New York State Office of the State Comptroller

Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Managed Care Organization Fraud and Abuse Detection

Medicaid Program

Department of Health

Executive Summary

Purpose

To determine if United HealthCare and Amerigroup made payments to ineligible health care providers and whether these managed care organizations established and implemented adequate Special Investigation Units to detect, prevent, and follow up on instances of fraud and abuse. Our audit covered the period January 1, 2011 through December 31, 2014.

Background

Through its Medicaid managed care program, the Department contracts with managed care organizations (MCOs) to coordinate the care for enrolled Medicaid beneficiaries. In exchange, MCOs receive a monthly premium payment for each enrollee. In 2014, New York State's Medicaid claim costs totaled more than $51 billion, of which managed care premiums comprised nearly $27 billion. Based on December 2014 data, Medicaid managed care provided coverage to 4.7 million members of the over 6 million enrolled in Medicaid. At the time of the audit, there were 53 MCOs that offered 81 different plans; United HealthCare (UHC) and Amerigroup were among the largest plans.

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 the majority of Medicaid services and enrollees to managed care could increase managed care's share of Medicaid expenditures to 90 percent or higher by the end of 2016.

Despite this operational shift, the State remains legally responsible for ensuring that MCOs comply with State and federal Medicaid regulations. For example, State oversight of MCOs must ensure that: enrollees receive needed services; MCOs fulfill contractual obligations for program quality; only eligible health care providers and enrollees participate in Medicaid; and MCOs report accurate and timely encounter claims (claims from providers that MCOs paid) and enrollee, provider, and financial data. Correspondingly, MCOs are responsible for ensuring that managed care payments are not made to ineligible health care providers. In addition, MCOs are required to have effective compliance programs, including full-time Special Investigation Units (SIUs) dedicated solely to the prevention, detection, and investigation of fraud and abuse.

Key Findings

- During our audit period, UHC and Amerigroup made improper and questionable payments totaling more than $6.6 million attributable to providers who were excluded from the Medicaid program. Initially, our audit testing identified $1.1 million (of the $6.6 million) in payments related to such providers. For instance, payments totaling $57,568 were made to pharmacies for medications that were prescribed by providers (physicians) who were deceased on the dates the prescriptions were purportedly written. In another example, $43,217 was paid to a pharmacy that was excluded from Medicaid due to abusive billing practices. Also, through our initial testing, we were unable to determine the full extent of MCO payments attributable to excluded providers because many MCO encounter claims (totaling about $445 million) lacked certain information. Therefore, we shared our findings with the Department, which performed

a supplemental review of a portion of these deficient claims and identified an additional $5.5 million in questionable payments attributable to excluded providers.

• Recoveries of improper payments by UHC's and Amerigroup's SIUs were very limited. For example, while the premiums paid to UHC increased annually, from approximately $930.9 million in 2011 to more than $1.4 billion in 2013, its recoveries actually decreased each year – and in 2013, its SIU recovered only $58,500 from fraud and abuse detection activities. We further note that both MCOs underreported their SIU recoveries to the Department. Additionally, there may be a disincentive for MCOs to report these recoveries because they are factored into the premium rate calculation and could result in reduced premiums.

• There is considerable risk that UHC and Amerigroup did not adequately staff their SIUs. With minimal staffing, the MCOs had limited ability to identify and recover fraudulent and improper payments, which increased the risk that Medicaid paid for improper claims. To illustrate, in 2013, UHC enrolled about 444,000 Medicaid recipients and paid about 15.2 million encounter claims. The same year, Amerigroup enrolled about 514,000 recipients and paid about 16.6 million encounters. Despite these high transaction volumes, UHC's and Amerigroup's SIUs had only 1.74 and 2.58 full-time equivalent staff, respectively, dedicated to New York's Medicaid program.

• New York's Medicaid program has no specific requirements or criteria for SIU staffing levels. However, New Jersey, for example, required its MCOs to maintain a minimum investigator-to-enrollee ratio of at least 1:60,000. In comparison, in 2013, UHC's ratio was 1:255,234 and Amerigroup's ratio was 1:199,173 for New York State Medicaid. Thus, the amount of staff that UHC and Amerigroup dedicated to SIU work was proportionally far less than New Jersey's program.

• The SIU staff at both MCOs received inadequate annual training.

Key Recommendations

We made 11 recommendations to the Department, including:

• Ensure improper MCO payments to ineligible providers are appropriately recovered, determine if the MCOs' recoveries have an impact on the monthly managed care premium rate calculations, and adjust the premiums as appropriate.

• Strengthen steps to oversee and monitor MCOs to ensure that only eligible providers are reimbursed.

• Take steps to establish appropriate criteria for SIU staffing levels, adequate training requirements for the SIU staff, and a process for ensuring consistency and accuracy in reporting SIU activities and recoveries.

Other Related Audits/Reports of Interest

Department of Health: Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care (2014-S-5)
Department of Health: Improper Managed Care Payments for Certain Medicaid Recipients (2010-S-66)

**State of New York
Office of the State Comptroller**

Division of State Government Accountability

July 15, 2016

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Medicaid Managed Care Organization Fraud and Abuse Detection*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

Medicaid is a federal, state, and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The New York State Medicaid program is administered by the Department of Health (Department). Through its Medicaid managed care program, the Department contracts with managed care organizations (MCOs) to coordinate the care for enrolled members. In exchange, MCOs receive a monthly premium payment for each enrollee. For the year ended December 31, 2014, New York State's Medicaid claim costs totaled over $51.3 billion, of which managed care premiums comprised $26.8 billion, including long-term managed care. Based on December 2014 data, Medicaid managed care provided coverage to 4.7 million members of the over 6 million enrolled in Medicaid. At the time of the audit, there were 53 Medicaid MCOs that offered 81 different plans, and United HealthCare (UHC) and Amerigroup were among the largest plans.

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 the majority of Medicaid services and enrollees to managed care by 2016 could increase managed care's share of Medicaid expenditures to 90 percent or higher. Claims management will be decentralized, with most claims processed in proprietary systems maintained by the MCOs.

Despite these operational shifts, 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 State Plan. For example, State oversight of MCOs must ensure that: enrollees receive needed services; MCOs fulfill contractual obligations for program quality and financial viability; only eligible health care providers and enrollees participate in Medicaid; and MCOs report accurate and timely encounter claims (claims from providers that MCOs paid) and enrollee, provider, and financial data. In addition, currently, provider credentialing is primarily conducted by MCOs. However, there are proposed changes to Medicaid regulations that would require the State to enroll all MCO network providers who are not otherwise enrolled with the State to provide services to Medicaid beneficiaries on a fee-for-service basis. Under fee-for-service, health care providers submit Medicaid claims for services rendered to Medicaid-eligible recipients directly to the Department's eMedNY computer system, which then processes the claims and generates payments to reimburse the providers for their claims.

Various rules and regulations require MCOs to have an effective compliance program to participate in the Medicaid program. For instance, New York Codes, Rules and Regulations (NYCRR) Title 10, Part 98, Section 1.21 requires MCOs to establish a full-time Special Investigation Unit (SIU) dedicated solely to the prevention, detection, and investigation of fraud and abuse. Furthermore, under the Department's Medicaid managed care model contract, those MCOs with more than 10,000 enrollees in a given year must also have a fraud and abuse prevention and detection plan (Compliance Plan). Additionally, MCOs must also have adequate systems in place to identify providers who have been terminated or excluded from the Medicaid program, deny their claims, and thus prevent improper payments.

