New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Managed Care Organizations: Payments to Ineligible Providers

Medicaid Program
Department of Health

Report 2016-S-59 February 2018

Executive Summary

Purpose

To determine whether the Department of Health (Department) and managed care organizations (MCOs) have adequate processes in place to prevent payments to ineligible providers, and whether improper payments were made to ineligible providers. Our audit covered the period January 1, 2012 to December 31, 2016.

Background

The Medicaid program provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Department administers New York's Medicaid program. For the State fiscal year ended March 31, 2017, New York's Medicaid claim costs totaled over $58 billion, of which managed care accounted for about $34 billion. Under managed care, Medicaid pays MCOs a monthly premium for each enrolled Medicaid recipient, and the MCOs arrange for the provision of services their members require.

Medicaid providers who violate statutory or regulatory requirements related to the Medicaid or Medicare programs or who have engaged in other unacceptable insurance practices face possible sanctions, such as exclusion or termination from the Medicaid program. Providers that are excluded or terminated from Medicaid are no longer eligible to receive payments from MCOs for services rendered to Medicaid recipients. With the State's recent 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 carry out this responsibility effectively, MCOs must have adequate resources and procedures to identify providers that have been excluded or terminated from the Medicaid program, deny their claims, and thus prevent improper payments.

Key Findings

During the audit period, the Department launched efforts to improve its ability to detect and prevent payments by MCOs to ineligible providers. Notwithstanding those efforts, however, we identified certain weaknesses in the Department's and MCOs' processes that, if properly addressed, could improve their ability to detect and prevent improper payments to ineligible providers.

- We determined MCOs improperly paid $50.3 million during the audit period, as follows:
  - $37.6 million for 379,761 claims paid to ineligible providers; and
  - $12.7 million for 198,515 claims paid to pharmacies where the prescribing physician was excluded from the Medicaid program or otherwise ineligible for Medicaid payments.

- We identified 22.5 million MCO encounter claims that lacked the provider identification information needed to assess the propriety of payments totaling over $2 billion. We obtained provider information for the encounter claims of two MCOs (totaling about $145 million) and determined the MCOs paid 951 claims totaling $82,943 to ineligible providers. In a separate analysis, we also determined the MCOs paid 1,320 claims totaling $295,635 to pharmacies

for prescriptions ordered by physicians who were excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments.

Key Recommendations

- Review the improper payments we identified and instruct MCOs to recover overpayments as appropriate.
- Obtain the missing provider IDs on the encounter claims that lacked this information, assess the propriety of these claims, and recover any improper payments.
- Improve monitoring efforts to assist MCOs in detecting and recovering improper payments to ineligible providers, including (but not limited to):
    - Notifying all MCOs of all ineligible providers identified by the Sanction Provider Reports;
    - Increasing the frequency of notifications to MCOs regarding ineligible providers; and
    - Performing routine audits of encounter claims that include matches against all available federal and State databases to identify payments made to ineligible providers.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Managed Care Organization Fraud and Abuse Detection (2014-S-51)

Department of Health: Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans (2015-S-9)

State of New York
Office of the State Comptroller

Division of State Government Accountability

February 26, 2018

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 *Managed Care Organizations: Payments to Ineligible Providers*. 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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State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.state.ny.us
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

The Medicaid program is a federal, state, and locally funded 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). Most of the State's Medicaid recipients receive their services through Medicaid managed care. Under managed care, Medicaid pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient, and the MCOs arrange for the provision of services their members require. For the State fiscal year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled over $58 billion, of which managed care accounted for over $33.8 billion. The federal government funded about 55.3 percent of New York's Medicaid claim costs; the State funded about 29 percent; and the localities (the City of New York and counties) funded the remaining 15.7 percent.

State oversight of MCOs must ensure that only eligible health care providers and enrollees participate in Medicaid managed care and that MCOs report accurate and timely encounter claims (claims from providers that MCOs paid) and enrollee, provider, and financial data to the Department. MCOs are contractually required to submit encounter claims to inform the Department about each medical service provided to their enrolled recipients. Encounter claims can include a National Provider Identifier (NPI), which is a unique identifier issued by the federal government to health care providers, and is intended to improve the efficiency of the health care system and reduce fraud and abuse.

