline for completion. The Department also explained that the MCOs were unable to provide information for the remaining 3.2 million encounter claims because some encounters were associated with MCOs that were no longer in business, and some provider ID numbers were not consistently maintained in the MCOs' claims systems prior to the 2015 implementation of the All-Payer Database.

Recommendation 3

Ensure the MCOs use all available federal and State databases during ineligible provider payment reviews, including reviews of claims that lack billing provider IDs.

Status – Partially Implemented

Agency Action – In our original audit, we found MCOs did not use certain State and federal databases for ineligible provider reviews because they were not explicitly required to do so by the Model Contract.

Following our initial audit, implementation of the 21st Century Cures Act requires Medicaid MCO network providers to undergo monthly sanction checks against mandated federal and State databases. Providers found in any of these databases are subsequently removed from the active Medicaid provider enrollment file. This file is published bimonthly on Open Data NY and is accessible to all MCOs to verify the status of providers in their networks and identify any corresponding improper payments. However, the Department was unable to demonstrate what steps it has taken to ensure MCOs utilize Open Data NY or the other federal and State databases.

In addition, our follow-up review found limitations with Open Data NY that could allow payments to ineligible providers. For example, we compared the provider listing on Open Data NY as of April 15, 2019 to the April 9, 2019 federal deactivated NPI list disseminated by CMS. We found 83 providers active in Open Data NY that had deactivated NPIs per the federal list, and two MCOs made combined payments of $21,310 to one of the deactivated providers.

Recommendation 4

Notify each MCO of all ineligible providers included in the Sanction Provider Reports.

Status – Implemented

Agency Action – In our initial audit, we identified Medicaid payments to providers listed on

the Department's Sanction Provider Report. We found that the Department would only notify an MCO about a provider on the Sanction Provider Report if that MCO had included that provider on its quarterly PNDS submission. After our initial audit, the Department started sharing all the results of the Sanction Provider Reports produced from all MCOs' PNDS submissions with all MCOs.

Recommendation 5

Increase the frequency of BMCCS's notifications to MCOs regarding ineligible providers.

Status – Implemented

Agency Action – In response to our audit, in the second quarter of 2017, the Department increased the frequency of the BMCCS notifications to the MCOs from semi-annually to quarterly.

Recommendation 6

Perform routine audits of encounter claims that include matches against all available federal and State databases in order to identify payments to ineligible providers.

Status – Not Implemented

Agency Action – In our original audit, we found that OMIG's review of encounter claims for one of two MCOs we selected did not identify certain excluded prescribers on OPMC lists and two deceased prescribers reported in eMedNY. As part of our follow-up review, we determined that OMIG did not have any ongoing or recently finalized audits with the objective of identifying payments to ineligible providers.

Recommendation 7

Ensure historical provider exclusion information for MCO network providers is maintained by the Department and accessible by all MCOs.

Status – Partially implemented

Agency Action – According to Department officials, beginning in the fourth quarter of 2018, the Department started retaining quarterly Sanction Provider Reports from PNDS submissions for historical purposes. However, as described in our original report, use of the Sanction Provider Report for the purposes of identifying improper payments to excluded providers is limited. OMIG also maintains an exclusion list, which is updated daily, on its website. However, the exclusion list does not contain all historical provider exclusion information. For example, if a health care provider is subsequently removed from OMIG's exclusion list (i.e., the exclusion was temporary), the historical information about the provider's exclusion is no longer listed. According to OMIG officials, historical provider exclusion information can be provided to MCOs on a case-by-case basis, upon request. However, this level of accessibility is inadequate for MCOs to use for comprehensive reviews of the appropriateness of payments to providers.

Recommendation 8

Monitor the adequacy of MCOs' retrospective analyses and recoupment of ineligible provider payments.

Status – Partially Implemented

Agency Action – After our initial audit, the Model Contract was updated and now requires MCOs to submit a quarterly Provider Investigative Report (PIR) to OMIG. According to OMIG officials, they use the PIR to monitor the adequacy of MCOs' retrospective analyses and recoupment of inappropriate payments made to ineligible providers. However, the PIR is currently used to report Medicaid overpayment recoveries in general, not just payments made to excluded providers. According to OMIG officials, the report is currently being updated to make the data more useful for monitoring MCO recoupments from ineligible providers.

Major contributors to this report were Salvatore D'Amato, Mostafa Kamal, and Linda Thipvoratrum.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Ms. Jessica Lynch, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General