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

September 30, 2016

Mr. Brian Mason
Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2014-S-51 entitled, "Medicaid Managed Care Organization Fraud and Abuse Detection."

Please feel free to contact Amy Nickson, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Enclosure

cc: Ms. Nickson

Department of Health
Comments on the
Office of the State Comptroller's
Final 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) Final 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. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

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 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 had asked 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.

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.

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 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, 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.

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 shared the OSC files with both Amerigroup and UHC and requested that they review the claims level detail and provide any additional information that would assist in establishing the billing providers' identity. The Department received two files for Amerigroup and UHC that identified 1.2 million claims totaling $106 million for encounters submitted with generic provider identification numbers. The Department continues to work with both MCOs to establish whether additional information is available to further identify the billing providers. The MCOs have been instructed to respond by October 10, 2016.

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.

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 worked with OMIG to expand Table 26C-1 on the MMCOR, commencing with the 2015 annual cost reports. Additional fields were added along with specific instructions as to how and what plans are to report in such fields.

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.

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.

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.

The Department is currently researching best practices for SIUs. 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 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; Title 10 of the NYCRR § 98-1.21(b)(1)-(3); and Managed Care Model Contract Section 23.2. Once identified, this information will be shared with the plans, and incorporated into the Managed Care Model contract.

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 OHIP response for Recommendation #3. Furthermore, if plans made any recoveries for prior periods as implied in this audit, such recoveries are reported and adjusted in the appropriate tables in the MMCOR and as such, included in the premium calculations.

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(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, including amounts for each prescription drug by National Drug Code, and also paid to a PBM for administrative services.
18.5(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(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(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(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 to be developed by the Department and OMIG) by December 31st of each calendar year.
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 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.

The Department will formally enhance and review the compliance plan information submitted by MCOs to ensure that they contain the appropriate and specific minimum training requirements for SIU staff as required by 10 NYCRR § 98-1.21 (b) (a) and § 98-1.21 (c).

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. The Department will continue to actively monitor MCO SIU staff training through its ongoing oversight and surveillance program of all MCOs.

State Comptroller's Comments:

OSC Comment #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.

OSC Comment #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.

OSC Comment #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.

OSC Comment #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.

OSC Comment #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.

Response to Comments #1 - 5:

As previously stated the Department takes the integrity of the NYS Medicaid program very seriously.

We again note that over the timeframe of this audit that a number of new initiatives have already been enacted to combat fraud, waste and abuse and as we have consistently demonstrated, the Department will continue to implement changes where needed to further strengthen its oversight and monitoring capabilities.

In that regard, we considered the recommendations related to the issue of utilizing the eMedNY Provider Enrollment Status Report in addition to the other reference sources identified in the OSC Final Report. The Department maintains its position that OSC's methodology of leveraging the eMedNY Provider Enrollment Status Report to determine if the Provider Network Data (PNDS) submissions by the MCO's for the purpose of combating fraud, waste and abuse is flawed and that other avenues exist to identify and prevent improper MCO payments to excluded providers.

The Department bases its reasoning upon the fact that the primary purpose of the PNDS data is to determine whether the MCO's network of providers is adequate to provide services to its Medicaid enrollees.

The data is submitted on a quarterly, retrospective basis and given the time elapsed between submissions, the Department firmly believes it cannot adequately address excluded providers on a real time basis.

To note, based on current policy providers may be excluded from these submissions only if that exclusion is in place at the time of the data submission and review. This point is critical because it is possible that an excluded provider may be reinstated by quarters end and therefore would not have been identified and removed from the quarterly submission of the PNDS data.

The Department also questions the merit that the MCO's would benefit by gaining access to the eMedNY Enrollment Status Report for the purpose of continually monitoring their network providers. Furthermore, we believe that checks of sanction databases currently required by the Federal government and specified in the Medicaid Model contract are addressing the integrity of provider networks of plans.

The Department believes it can further strengthen the oversight and monitoring of the program via changes to federal Medicaid regulations that will require the State to enroll all MCO network providers starting in 2018.

Enabling this process will provide the Department with one central repository containing the enrollment status of all FFS and managed care providers thereby allowing the Department to leverage this information for both FFS and MCO claims payments.

We appreciate the opportunity provided by the Comptroller to respond and recommend that the above information be utilized in its future review of MCO provider network integrity.

OSC Comment #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.

Response to Comment #6:

The Department is currently researching the best practices for SIU staffing levels. 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 already outlined in NYS PHL§ 4414; 10 NYCRR §98-1.21 (b) (1)-(3) and Managed Care Model Contract Section 23.2.

OSC Comment #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.

Response to Comment #7:

The Department will formally enhance and review the compliance plan information submitted by MCOs to ensure that they contain the appropriate and specific minimum training requirements for SIU staff as required by 10 NYCRR§ 98-1.21 (b) (a) and § 98-1.21(C).

OSC Comment #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.

Response to Comment #8:

The Department's operational survey process is very thorough and comprehensive and covers a myriad of operational requirements. However, the Department will review its SIU training questions to ensure that they capture the need for appropriate training.