Audit Findings and Recommendations

MCOs must prevent improper payments to ineligible providers. MCOs are also required to establish SIUs to investigate fraud and abuse. We found that neither of the MCOs we reviewed adequately ensured that payments to ineligible providers were prevented. We also found that the MCOs did not have adequate SIU programs to detect, prevent, and follow up on instances of apparent fraud and abuse.

During the four-year period January 1, 2011 through December 31, 2014, UHC and Amerigroup made improper and questionable payments totaling more than $6.6 million attributable to providers who were excluded from Medicaid program participation. Additionally, for the period January 1, 2011 through December 31, 2013, we identified inadequacies in both MCOs' SIU staffing and the training provided to SIU staff. We determined there are few specific regulations or policies telling MCOs how to establish SIUs and otherwise little incentive for MCOs to invest in their SIU staff to ensure effective claims investigation and improper payment recovery. Further, we determined that the MCOs did not accurately report recoveries resulting from fraud, waste, and abuse to the Department.

Identification of Terminated and Excluded Providers

MCO Payments to Ineligible Providers and Prescribers

Payments to Terminated and Excluded Providers

With the State's operational shift to providing Medicaid services under managed care, MCOs have a greater responsibility for ensuring that managed care payments are not made to ineligible health care providers. To handle this responsibility effectively, MCOs must have adequate resources and procedures to identify providers who have been excluded or terminated[1] from the Medicaid program, deny their claims, and thus prevent improper payments. For the four years ended December 31, 2014, we found that UHC and Amerigroup made improper and questionable payments totaling $862,258 to such ineligible providers.

Medicaid providers who have violated statutory or regulatory requirements related to the Medicaid or Medicare programs or who have engaged in other unacceptable insurance practices face possible sanctions by the Department, including exclusion or termination from the Medicaid program. OMIG and the Department each maintain lists of excluded and terminated providers (hereafter referred to as excluded providers).

OMIG publishes a continually updated list, called the NYS Medicaid Exclusion List, on its website,

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[1] The State Office of the Medicaid Inspector General (OMIG) and the U.S. Department of Health & Human Services Office of Inspector General (OIG) have the authority to exclude individuals and entities from certain state and federal health care programs, including Medicaid. When providers are "excluded" from Medicaid, they are no longer eligible to receive managed care payments from MCOs participating in the program. The Department assigns the status of "terminated" to any provider who was excluded from participation by the OMIG or the OIG, or who was terminated from participation for reasons other than exclusion, such as an expired professional license.

and the Department maintains a comprehensive file of excluded fee-for-service providers, called the Enrollment Status File, in its eMedNY Medicaid claims processing system. The Department's Enrollment Status File includes providers from OMIG's list as well as other sources, including OIG's List of Excluded Individuals and Entities (LEIE), and providers identified by the Department's Office of Professional Medical Conduct. The Enrollment Status File is used to deny fee-for-service claim payments to excluded providers. The Department also maintains a Prescribing Physician Exception List, which indicates the status (e.g., excluded, deceased) of prescribing physicians. Department officials stated they use the prescribing physician status information to flag claims for further review, as opposed to an automatic denial of claims.

MCOs have access to OMIG's list, but not the Department's Enrollment Status File. To ensure MCOs do not pay claims for services rendered by ineligible providers, on a monthly basis, the Department requires MCOs to check their active network of providers against OMIG's excluded provider list as well as various other federal and State databases. In addition, the MCOs are required to use OMIG's excluded provider list and the other sources to create and update their own comprehensive list of excluded providers.

As previously stated, the Department's Enrollment Status File includes providers from OMIG's list as well as additional sources. Using the provider information from the Enrollment Status File, we analyzed certain UHC and Amerigroup encounter payments to determine whether the MCOs paid claims from providers who the Department identified as having Medicaid participation restrictions. For the four years ended December 31, 2014, we found that UHC and Amerigroup made improper payments totaling $862,258 to ineligible providers (UHC paid 6,954 encounters totaling $400,916, and Amerigroup paid 9,705 encounters totaling $461,342). See Table 1 for the reasons for the improper payments.

Table 1 – MCOs' Improper Payments

Provider Enrollment Status	UHC		Amerigroup	
	Amount Paid	Number of Encounters	Amount Paid	Number of Encounters
Excluded/Terminated	$320,211	6,101	$291,395	8,258
Terminated: Deceased	2,165	71	1,682	15
License Expired, Revoked	76,499	734	158,769	1,261
Pending: Provider Ineligible to Receive Payment	2,041	48	9,496	171
Totals	$400,916	6,954	$461,342	9,705

We determined that UHC's and Amerigroup's systems for preventing payments to excluded providers were not working as intended. Had adequate procedures been in place, improper claims would not have been paid.

We compared UHC's and Amerigroup's excluded provider lists with the Department's Enrollment Status File and found that the MCOs' lists were incomplete. For example, in August 2008, OMIG excluded a pharmacy from the Medicaid program because of its abusive billing practices.

Specifically, pharmacy staff billed Medicaid for prescription drugs that were not dispensed and dispensed prescription medications for cash without the patient presenting a prescription. OMIG's sanction letter prohibited the provider from "being involved in any activity relating to furnishing medical care, services or supplies to Medicaid recipients for which claims are submitted to the Medicaid program." Nonetheless, we determined that this pharmacy submitted claims to both UHC and Amerigroup during the sanction period (August 2008 to September 2013). Neither MCO updated its list to exclude this provider, and thus, both MCOs paid the claims. UHC reported 439 encounter payments totaling $24,708, and Amerigroup reported 595 encounter payments totaling $18,509.

We also found providers from OMIG's list who were excluded by one MCO, but were paid by the other MCO during the exclusion period. For example, a provider who was excluded by OMIG on November 13, 2011 was on Amerigroup's excluded provider list, and Amerigroup did not make any payments to this provider during the exclusion period. However, UHC's excluded list did not contain this provider, and UHC paid the provider $4,346 for 136 claims during the exclusion period.

In addition to the incompleteness of UHC's and Amerigroup's excluded provider lists, we determined Amerigroup paid 416 encounters totaling $24,290 to four excluded providers even though the providers were on the MCO's excluded provider list. When presented with this information, Amerigroup officials agreed they should not have paid these claims and stated they would take the necessary steps to recover the payments.

We provided the encounter claims totaling MCO payments of $862,258 to the Department for review. The Department matched the encounter claims against its listing of excluded, sanctioned, and terminated providers generated from data maintained by OMIG, OIG, and the Department's Office of Professional Medical Conduct. According to Department officials, 2,090 of the UHC encounter claims totaling $163,998 and 3,825 of the Amerigroup encounter claims totaling $150,181 were paid appropriately. However, we further examined the encounters the Department believed were paid appropriately, and concluded there was considerable risk that many of those payments were improper.

Using other available information, obtained from the eMedNY system and State professional licensing websites, we determined that during the time the claims were paid, the providers were either excluded by OMIG, had stipulations which limited them to providing particular services, or had expired licenses. For example, as noted previously, OMIG excluded a pharmacy in August 2008 because of its abusive billing practices. However, during the exclusion period, UHC and Amerigroup collectively reported 1,034 encounter claims in the amount of $43,217. In addition, Amerigroup reviewed the 3,825 encounter claims (totaling $150,181) that the Department believed were properly paid and confirmed that 428 of the claims totaling $23,232 were, in fact, improperly paid. (UHC did not similarly provide results of a separate review of the claims we identified.) As such, the Department should further investigate all improper payments we identified and take action to recover those amounts, as appropriate.