Prior to September 2015, MCOs submitted encounter claims to the Department's eMedNY claims processing system. Generally, the Medicaid provider ID and NPI were submitted on the encounter claim to identify the provider that rendered the service. However, many encounter claims, particularly claims from out-of-network providers, lacked an NPI and were submitted using one of seven generic Medicaid provider IDs (based on service type) established by the Department. For these claims, lacking actual provider information, the Department had no means to identify the provider that rendered care to Medicaid recipients. As of September 2015, as part of the Department's implementation of its All-Payer Database (APD), a new Encounter Intake System (EIS) began accepting encounter claims from Medicaid MCOs. Within the EIS, the system logic expects the claim's billing provider to be identified by its NPI or a secondary identifier, such as a Medicaid provider ID, thus providing the Department with a greater capacity for accurately identifying providers that are rendering care to Medicaid recipients.

Health care providers, such as physicians, may become ineligible or excluded from the Medicaid program for various reasons. The State's Office of the Medicaid Inspector General (OMIG) and the U.S. Department of Health and Human Services' Office of Inspector General (OIG), for instance, have the authority to exclude individuals and entities found to be in violation of statutory or regulatory requirements. Payment of Medicaid dollars to such ineligible providers is inappropriate. The State's Office of Professional Medical Conduct (OPMC) also has the authority to deactivate a provider's license (to a status of "inactive," "disciplined," or "sanctioned"), but payment of Medicaid dollars might not be prohibited. OMIG, OIG, and other authorities maintain

lists of ineligible providers (herein referred to as "Ineligible Lists"), which are among the tools the Department and MCOs use to prevent improper payments to ineligible providers.

With the State's recent 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 carry out this responsibility effectively, MCOs must have adequate resources and procedures to identify providers that have been excluded or terminated from the Medicaid program, deny their claims, and thus prevent improper payments. According to 42 CFR 455.436 and Section 18.9 of the Medicaid Managed Care Model Contract (Model Contract), MCOs are required to determine the exclusion status of new, re-enrolled, and current providers through routine checks of federal and State databases at least monthly. Similarly, the MCOs are required to confirm the exclusion status of out-of-network providers upon, or no later than 30 days of, payment of the first claim. MCOs are also responsible for reporting payments made to ineligible providers, recouping payments, and properly accounting for the recoveries, for instance on their Medicaid Managed Care Operating Reports (MMCORs), which are used to establish the monthly MCO premium payments.

While it is primarily the MCOs' obligation to ensure claims are not paid to ineligible providers, the Department also has procedures in place to notify MCOs of ineligible providers in their network, so that MCOs can then take appropriate action to remove them and prevent improper payments. A key tool in this process is the Department's Provider Network Data System (PNDS), a database of health care providers, including MCO network providers, contracting with health insurers operating in the State.

MCOs submit provider network data to PNDS quarterly, identifying all providers in their networks. PNDS submissions are a snapshot of the network taken on a specific day at the end of each quarter. The Department's Division of Health Plan Contracting and Oversight (DHPCO) evaluates the PNDS quarterly to identify any MCO network providers that have been identified as an ineligible provider by federal and State authorities or otherwise deemed inactive. For this purpose, DHPCO compares PNDS data with:

- OMIG and OIG Ineligible Lists;
- OPMC inactive provider data; and
- A list of deactivated NPIs generated by the Centers for Medicare & Medicaid Services (CMS) National Plan & Provider Enumeration System (NPPES).

From these analyses, DHPCO produces its quarterly Sanction Provider Reports of excluded, terminated, or sanctioned providers (e.g., physicians, dentists, nurses) and excluded ancillary providers (e.g., pharmacies, labs). As part of its oversight activities, DHPCO's Bureau of Managed Care Certification and Surveillance (BMCCS) sends a notification, along with a list of the sanctioned providers, to each MCO that submitted these providers' data to PNDS. BMCCS also requests each MCO to investigate its identified providers and remove them from the network. For most of our audit scope period, this process was performed on a quarterly basis; however, as of June 2016, notifications to MCOs have occurred biannually, using the second- and fourth-quarter Sanction Provider Reports of each calendar year. DHPCO can also use encounter data to determine if any

claims were billed after the federal or State exclusion dates and if any corrective action is required by the MCO. According to DOH officials, there should not be any encounter claims for those providers after these dates.

Audit Findings and Recommendations

Under the Model Contract, MCOs are responsible for determining the exclusion status of providers, reporting payments made to ineligible providers, and recovering improper payments. Using the DHPCO Sanction Provider Reports and other available State and federal exclusion databases, we determined that MCOs improperly paid a total of $50.3 million for 578,276 ineligible claims during the audit period, including:

- $37.6 million for 379,761 claims paid to ineligible providers; and
- $12.7 million for 198,515 claims paid to pharmacies for prescriptions ordered by physicians who were excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments.

