Department of Health

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Executive Deputy Commissioner

May 4, 2018

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

Dear Mr. Shulman:

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 2016-S-59 entitled, "Managed Care Organizations: Payments to Ineligible Providers."

Please feel free to contact Estibaliz Alonso, 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: Estibaliz Alonso

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2016-S-59 entitled,
Managed Care Organizations: Payments to Ineligible Providers

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2016-S-59 entitled, "Managed Care Organizations: Payments to Ineligible Providers."

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 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1:

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

Response #1:

The Department will distribute these claims to the Managed Care Organizations (MCOs) with instructions to recover improper payments where appropriate. The MCOs will be further instructed to provide a reconciliation which will be shared with OMIG. Recoveries by Managed Care Plans are reported on Table 26C-1 of the MMCORs and reflect recoveries that were completed up to two years prior to Table reporting. The Department would like to note that most of these claims involve dates of service exceeding the two-year limitation for resubmission of encounter data. OMIG has MMCOR audits in various stages of the audit process. As part of OMIG's MMCOR audits, OMIG reviews claim data to ensure that recoveries are appropriately reported on the MMCORs.

Recommendation #2:

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

Response #2:

The Department has conducted and completed its outreach to the MCOs on the 22.5 million encounters identified by OSC as missing identification numbers. The outreach requested that these encounters be further identified by the National Provider Identifier (NPI), Provider Name and/or Medicaid Management Information System (MMIS) Number. OMIG is analyzing these claims, and will pursue recovery of any payment determined to be inappropriate.

Recommendation #3:

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

Response #3:

The Medicaid Model Contract contains a provision requiring the MCOs to confirm the identity and determine the exclusion status of Participating and Non-Participating Providers through routine checks of Federal and State databases. The Department believes this provision will be further enhanced with the enactment of the 21st Century Cures Act, which required managed care network providers to enroll in the State's Medicaid program by January 1, 2018. During the Medicaid enrollment and revalidation process such network providers will be checked against State and Federal databases, and be appropriately sanctioned or terminated from the program if necessitated. Enrolling network providers into the Medicaid program would centralize the Medicaid enrollment process and align both the fee-for-service (FFS) and network enrollment processes for all ordering and referring physicians or professionals providing services under both the State Plan and under the waiver.

Recommendation #4:

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

Response #4:

The primary purpose of the Provider Network Data System (PNDS) is to collect data needed to evaluate the adequacy of provider networks. In performing such evaluation, the PNDS network submissions are matched against the Health and Human Services Office of the Inspector General (OIG), OMIG and Office of Professional Medical Conduct (OPMC) sanctioned provider lists. The purpose of such matches is to identify sanction providers and remove them from the MCO's networks. Plans are notified of such matches and are notified by the Department to remove sanctioned provider from their network within 90 days, before the next network submission to PNDS. The Department does not object to OSC's recommendation and will develop procedures for sharing results of the sanctioned providers match with all MCOs.

Recommendation #5:

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

Response #5:

A new PNDS has been created to replace the PNDS used during the audit period. The previous PNDS had many limitations, as well as being an outdated system. The new PNDS system was operationalized in the first quarter of calendar year 2017. Under the new PNDS, MCOs are required to report changes in their networks within 15 business days. This should improve timeliness of exclusions by MCOs. As the Department continues to work with developers in its implementation, the Department will explore options for reporting to MCOs matches of their excluded providers on a more frequent basis.

Recommendation #6:

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

Response #6:

OMIG will perform routine reviews of encounter claims that include matches against available federal and State databases to identify payments to ineligible providers.

Recommendation #7:

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

Response #7:

With the enactment of the 21st Century Cures Act, and by January 1, 2018, enrollable providers in the MCOs Medicaid Managed Care networks were required to initially enroll in the State's Medicaid FFS program, and revalidate their enrollment status on a regular basis thereafter. As a condition of their continuous enrollment, such enrolled providers are screened monthly against the mandatory State and Federal databases, and enrollment status is verified or terminated accordingly. Therefore, it will not be necessary to maintain separate historical provider exclusion information for MCO network providers, as the MMIS will maintain this information. Additionally, OMIG maintains a current exclusion list, that is updated daily on the OMIG website. Upon request, OMIG can provide historical provider exclusion information, on a case by case basis.

Recommendation #8:

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

Response #8:

With the approval of the current mainstream managed care model contract by CMS, OMIG will monitor the adequacy of MCOs' retrospective analyses and recoupment of ineligible provider payments utilizing the Provider Investigative Report, which is a tool that the MCOs will use to report the results of their provider reviews to OMIG.

State Comptroller's Comments:

Comment #1:

As the administrator of the Medicaid program, the Department should determine the best way MCOs can provide proof of their recoupment efforts.

Response to comment #1:

Recoveries by Managed Care Plans are reported on Table 26C-1 of the MMCORs and reflect recoveries that were completed up to two years prior to Table reporting.

Comment #2:

We agree that no separate historical provider exclusion dataset for MCO network providers is necessary (as the MMIS is expected to maintain this information with the enactment of the 21st Century Cures Act). As we recommended, the Department should ensure that all MCOs have access to this information in the MMIS.

Response to comment #2:

Currently, the Department publishes a list of enrolled providers on the Open Data NY website. Additionally, a similar file, listing providers pending enrollment is posted on the MMIS website. Both of these files are updated on a monthly basis and the Department is exploring ways to refresh data more frequently, such as bi-weekly.