Payments for Pharmacy Claims Ordered by Excluded Prescribers

As stated previously, the Department maintains a Prescribing Physician Exception List, which indicates the status (e.g., excluded or deceased) of prescribing physicians. Unlike the Department, UHC and Amerigroup did not maintain separate lists of excluded prescribing physicians for Medicaid. Rather, both MCOs based their reviews of prescribing physicians on their comprehensive lists of excluded providers.

To determine if pharmacy encounter claims were appropriate, we compared UHC's and Amerigroup's prescribing provider information with the Department's Prescribing Physician Exception List and the Enrollment Status File. As a result, we found UHC and Amerigroup paid pharmacy encounters for prescriptions that were written by ineligible prescribers as of the prescription order date, as follows.

- UHC made improper and questionable payments to pharmacies totaling $172,452, including:
  - 4,859 encounter claims totaling $133,449 due to disqualified/suspended prescribers
  - 764 encounter claims totaling $39,003 due to deceased prescribers
- Amerigroup made improper and questionable payments to pharmacies totaling $135,470, including:
  - 2,796 encounter claims totaling $116,905 due to disqualified/suspended prescribers
  - 562 encounter claims totaling $18,565 due to deceased prescribers

According to Department officials, a majority of these claims (5,437 of the UHC claims totaling $167,184 and 2,009 of the Amerigroup claims totaling $96,382) were properly paid by the MCOs. We disagree, however, as we arrived at our findings by identifying pharmacy encounter claims for prescriptions that were written by disqualified prescribers according to the Prescribing Physician Exception List and who were also identified as terminated according to the Enrollment Status File. Therefore, these providers should not have prescribed drugs for Medicaid recipients or received any payments from the MCOs. Furthermore, a review by Amerigroup confirmed that 1,154 claims (totaling $60,053) of the 2,009 claims (totaling $96,382) that the Department believed to be properly paid were, in fact, improperly paid. (Note: UHC did not provide the results of a separate review of the claims we identified.) As such, the Department should further investigate all improper payments we identified and take action to recover those amounts, as appropriate.

We found that a lack of communication and coordination between the Department and the MCOs contributed to the improper payments to the excluded providers and prescribers. We determined the MCOs did not have access to the Department's Enrollment Status File. Department officials, however, do not believe that the Enrollment Status File should be used to determine the excluded status of managed care providers and prescribers, as this file applies specifically to fee-for-service payments. Officials further stated that MCOs should rely on the listing of excluded providers available from the OMIG, the federal LEIE list, and the Department's Office of Professional Medical Conduct to determine which providers should be excluded from payments in managed care programs. However, based on the exceptions we identified, we concluded that the MCOs did not use these multiple sources adequately. We determined that the Enrollment Status File was useful,

and the exceptions we identified demonstrate that information on the Enrollment Status File can help identify additional questionable providers. The Department should make this information available to the MCOs so that there is greater assurance that MCOs maintain a network of eligible providers and that inappropriate payments are not made to excluded providers.

We also found that the Department needs to strengthen its oversight of the MCOs' matching of its providers with the various exclusion databases. Department officials stated they currently monitor MCO actions pursuant to exclusion database matches through the Department's bi-annual Comprehensive Operational Surveys, one of which took place in March 2014. These surveys include reviews of MCO policies and procedures and compare MCO provider networks with certain exclusion lists. As a result of the surveys, the Department: notifies MCOs of excluded providers in their networks; advises the MCOs to assess these providers; and then advises MCOs to prohibit excluded providers from providing care to the MCOs' Medicaid enrollees.

Although the Department examined the program integrity activities of the MCOs in 2014 and reviewed the steps the MCOs took to address payments to excluded providers, we noted no significant reduction in payments to excluded providers in 2014. In two cases, for example, even though the Department notified the MCOs that certain providers should be excluded, the MCOs still made payments to those providers. Furthermore, in reviewing one of the Department's quarterly comparisons of MCO network providers with the excluded provider lists, we noted that 13 of the excluded providers we identified in Table 1 (which was based on our review of the Enrollment Status File) were not included on the Department's notifications to the MCOs. This occurred because the Department did not use the Enrollment Status File to monitor MCO provider networks. The Department's oversight process would be enhanced if it used the Enrollment Status File to help monitor the MCOs.

Providers Without Medicaid Identification Numbers

We were unable to determine the full extent of MCO payments made to excluded providers during our audit period because UHC and Amerigroup, collectively, submitted more than 7.2 million encounter claims (totaling over $445 million) that contained incomplete or otherwise untraceable provider information. We provided the results of our review to Department officials, who performed a supplementary review of a portion of these claims (totaling $340 million) and identified $5.5 million in questionable payments to excluded providers. The following narratives detail the results of the reviews.

- 6,089,810 encounter claims submitted by the two MCOs did not contain Medicaid billing provider identification numbers (IDs) and/or provider names. UHC paid more than 3.3 million encounter claims totaling over $122 million, and Amerigroup paid more than 2.7 million encounter claims totaling more than $218 million that were missing this important information. We provided these encounter claims to Department officials for their review. Using National Provider Identifier codes (NPIs), officials matched the 3.3 million UHC encounter claims against its listing of excluded providers and identified 214 questionable providers whom UHC paid over $2.5 million for 53,276 claims. At the time of our audit fieldwork, Department officials indicated that they would share their results with UHC

and instruct UHC to review and recover improper payments where appropriate. The Department also performed a similar match with Amerigroup's encounter claims and identified 382 questionable providers who were paid for 59,710 claims totaling over $3 million. The Department will share its results with Amerigroup as well for review and recovery of any improper payments.

- 1,252,578 encounter claims contained generic billing provider IDs (such as one common billing ID generated for out-of-state pharmacies) and for which NPIs were unavailable. UHC paid 911,568 encounter claims totaling more than $92 million, and Amerigroup paid 341,010 encounter claims totaling more than $13.8 million. We provided these claims to Department officials, who agreed to review them and determine whether any of the payments were made to excluded providers and should be recovered.

Although Medicaid IDs are not required for participation in MCO provider networks, monitoring could be enhanced by requiring providers to have Medicaid IDs. As such, Department officials are pursuing changes to Medicaid regulations that would require the State to enroll all MCO network providers.

Recommendations

1. Review the MCO payments to ineligible providers that we identified and direct UHC and Amerigroup to recover the payments as appropriate.

2. Complete the review of the 7.2 million encounter claims, totaling over $445 million, that contained incomplete or otherwise untraceable provider information to determine if the MCOs made payments to ineligible providers, and instruct the MCOs to review and recover improper payments where appropriate.

3. Determine the impact that UHC's and Amerigroup's recoveries have on the managed care premium calculations, and adjust the premium rates accordingly.

4. Strengthen steps to oversee and monitor MCOs to ensure that providers who are not eligible for reimbursement are removed from MCO provider networks so that only eligible Medicaid providers are reimbursed. These steps should include (but not be limited to):

   - Utilizing all available eMedNY information, including information contained on the Enrollment Status File;
   - Sharing the Enrollment Status File information with the MCOs;
   - Updating the Enrollment Status File to include all providers within MCOs' provider networks, including those who do not have a Medicaid ID; and
   - Continuing pursuit of changes to Medicaid regulations that would require the State to enroll all MCO network providers in Medicaid (thereby requiring network providers to have Medicaid IDs).