Additionally, 22.5 million encounter claims, totaling over $2 billion, lacked the provider ID needed to assess the propriety of payments. We obtained provider information for the encounter claims of two MCOs – collectively about 4 million encounter claims totaling over $324 million. The MCOs were only able to provide the NPIs for 2.9 million claims totaling over $145 million (less than 8 percent of the $2 billion in payments). For their remaining 1.1 million claims, totaling about $179 million, the MCOs were unable to provide the NPIs because, according to MCO officials, this information was not consistently maintained in their claims systems prior to the implementation of the APD. We analyzed the 2.9 million encounter claims, and determined the MCOs paid 951 claims totaling $82,943 to ineligible providers. In a separate analysis, we also determined the MCOs paid 1,320 claims totaling $295,635 to pharmacies for prescriptions ordered by physicians who were excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments. (A summary of the improper payments we identified is presented in the Exhibit at the end of the report.)

We found that, during our audit scope, the Department launched efforts to improve its ability to detect and prevent payments by MCOs to ineligible providers – actions that, according to Department officials, will be further strengthened when they implement the 21st Century Cures Act (effective January 1, 2018).

These factors notwithstanding, we identified some weaknesses in the Department's monitoring that, properly addressed, could improve MCOs' ability to detect and prevent improper payments to ineligible providers. The Department can take corrective measures by sending ineligible provider notifications to all MCOs, rather than just the MCOs that have the provider reported in a PNDS submission; sending notifications to MCOs more frequently; and performing routine audits of encounter claims using all available exclusion data to identify payments made to ineligible providers.

Improper Payments Based on Sanction Provider Reports

DHPCO's Sanction Provider Reports are a snapshot of the MCOs' network of providers as of a specific day at the end of each quarter and thus, as we determined, may not capture all MCOs'

providers for a particular quarter. Based on the Sanction Provider Reports for the first quarter of 2014 through the second quarter of 2016,[1] we identified improper claims totaling $14.6 million, as follows:

- 112,765 claims, totaling over $8.8 million, paid to ineligible providers; and
- 102,737 claims, totaling about $5.8 million, paid to pharmacies for prescriptions ordered by physicians who were excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments.

Because DHPCO's quarterly Sanction Provider Reports are based on MCOs' most recent quarterly ("snapshot") reporting of providers to PNDS – which does not necessarily include all providers in the MCOs' network during the quarter – they may not be complete. For example, providers omitted from an MCO's PNDS submission will not be included in a match comparison.

We provided the Department with a sample of eight providers that were excluded according to OMIG or OIG Ineligible Lists during the fourth quarter of 2015 or the first quarter of 2016, but that did not appear on the Sanction Provider Reports. The providers were selected based on the dollar amount paid to the provider or the evidence of exclusion from eMedNY. According to DHPCO officials, six of these providers did not appear on DHPCO's Sanction Provider Reports because they had not been submitted to the PNDS by any MCO for those two quarters. All six providers were active during the fourth quarter of 2015, and MCOs paid 981 claims totaling $47,827 to those providers. In addition, two of these six providers were active the first quarter of 2016, and MCOs paid 868 claims totaling $40,120 to those providers. One ineligible provider rendered services simultaneously to members of four different MCOs during these two quarters. This provider was excluded by OMIG effective December 8, 2014, and six MCOs paid 5,071 claims totaling $244,078 to the provider during the exclusion period. For the remaining two of the eight providers, DHPCO officials informed us that the providers were re-enrolled prior to the date of the PNDS submission. Therefore, those providers were not on the OMIG Ineligible List when the matches were made and also not on the Sanction Provider Reports. We found that one of the providers was paid 475 claims totaling $10,528 during the exclusion period, prior to re-enrollment.

Department officials agreed that the Sanction Provider Reports were not a complete listing of ineligible providers as they only represented those providers that MCOs submitted to PNDS. However, officials expected this process would improve with the Department's new PNDS, which replaced the one used during the audit period. Under the new PNDS, MCOs are required to report changes in their networks within 15 business days. According to officials, the new PNDS system became operational during the first quarter of calendar year 2017.

Improper Payments Due to Certain Procedural Weaknesses

Based on our analysis of Ineligible Lists and MCOs' encounter claims, we determined MCOs made $6.3 million in improper payments during the audit period due to various procedural weaknesses. The improper payments included:

[1] Department officials were unable to provide these quarterly reports for any period prior to 2014.

- 44,789 claims totaling over $3 million paid to ineligible providers; and
- 43,543 claims totaling over $3.3 million paid to pharmacies for prescriptions ordered by physicians who were excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments.

We determined these improper payments may have occurred for various reasons, such as:

- MCOs did not conduct adequate database searches. For example, Emblem does not use the OPMC list since it is not explicitly required to by the Model Contract.
- MCOs omitted these providers when matching against federal and State Ineligible Lists due to a complex matching process that does not allow for easy identification of the providers (as discussed below).
- MCOs paid providers that later were excluded retroactively for the periods during which payments were made (retro-exclusion).
- MCOs had delays in notifying providers and terminating them from their networks.
- MCOs did not perform adequate retrospective analyses of ineligible provider payments and take appropriate action.

We also noted that, while MCOs have access to State and federal exclusion databases, most of the databases do not contain every provider's NPI, thus limiting MCOs' ability to perform match comparisons to identify ineligible providers. In the absence of an NPI, MCOs rely on other provider information, such as first and last name or license number. However, any inconsistencies in data entry (e.g., spelling variations) will further hamper appropriate matching and prevent MCOs from identifying ineligible providers.

We provided a sample of nine of Healthfirst's ineligible providers to Healthfirst officials for review. The providers were selected based on the numerical order of the providers' NPIs and the evidence of exclusion from the Ineligible Lists. Healthfirst officials identified exclusion information for seven of the nine providers, and indicated they would initiate recoveries from them. We found the licenses of the remaining two providers were revoked or suspended, one of whom was excluded from Medicaid in 1996 due to incompetence and gross negligence, and yet received over $5,000 in improper payments from Healthfirst. MCO officials stated, however, that they have no records of exclusion for this provider. During the audit scope, this provider also received more than $1.1 million in improper payments from 23 other MCOs, including Emblem.

Improper Payments to Terminated and Deceased Providers

The Department's Enrollment Status File – a comprehensive database of fee-for-service Medicaid providers – is another resource that MCOs could use, but cannot access, to identify ineligible providers. We compared providers identified in the database as "terminated" or "deceased" against the encounter claims data for the audit period, and identified $7.9 million in improper payments, as follows:

- $3.7 million for 72,851 claims paid to ineligible providers; and
- $4.2 million for 63,621 claims paid to pharmacies for prescriptions ordered by physicians

who were excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments.

We conducted further analyses of these providers using data from both eMedNY and the Social Security Administration's (SSA) Death Master File. We were able to confirm a total of 9,540 payments totaling $467,110 were made to 188 deceased providers.

Encounter Claims With Deactivated National Provider Identifiers

According to CMS guidelines, deactivated NPIs should not be used to submit claims (as they will result in improper payments). Since 2007, CMS has disseminated NPI data via the Internet through the NPI Registry and monthly downloadable NPPES files, both of which are available to MCOs to verify the NPI activation status of providers in their networks. In addition, CMS started disseminating NPI deactivation data, including deactivation dates, in August 2016. Despite CMS guidelines, we determined MCOs do not always check these files to ensure that provider NPIs are active in order to prevent improper payment to deactivated providers.

We analyzed the Department's deactivated NPI files in eMedNY, which include beginning and ending dates for each deactivated NPI, and found that MCOs paid a total of $26.3 million in claims with deactivated NPIs, including:

- $24.8 million for 177,831 encounter claims paid to 312 providers with deactivated NPIs; and
- $1.5 million for 11,915 encounter claims paid to pharmacies for prescriptions ordered by 684 prescribers whose NPIs were deactivated.

We identified 27 NPIs that had been deactivated (through June 30, 2016) but still received payments from Healthfirst. We provided Healthfirst officials with one sample claim for each NPI to determine whether Healthfirst made payments in error. According to the MCO, for 20 of the NPIs, the providers were deactivated at the time of payment. For the remaining seven NPIs, we found the providers had been reactivated during our audit scope. Since the CMS deactivated NPI file does not include historical data (and only shows the current status of the provider), the prior deactivation status of the seven providers did not appear in the CMS files. We also identified 36 NPIs that had been deactivated (through June 30, 2016) but still received payments from Emblem. We provided Emblem officials with one sample claim for each NPI to determine whether Emblem made payments in error. Emblem agreed that the claims were paid after the NPI deactivation date. Both MCOs asserted that they regularly update deactivated NPIs based on the data provided by CMS.