Special Investigation Unit Activity

Amount of Unit Staff

Under both the NYCRR and the Department's Medicaid managed care model contract, MCOs are required to establish SIUs to investigate fraud and abuse. Although neither the regulation nor the managed care contract establishes specific requirements or criteria for determining SIU staffing levels (e.g., a specific investigator-to-enrollee ratio), NYCRR Title 10, Part 98 states that MCOs should use some objective criteria, such as number of beneficiaries, number of claims, or suspected fraudulent claims, to create an SIU that is sufficiently staffed to ensure optimal effectiveness of its fraud and abuse prevention and detection plan (Compliance Plan). We determined that in the absence of any contractual requirements or regulations mandating specific SIU staffing levels, MCOs have little incentive to maintain staffing at levels that can effectively prevent, detect, and investigate fraud and abuse. We found this to be the case with both UHC and Amerigroup, two of the largest MCOs in the State's Medicaid program.

In each year from January 2011 through December 2013, UHC's SIU had fewer than two full-time equivalent (FTE) investigators dedicated to the New York Medicaid program, and in 2011 and 2012 had no individual investigators dedicated to the Medicaid program on a full-time basis. Amerigroup had a total of approximately two to three and one-half FTEs. Based on the MCOs' enrollment levels and the number of encounters reported, we question the adequacy of these staffing levels.

As shown in Table 2, from 2011 to 2013, both UHC and Amerigroup reported significant increases in enrollment and number of encounters. However, the MCOs did not increase their SIU staffing levels proportionally to accommodate these surges and, in fact, in certain instances staffing levels actually decreased. For example, from 2011 to 2012, UHC's enrollment increased by 52,968 members (15.4 percent) while FTEs for its SIU decreased from 1.98 to 0.88. In another example, Amerigroup's enrollment increased from 2012 to 2013 by 25,514 members (5.2 percent) while SIU FTEs decreased from 3.60 to 2.58.

Table 2 – MCOs' SIU Staffing Per Enrollment and Number of Encounters

	UHC			Amerigroup		
Year	2011	2012	2013	2011	2012	2013
SIU FTEs for NYS Medicaid	1.98	0.88	1.74	1.75	3.60	2.58
Number of Medicaid Enrollees	343,763	396,731	444,108	138,375	488,353	513,867
Enrollees per FTE	173,618	450,831	255,234	79,071	135,654	199,173
Number of Encounter Claims	9,711,547	13,596,682	15,214,886	2,736,449	11,771,095	16,594,729
Encounter Claims per FTE	4,904,822	15,450,775	8,744,187	1,563,685	3,269,749	6,432,066

To evaluate the effectiveness of UHC's and Amerigroup's SIUs, we also reviewed the status of cases referred to the SIUs by vendors, claim analysts, and other sources during the audit period, and our findings further support our conclusion that the SIUs had limited effectiveness. Due to the inconsistency in how each MCO defines a case, there was a wide disparity in numbers of cases reported by the MCOs. However, we concluded that, given the enrollment levels and the number of encounters reported by the MCOs during the audit scope (see Table 2), UHC's and Amerigroup's SIU activity was limited (see Table 3).

For example:

- In 2013, despite reporting more than 15.2 million encounters, UHC's SIU investigated only 27 cases and closed seven; and
- During the three-year period, the number of open cases for Amerigroup increased from 48 cases in 2011 to 141 cases in 2013.

Table 3 – MCOs' SIU Activity

	UHC			Amerigroup		
Year	2011	2012	2013	2011	2012	2013
Cases Investigated	28	31	27	174	227	329
Cases Closed/Completed	10	22	7	126	142	188
Cases Open at Year End	18	9	20	48	85	141

UHC officials informed us the SIU staffing levels are need-based; however, we note that UHC does not have a formal policy that establishes "need" criteria nor a process for measuring factors, such as results of SIU activities, to ensure sufficient staff are assigned to the SIU to effectively prevent, detect, and investigate fraud and abuse. Although Amerigroup has a formal written staffing policy, it is very general and does not base staffing levels on significant factors such as enrollment or number of encounters. For comparative purposes, we note that New Jersey's Medicaid program contractually requires its MCOs, including UHC, to maintain a minimum investigator-to-enrollee ratio of at least 1:60,000. In comparison, for New York State's Medicaid program in 2013, UHC's ratio was 1:255,234, and Amerigroup's ratio was 1:199,173 (see Table 2).

The potential cost to MCOs of increasing their SIU staffing may be a deterrent from expanding the SIUs. MCOs' SIU staffing costs are considered an administrative cost. Although the Department compensates MCOs for administrative costs in the form of higher premiums, there is a cap limitation, and MCOs are not compensated for administrative expenses that exceed the cap. For the 2014 managed care premium rate calculation, both UHC's and Amerigroup's reported administrative expenses exceeded the Department's cap on administrative costs. Thus, especially in the absence of any contractual requirements or regulations governing SIU staffing levels, the MCOs have little incentive to incur greater administrative costs (which might compromise profitability) to better staff their SIUs.

Inadequate SIU staffing levels limits the number of cases that can be reviewed and negatively impacts MCOs' ability to identify fraudulent or unnecessary payments. In particular, it inhibits the

recovery of improper payments. In this regard, the Department establishes the monthly managed care premiums based on financial information – including the MCOs' reported medical expenses paid out on behalf of enrollees – that MCOs submit to the Department on their Medicaid Managed Care Operating Reports (MMCORs). Because MCOs are reimbursed for medical expenses as reported on their MMCORs, inadequate claims investigation processes increase the risk that the Medicaid program is paying for fraudulent or unnecessary claims, which could result in inflated premiums to MCOs. More importantly, inadequate fraud and abuse prevention, detection, and investigation efforts may result in care being provided by unqualified or unethical providers, which could potentially impact the health and safety of MCO members.

In response to our findings, Department officials stated they would research best practices regarding the investigator-to-enrollee ratio for MCO SIUs and review all current MCO SIU staffing levels to establish an acceptable baseline ratio. They will also consider revising managed care contract provisions for establishing SIU staffing levels.

Recommendations

5. Establish appropriate criteria for SIU staffing levels.

6. Revise the managed care model contract language to require that MCOs meet the established criteria for SIU staffing levels.

Reporting of Recoveries

MCOs are required to report recoveries of improper payments on the MMCORs they file with the Department. When calculating MCOs' premiums, the Department subtracts MCOs' reported recovery amounts from the MCOs' medical expense component of providing services; thus, larger recoveries will reduce MCOs' medical expenses and, in turn, could decrease the amount of premium payments MCOs receive. UHC and Amerigroup maintain an internal report of the MCOs' recoveries.

We determined that the actual recoveries by UHC's and Amerigroup's SIUs were very limited in comparison to the MCOs' reported encounter payments and the premiums paid by Medicaid to the MCOs during the audit scope (see Tables 4 and 5). Notably, while the premiums paid to UHC increased each year during the audit scope, from approximately $930.9 million in 2011 to more than $1.4 billion in 2013, its recoveries actually decreased each year – and in 2013 its SIU recovered only $58,500 from fraud and abuse detection activities. We concluded that the inadequate staffing, noted previously in this report, may have led to the diminished recoveries.

Table 4 – UHC Recoveries

Year	2011	2012	2013
Premiums Received	$930,942,203	$1,308,244,720	$1,442,042,113
Encounter Payments	$639,112,230	$884,306,859	$1,065,925,829
SIU Recoveries	$490,300	$137,725	$58,500
Recoveries vs. Premiums	0.053%	0.011%	0.004%
Recoveries vs. Encounters	0.077%	0.016%	0.005%

Table 5 – Amerigroup Recoveries

Year	2011	2012	2013
Premiums Received	$335,890,128	$1,299,789,026	$1,751,921,864
Encounter Payments	$235,510,069	$908,355,228	$1,271,798,922
SIU Recoveries	$315,575	$479,987	$687,905
Recoveries vs. Premiums	0.094%	0.037%	0.039%
Recoveries vs. Encounters	0.134%	0.053%	0.054%

We also reviewed the MMCOR data reported to the Department by UHC and Amerigroup during the audit scope, and found numerous instances of underreporting of recoveries on the MMCORs. We found that UHC did not report any Medicaid recoveries on its MMCOR for 2011 through 2013. Amerigroup reported recoveries on its MMCOR for 2013, but did not report any for 2011 and 2012. Based on our findings, there may be a disincentive for MCOs to report these recoveries on their MMCORs, since recoveries are factored into the premium rate calculation and could result in reduced premiums.

According to NYCRR Title 10, Part 98, Section 1.21(d), MCOs are also required to file an annual report with the Department describing their experience, performance, and cost-effectiveness in implementing their fraud and abuse prevention and detection plans (Compliance Plans), including the number and dollar value of fraud and abuse complaints. MCOs are also required to report to the Department, on an ongoing basis, all confirmed cases of fraud and abuse. Both UHC and Amerigroup maintain an SIU activity report documenting the various fraud and abuse detection activities and cases handled by the unit.

We reviewed the annual reports on the MCO Compliance Plans that UHC and Amerigroup submitted to the Department for the year 2011, and identified numerous instances of underreporting of recoveries and other problems with the annual reports. For example:

- For 2011, UHC's annual report to the Department omitted seven cases of recoveries, totaling $139,854, that were included on its SIU activity report.
- Amerigroup's annual report to the Department presented its SIU recovery data as estimated amounts rather than actual recoveries.
- UHC's 2011 SIU activity report listed three cases of suspected fraud and abuse, but only one case was included on its annual report to the Department.

- Amerigroup's 2011 SIU activity report showed 18 cases of suspected fraud and abuse, but none were included on its annual report to the Department.
- Amerigroup's 2011 annual report to the Department included seven confirmed cases of fraud and abuse, but these cases lacked certain detail required by regulations, such as the name of the entity that committed the fraud or abuse and a description of the activity.

We determined the Department did not exercise proper oversight, as it did not monitor recoveries reported on the MMCORs or the accuracy of MCOs' Compliance Plan recoveries resulting from fraud and abuse investigations. We also identified an apparent lack of communication between the MCOs and the Department, which resulted in inconsistencies in how dollar amounts of recoveries were reported and how suspected and confirmed fraud cases were reported.

Although Medicaid pays hundreds of millions of dollars in premiums to the MCOs, the SIUs investigate a limited number of cases and identify few recoveries, and consequently, have rather limited effectiveness. In addition, it is unclear that the SIUs' activities were sufficient to effectively prevent, detect, and investigate provider fraud and abuse. The Department should identify actual recoveries by UHC and Amerigroup for our audit period and determine if there is any impact on the monthly premium rates. Additionally, in response to our findings, Department officials stated they will provide additional guidance to plans regarding what should be reported on the MMCOR.

Recommendations

7. Identify the actual recoveries by UHC and Amerigroup, determine if there is any impact on the monthly managed care premium rates, and adjust the premiums rates as appropriate.

8. Instruct MCOs on how to properly report SIU activities to help ensure consistency in SIU reporting activities.

9. Establish an oversight process to help ensure MCOs properly report all recoveries resulting from fraud, waste, and abuse investigations on their MMCORs and on the annual reports that detail the MCOs' Compliance Plans.

Staff Training

According to NYCRR Title 10, Part 98, Section 1.21, MCOs' Compliance Plans must contain provisions for training investigative personnel on identifying and evaluating instances of suspected fraud and abuse. Although there are no regulations that specify a minimum training requirement and the managed care model contract does not include a training requirement provision, both UHC and Amerigroup have mandatory core and specialized training programs for their SIU employees. While UHC's Compliance Plan did not indicate a specific number of training hours required for its staff, UHC officials stated there is a 9-hour minimum annual training requirement. Also, Amerigroup's Compliance Plan requires that staff receive "approximately 40 hours" of training per year.

We found that, despite the annual training requirements, the MCOs' investigators did not always meet those requirements. For instance, despite UHC's nominal required training time, in 2011, five of the six SIU staff at UHC failed to meet the 9-hour minimum training requirement, including one who worked 50 percent of the time in the SIU and had no training at all during the year. Due to the ambiguity of Amerigroup's training requirement, we could not fully determine whether employees met the requirement. However, in 2012 three of the six SIU staff received fewer than 26 hours of training, including one employee who worked 98 percent of the time in the SIU and received no training during that year.

Given these statistics, it is unclear that all SIU staff have been adequately trained, particularly with regard to emerging investigative techniques – and they may not maintain the necessary skills to detect fraud and abuse. Additionally, neither the MCOs nor the Department adequately monitored compliance with internal SIU staff training requirements.

In response to our preliminary observations, Department officials stated they have recently enhanced their monitoring of requirements under the NYCRR by conducting ongoing operational surveys of all MCOs, including a review of staff training provided by the MCOs. However, when we reviewed these surveys, we found that they did not identify the training deficiencies we noted for UHC and Amerigroup. We, therefore, question the reliability of the Department's surveys as a monitoring tool.

Recommendations

10. Formally review Compliance Plan information submitted by the MCOs to assess whether they contain appropriate and specific minimum training requirements for SIU staff.

11. Actively monitor MCO SIU staff training to ensure training requirements are met.

Audit Scope and Methodology

The objectives of this audit were to determine if UHC and Amerigroup made payments to excluded/ineligible providers and whether the MCOs established and implemented adequate SIUs to detect, prevent, and follow up on instances of fraud and abuse. For our review of payments to excluded/ineligible providers, our audit scope covered the period January 1, 2011 through December 31, 2014. For our review of the MCOs' SIU activity, our audit covered the period January 1, 2011 through December 31, 2013. Although UHC and Amerigroup officials informed us that they have extensive information technology system controls to prevent certain inappropriate payments and facilitate the detection of fraud and abuse, we did not comprehensively audit these systems and, therefore, did not comment on them.

To accomplish our objectives and assess internal controls, we interviewed Department, OMIG, UHC, and Amerigroup officials, and reviewed relevant Medicaid laws, rules, regulations, and policies pertaining to the reporting of fraud and abuse. We analyzed recoveries made by the SIUs, and reviewed capitation and encounter claims for two MCOs (UHC and Amerigroup). We

reviewed relevant sections of the MMCORs and MCO model contracts and analyzed various other eMedNY data.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials concurred with most of our recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

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Agency Comments

NEW YORK STATE OF OPPORTUNITY. | **Department of Health**

ANDREW M. CUOMO
Governor

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

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

June 2, 2016

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

　　Enclosed are the Department of Health's revised comments on the Office of the State Comptroller's Draft Audit Report 2014-S-51 entitled, "Medicaid Managed Care Organization Fraud and Abuse Detection."

　　Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2014-S-51 entitled,
Medicaid Managed Care Organization Fraud and Abuse Detection

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2014-S-51 entitled, "Medicaid Managed Care Organization Fraud and Abuse Detection."

Background:

New York State (NYS) is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

General Comments:

The Department takes the integrity of the NYS Medicaid program very seriously. It is a goal of the Department to control Medicaid costs while ensuring that all members have access to the clinically effective, efficiently delivered services they require. Over the course of the timeframe of this audit, the landscape regarding delivery of healthcare services to Medicaid members has changed significantly. During the past three years, major new initiatives have been enacted to combat fraud, abuse, and waste in government programs.

During the past two years, the Department has responded vigorously to recent Centers for Medicare and Medicaid Services Program Integrity Audit Findings. The NYS Medicaid Director's letter dated December 18, 2013 to all plans stressed the requirements for plans to conduct fraud and detection activities, and the penalties for failing to meet those requirements. As such, during March 2014, each Managed Care Organization (MCO) underwent a thorough review of program integrity activities by a team of Department and OMIG reviewers. The survey resulted in Statements of Findings and/or written recommendations being issued to eighteen (18) MCOs. The MCOs have submitted plans of correction to remedy areas of non-compliance.   The Department has followed up with MCOs to ensure full compliance after implementation of the corrective action plan.

The Department has provided OSC with the Program Integrity (PI) Module developed for the focused reviews utilized during the Department's ongoing comprehensive operational survey of mainstream MCOs and Human Immunodeficiency Virus Special Needs Plans.

The Department and OMIG have responded to the fourteen OSC recommendations based on OSC's audit. Additionally, we were granted permission by OSC to share the plan data OSC reviewed with the respective plans, United Healthcare (UHC) of New York and Amerigroup. We have previously shared the plan's comments with OSC and the plans have confirmed our opinion that the data may have been incomplete, inaccurate, and/or misleading. It should be noted that the OSC 2011-2014 timeframe pre-dates many of the Department's recent efforts to monitor MCO compliance with PI requirements. Moreover, OSC's audit only examines two plans but makes sweeping generalizations for all plans. As such, our responses will attempt to address a macro level understanding of the recommendations.

In addition, the Department responded to OSC's preliminary findings on MCO Fraud and Abuse Detection (Audit 2014-S-51) on July 28, 2015. Subsequently, the Department participated in an August 11, 2015 closing conference call with OSC staff. As a result of that discussion, the Department and OSC agreed that more analysis needed to be conducted specific to the numbers for both UHC and Amerigroup in relation to potential payments made to excluded providers and the methodology used to identify such payments. In subsequent conference calls with UHC on September 9, 2015 and Amerigroup on September 14, 2015, all parties agreed to further analysis. The Department's results, UHC and Amerigroup's response and results have previously been shared with OSC.

Prior to issuing OSC's final report, we ask that on behalf of the Department and the audited plans, that OSC reviews the significant discrepancies in OSC findings and the attached findings for both excluded providers and payments made to those providers for each of the respective plans. The Department and the plans state that the actual numbers in both categories are significantly lower and should be reflected as such. The Department is unclear as to how excluded providers were identified since they do not seem to match the exclusionary lists currently utilized.

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Recommendation #1:

Review the MCO payments to ineligible providers that we identified and direct UHC and Amerigroup to recover the payments as appropriate.

Response #1:

The Department agrees that payments to excluded providers should be recovered and will work with the MCOs to ensure that any amounts paid to excluded providers are recovered and reported accordingly.

The audit performed by the OSC identified 16,659 encounter claims submitted by Amerigroup and UHC as being paid to ineligible providers for the period January 1, 2011 through December 31, 2014. It should be noted that during this same time period the total volume of encounter claims from Amerigroup and UHC exceeded 127 million encounter claims.

As noted in our preliminary response to the OSC, the Department does not agree with the methodology of employing the fee-for-service (FFS) eMedNY Enrollment Status File as the sole means of determining a provider's eligibility to participate in an MCO's network.

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Excluded providers by definition are listed in Federal and State databases including the Social Security Administration's Death Master File (SSDM), the National Plan and Provider Enumeration System (NPPES), the Excluded Parties List System (EPLS), either the List of Excluded Individuals

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*See State Comptroller's Comments, Page 30.

and Entities (LEIE) or the Medicare Excluded Database (MED), and the NYS OMIG Exclusion List. MCOs are required to check these databases upon credentialing the provider and on an ongoing basis per Model Contract Sections 18.9 and 21.5. As no comprehensive list of excluded/sanctioned providers exists and both the Department and MCOs are required to download separate lists from various State and Federal agencies to manually review excluded providers.

The Department also checks these same databases and maintains its eMedNY Enrollment Status File with the results of any exclusions. However, the eMedNY Enrollment Status File is currently not one of the databases MCOs are required to check, as this database is used by the Department for the administration of its Medicaid FFS program to enroll and maintain information on providers.

Besides maintaining records of exclusions, eMedNY also maintains a record of FFS administrative terminations. This point is critical as a termination by FFS does not in itself render a MCO's network provider ineligible for payment. At this time providers participating in an MCO's network are not currently required to be enrolled in Medicaid FFS.

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Recommendation #2:

Complete the review of the 7.2 million encounter claims, totaling over $445 million, that contained incomplete or otherwise untraceable provider information to determine if the MCOs made payments to ineligible providers, and instruct the MCOs to review and recover improper payments where appropriate.

Response #2:

The file of 7.2 million encounter claims provided by OSC did not contain any information identifying the billing provider other than the generic provider identification number used by MCOs to report encounters involving out-of-network providers (both in-state and out-of-state). These generic provider identification numbers are established by the Department and instruction was provided to the MCOs to use these to report encounter claims involving out-of-network providers. (MCOs must reimburse out-of-network providers for covered services.)

The Department cannot use generic provider identification numbers to match against its list of excluded providers. Therefore, in an attempt to gain further identifying information, the Department will share the OSC files with both Amerigroup and UHC and request that they review the claims level detail and provide any additional information that would assist in establishing the billing providers' identity. Upon receipt of the responses from Amerigroup and UHC, the Department will attempt to match any additional information received for these encounter claims against its listing of excluded providers.

Any and all records with additional information received that the Department can match against its listing of excluded providers will then be forwarded to the MCO with the request that it review our findings and either confirm that a recovery is needed or provide detail for why the provider in question should not be deemed ineligible.

Recommendation #3:

Determine the impact that UHC's and Amerigroup's recoveries have on the managed care premium calculations, and adjust the premium rates accordingly.

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Response #3:

Monthly premiums are impacted by recoveries. Plan recoveries are incorporated into rate making methodology. Both the current and prior period recoveries reported in the plans' Medicaid Managed Care Operating Reports (MMCORS) are included in the premium calculation and appropriately netted out of the overall premium rate. Specifically, any prior period accrued medical expenses (including accrual for prior medical expenses within Table 25C as well as the recoveries reported in Table 26C-1) are included as a subset of the plan's prior period accrual adjustment and as such netted out of the premium rate calculation. Recoveries made on claims incurred during the current reporting period are included in the current period accruals within the financial tables and, therefore, are also appropriately counted in the premium rate calculation. The Department will issue additional guidance to plans regarding what should be reported in these tables by September 1, 2016.

Recommendation #4:

Strengthen steps to oversee and monitor MCOs to ensure that providers who are not eligible for reimbursement are removed from MCO provider networks so that only eligible Medicaid providers are reimbursed. These steps should include (but not be limited to):

- Utilizing all available eMedNY information, including information contained on the Enrollment Status File;

- Sharing the Enrollment Status File information with the MCOs;

- Updating the Enrollment Status File to include all providers within MCOs' provider networks, including those who do not have a Medicaid ID; and

- Continuing pursuit of changes to Medicaid regulations that would require the State to enroll all MCO network providers in Medicaid (thereby requiring network providers to have Medicaid IDs).

Response #4:

Model Contract Sections 18.9(c)-(d) require Medicaid MCOs to confirm the identity and determine the exclusion status of new Participating Providers, re-enrolled Participating Providers and all current Participating Providers, any sub-contractors, and any person with an ownership or control interest or who is an agent or managing employee of the Participating Provider or sub-contractor through routine check of Federal and State databases. These include the SSDM, the NPPES, the EPLS, either the LEIE or the MED, the NYS OMIG Exclusion List, and any other databases as may be required.

As part of its oversight role, the Department, on a quarterly basis, reviews MCO networks and when necessary, issues requests to MCOs to terminate contracts with providers found to be on the State or Federal provider exclusions or sanctions lists. MCOs are required to terminate contracts within a specific timeframe or the Department will issue a Statement of Deficiency.

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Compliance is also monitored during the bi-annual Comprehensive Operational Survey. The Department reviews MCO credentialing/re-credentialing and exclusion list policies and procedures, provider credentialing files and the network of participating provider and managing employees and agents.

The Department conducted a focused review of activities of all MCOs in 2014 to ensure compliance with all exclusion database matches. At that time, each MCO underwent a thorough review of PI activities by a team of Department and OMIG reviewers. Statements of Findings and/or written recommendations were issued to any MCO not in compliance with the required activities, and a plan of correction was required to be submitted. After implementation of the plan of correction, the Department then followed up with the MCO. The PI Module developed for the focused review is a component of the Department's bi-annual comprehensive Operational Survey of MCOs.

CMS issued proposed regulations in June 2015 to 42 Code of Federal Regulations (CFR) 438.608 that requires states to screen and enroll all MCO network providers that are not otherwise enrolled in FFS consistent with the Affordable Care Act program integrity provisions in 42 CFR Part 455, subpart B and E. According to CMS, this standard will help ensure that all providers that furnish services under the State plan or waiver are screened and enrolled to improve program integrity in the Medicaid program. The final federal rules were just adopted and include this provision and implementation timeframes. The Department is reviewing the need for contract, regulatory or system changes to complete enrollment within the next several years, as required under the Federal rules. Systematic changes will also be evaluated and prioritized regarding sharing certain FFS enrollment information from eMedNY Provider File tables with the MCOs.

As noted above, Medicaid MCOs in New York are currently required to perform the same PI checks for excluded providers, using the same data sources, as FFS enrollment performs and maintains in eMedNY. The Department agrees that excluded providers are ineligible for participation in FFS and MCOs. However, providers terminated by FFS through administrative action not related to Medicaid PI or quality of care concerns, are not necessarily ineligible for participation in MCOs as the audit recommendations contend. MCOs are required to utilize their own provider credentialing systems and procedures to appropriately terminate participation through their internal established operational and administrative procedures.

* Comments 4, 5

Recommendation #5:

Establish appropriate criteria for SIU staffing levels.

Response #5:

The Department disagrees with the recommendation that the size of the Plan's Special Investigation Unit (SIU) should be mandated without researching SIU best practices and reviewing all current MCO SIU staff levels. The SIUs are an important component of the Plan's overall program integrity effort. Plans need to have the flexibility to allocate resources to utilize various program integrity tools, including pre-payment and post-payment activities. Plans and other payers have found that preventing inappropriate payments is more cost effective than attempting to recoup inappropriate payments.

* Comment 6

The Department will research best practices for SIUs. The Department will review all current MCO SIU staffing levels and investigate potential appropriate minimum baseline ratios which will

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be compared to the criteria for staffing managed care SIU already outlined in New York State Public Health Law § 4414; 10 NYCRR § 98-1.21(b)(1)-(3); and Managed Care Model Contract Section 23.2.

Recommendation #6:

Revise the managed care model contract language to require that MCOs meet the established criteria for SIU staffing levels.

Response #6:

The Department will review all current MCO SIU staffing levels and investigate potential appropriate minimum baseline ratios which will be compared to the criteria for staffing managed care SIUs outlined in New York State Public Health Law § 4414; 10 NYCRR § 98-1.21(b)(1)-(3); and Managed Care Model Contract Section 23.2.

The Department will work with all stakeholders to ensure appropriate compliance standards are incorporated into the MCO contracts.

Recommendation #7:

Identify the actual recoveries by UHC and Amerigroup, determine if there is any impact on the monthly managed care premium rates, and adjust the premiums rates as appropriate.

Response #7:

See the Department's response for Recommendation #3.

Recommendation #8:

Instruct MCOs on how to properly report SIU activities to help ensure consistency in SIU reporting activities.

Response #8:

Many of the inconsistencies identified may be relative to the timing of the reporting of the findings by the MCOs. For instance, in the plans' MMCORs, the recoveries reported on Table 26C-1 reflect recoveries that were completed up to two years prior to Table reporting. The Department will enhance its surveillance efforts to compare information reported in the annual report to the activities conducted by plans on the operational survey.

As a result of collaborative efforts among the Attorney General's Medicaid Fraud Control Unit, OMIG and the Department, consistent reporting requirements and forms have been developed and have been added to the model contract. These requirements are listed in the following table:

Section and Title	Report Details
18.5(a)(xx) – Pharmacy Benefit Manager (PBM) Report	The Contractor shall submit to the Department and OMIG a quarterly report of the amount paid to a PBM for pharmaceutical services by categories,

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	including amounts for each prescription drug by National Drug Code, and also paid to a PBM for administrative services.
18.5(a)(vii)(E) – Par Providers Terminated "For Cause"	The Contractor shall report monthly to the Department and OMIG, in a form and format to be determined by the Department and OMIG, any Participating Providers whom the Contractor has terminated "for cause." "For cause" includes, but is not limited to, fraud and abuse, integrity, or quality.
18.5(a)(vii)(F) – Par Providers Not Renewed "For Cause"	The Contractor shall report monthly to the Department and OMIG, in a form and format to be determined by the Department and OMIG, any Participating Providers whom the Contractor has not renewed its Participating Provider agreement with "for cause." "For cause" includes, but is not limited to, fraud and abuse, integrity, or quality.
18.5(a)(xviii) – Comprehensive Provider Report	The Contractor shall submit to the Department and OMIG quarterly, in a form and format to be determined by Department and OMIG, a report which shall include the total dollar amount of claims submitted by Participating and Non-Participating Providers under the Medicaid Managed Care (MMC) Program to the Contractor or any agent of the Contractor, including any PBM, the total dollar amount paid to Participating and Non-Participating Providers under the MMC Program by the Contractor or any agent of the Contractor, including any PBM, and the total dollar amount of services ordered, referred or prescribed by Participating and Non-Participating Providers under the MMC Program during the reporting period.
18.5(a)(xix) – Program Integrity Annual Assessment Report	The Contractor shall conduct an annual assessment and submit to OMIG an annual report, in a form and format to be determined by the Department and OMIG, of the status of their conformity with all Contractor regulatory and contractual Medicaid program integrity obligations (list

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21.5(c) Exclusion or Termination of Providers	If Medicaid payments are made by the Contractor to an excluded or terminated provider for dates of service after the provider's exclusion or termination effective date, the Contractor shall report and explain within 60 days of identifying the payment, in a form and format to be determined by OMIG in consultation with the Department, when and how the payment was identified, and the date on which the encounter data was adjusted to reflect the recovery.

PI training sessions are available and conducted periodically for the State staff. OMIG is now conducting regular trainings on specific PI topics. OMIG participates in Webinars and Medicaid Integrity Institute (MII) classes. OMIG and the Department will continue to hold periodic program integrity training sessions for both State and MCO staff.

OMIG will continue to chair quarterly meetings with the MCO SIUs. OMIG ensures provider and investigation information is shared amongst all plans to identify trends and potential program losses. The Department and OMIG are taking steps to ensure coordination of integrity efforts across plans.

Recommendation #9:

Establish an oversight process to help ensure MCOs properly report all recoveries resulting from fraud, waste, and abuse investigations on their MMCORs and on the annual reports that detail the MCOs' Compliance Plans.

Response #9:

The Department has an established process for the oversight and the submission of the MMCORs as well as the oversight of MCO compliance with the regulations for operational and financial requirements. The Department reviews the accuracy and timeliness of financial data submitted by MCOs on a quarterly basis utilizing a number of review tools including standard and ad hoc reports which are developed to ensure that MCOs' allocation of costs are appropriate and in line with programmatic and policy decisions guiding the provision of services. Specifically, plans are required to submit specific tables within their quarterly financial reports detailing fraud, waste and abuse recovery activities (Table 26C-1) which are netted out of the premium rate calculations during the premium rate promulgation process.

Additionally, the Department and OMIG are implementing a joint initiative establishing recovery targets designed to incentivize MCOs in their fraud, waste and abuse efforts. Under the initiative, each year the State will review previous recoveries and determine an overall recovery target. In

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addition to annual fraud plans and quarterly MMCOR submissions, each MCO must also provide monthly updates to OMIG outlining its investigative and recovery progress with specific case and claim-level detail in a format to be determined by OMIG.

Recommendation #10:

Formally review Compliance Plan information submitted by the MCOs to assess whether they contain appropriate and specific minimum training requirements for SIU staff.

Response #10:

The Department already requires that MCOs have adequate training for SIU staff. For instance, 10 NYCRR § 98-1.21(b)(9) requires that all MCOs, as part of their required fraud and abuse prevention plan, include in-service training programs for investigation, claims, quality, utilization management, and other personnel in identifying and evaluating instances of suspected fraud and abuse, including an introductory training session and periodic refresher sessions. This provision further requires that an MCO's Fraud and Abuse prevention plan include the course descriptions, the approximate number of hours to be devoted to these sessions, and their frequency. In addition, Section 98-1.21(c) requires that persons employed by SIUs as investigators shall be qualified by education or experience and it elaborates on those particular requirements.

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Recommendation #11:

Actively monitor MCO SIU staff training to ensure training requirements are met.

Response #11:

The Department (and more recently, the Department in conjunction with OMIG) monitors compliance with 10 NYCRR § 98-1.21(b)(9) by conducting ongoing operational surveys of all MCOs. The PI Module used when surveying MCOs on PI requirements captures information on training requirements in questions 95-97. If the MCO is required to submit a plan of correction to the Department for review and approval, the plan of correction requires a timetable for implementation. Furthermore, when the Department conducted a survey in March 2014, only 2 of the 19 MCOs were found to be deficient in this area. An acceptable plan of correction was submitted by both plans.

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Comment 8

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State Comptroller's Comments

1. The Department states the data we reviewed for UHC and Amerigroup may have been incomplete, inaccurate, and/or misleading. However, as the Department acknowledges, we met with Department and MCO officials during the audit to discuss the data presented in our report. As a result of those communications, we adjusted the numbers, as necessary, based on feedback from the Department and the MCOs.

   Further, as our report explains, we examined the discrepancies referenced by the Department (i.e., the encounters the Department believes were paid appropriately) and concluded there was considerable risk that the payments were improper. For instance, page 8 of the report makes it clear that we reviewed other available information (in addition to the exclusionary lists) from the eMedNY system and state professional licensing websites. Further, based on that, we determined that during the time the claims were paid, the providers either were excluded by OMIG, had stipulations which limited them to providing particular services, or had expired licenses.

   We also identified flaws in the Department's analysis of the discrepancies that Department officials take exception with. For example, pages 8 and 9 of the report illustrate how reviews by Amerigroup confirmed that certain claims the Department believed were properly paid were, in fact, improperly paid.

   Lastly, our auditors had multiple communications with Department officials to discuss how the findings were arrived at and how excluded providers were identified. We also describe throughout the audit report the methods we used to arrive at the audit findings. In response to the Department's comments, we provided officials with another copy of the exception claims. The file contained the information OSC used to identify excluded providers.

2. The Department misrepresents the audit in asserting that we made sweeping generalizations for all MCOs based on an examination of two MCOs. In fact, we assessed the Department's general policies and procedures to oversee and monitor MCOs' fraud and abuse detection programs, although we placed emphasis on the programs of two selected MCOs to detail audit condition and assess audit impact. Further, in its response, the Department does not assert that its oversight and monitoring of the MCOs we selected for review were in any way different from its oversight and monitoring of MCOs we did not select for review.

3. The Department is incorrect in its assertion. We did not use the fee-for-service (FFS) eMedNY Enrollment Status File as the sole means of determining a provider's eligibility to participate in an MCO's network. The Enrollment Status File was one source we used in identifying an initial population of questionable providers. This population was then refined based on input from the Department, the MCOs, and other available information obtained from eMedNY and other sources.

4. As stated on page 9 of the audit report, we are aware the Enrollment Status File applies

to FFS payments. We are also aware that a termination by FFS does not always make an MCO's network provider ineligible for payment. However, based on the exceptions we identified, we concluded the MCOs did not use the various other sources of excluded providers adequately. In that regard, we determined the Enrollment Status File was useful, and the audit findings demonstrate that information on the Enrollment Status File helped identify additional questionable providers and payments.

5. Contrary to what the Department indicates, our audit report does not state providers are ineligible for participation in MCOs if they are terminated by FFS through administrative actions not related to program integrity or quality of care concerns. In fact, we eliminated providers in these categories from the audit findings.

6. Contrary to what the Department indicates, we did not recommend that the size of the MCOs' Special Investigation Units (SIU) should be mandated without considering best practices. In fact, on page 14 of the report, in response to the lack of specific requirements for SIU staffing levels and the deficiencies in SIU staffing levels we identified, we noted that the Department would research best practices regarding SIU staffing levels to establish an acceptable baseline ratio. Accordingly, we recommended that the Department establish appropriate criteria for SIU staffing levels and require that the MCOs meet the established criteria.

7. The Department's response cites regulations pertaining to the requirements of SIU staff training. However, the regulations do not identify specific measurable requirements, and without adequate oversight, the regulations alone provide little assurance that staff training is sufficient. Despite the regulations, we identified several staff training deficiencies in our report. Therefore, as we recommend, the Department should formally review Compliance Plan information submitted by the MCOs to assess whether they contain appropriate and specific minimum training requirements for SIU staff.

8. As indicated on page 17 of our report, we reviewed the operational surveys conducted by the Department and found that the surveys did not identify the UHC and Amerigroup training deficiencies we noted in our report. Therefore, we questioned the reliability of the Department's surveys as an adequate monitoring tool.