According to Healthfirst officials, the deactivated NPI file was not available until August 2016. We confirmed that, after this date, Healthfirst did not make any payments to deactivated NPIs, and Emblem significantly reduced payments to providers with deactivated NPIs. However, our review of all encounter claim payments shows this is not the case with other MCOs, whose overall payments to providers with deactivated NPIs remain significantly high. For the period September 1, 2016 through December 31, 2016, other MCOs paid 17,143 claims totaling over $1.27 million

to providers with deactivated NPIs. One primary reason for the continued payments to providers with deactivated NPIs is that the Department only sends notifications of deactivated providers to those MCOs that submitted the provider to the PNDS.

We performed a further analysis of the 312 deactivated providers to determine if any were deceased. Using data from both eMedNY and the SSA Death Master File, we were able to confirm MCOs paid 20,450 payments totaling $837,372 to 83 deceased providers. We performed a similar match with pharmacy encounter claims, and determined MCOs paid pharmacies a total of $33,828 for 370 claims where the prescriber was deceased at the time the prescriptions were ordered.

Payments to Providers That Lacked Identification Numbers

Although the Department has access to MCOs' encounter claims data, when the provider ID number and NPI are missing, it prevents identification of the provider rendering services.

During the audit period, MCOs paid more than $2 billion for over 22.5 million encounter claims that lacked provider ID numbers and NPIs. Instead, MCOs used one of seven generic IDs assigned by the Department based on the type of medical services provided. Without actual provider data, the Department cannot appropriately match these encounter claims to any of the Ineligible Lists to identify improper payments.

We asked Healthfirst and Emblem to provide us with the provider NPIs for encounter claims with generic IDs paid during the period January 1, 2012 through June 30, 2016. Healthfirst was able to provide the NPIs for 304,702 of 468,056 claims (65 percent), and Emblem was able to provide the NPIs for over 2.6 million of 3.5 million claims (74 percent). The MCOs were unable to provide the remainder of the NPIs (about 1.1 million claims totaling approximately $179 million) because this information was not consistently maintained in their claims system prior to the implementation of the APD. In total, the 2.9 million claims accounted for $145 million (less than 8 percent) of the $2 billion in payments. An analysis of these encounter claims determined the MCOs improperly paid 951 claims totaling $82,943 to ineligible providers.

Further, of the 22.5 million encounter claims, we reviewed 3.3 million pharmacy encounter claims totaling more than $645 million that lacked a pharmacy ID but contained a prescriber NPI. Based on available exclusion data (e.g., OMIG and OIG Ineligible Lists), we determined that MCOs paid pharmacies a total of $295,635 on 1,320 claims where the prescriber was an ineligible provider. For 312,163 pharmacy encounter claims totaling more than $44.1 million, neither pharmacy billing IDs nor prescriber IDs were available. Therefore, we could not determine whether these claims were appropriate.

With the implementation of the APD, MCOs began submitting encounter transactions through the EIS. Within the EIS, the current system logic expects the claim's billing provider to be identified by its NPI. However, we found that provider NPIs were still missing from a significant number of encounter claims even after the implementation of APD. From July 1, 2016 through December 31, 2016, we found NPIs were missing for 985,223 encounter claims, totaling $83.5 million. Although this is a significant improvement over the six-month period prior to the new EIS, which had missing NPIs for about 2.2 million claims totaling over $125 million, the Department needs to

ensure additional information is provided in encounter claim submissions that will help to directly identify the actual provider associated with the claim.

Given the extent of MCO payments to providers with missing IDs, the Department should implement procedures to identify the providers with missing IDs, determine whether they are excluded, and ensure that payments to any ineligible providers are recovered.

Department Notification of Ineligible Providers to MCOs

Once DHPCO matches providers on MCOs' PNDS submissions with Ineligible Lists and prepares the Sanction Provider Reports, rather than notify all MCOs of the ineligible providers, BMCCS only notifies those MCOs whose quarterly PNDS submission included these providers. Our review of encounter claim payments to providers that were included on BMCCS's 2015 fourth-quarter notifications to three selected MCOs – Healthfirst, Fidelis, and United Healthcare (UHC) – found that the three MCOs generally stopped paying the providers, as illustrated in Table 1.

Table 1 – MCO Payments to Ineligible Providers

	Healthfirst	Fidelis	UHC	Totals
Number of ineligible providers listed in BMCCS notification to MCO (2015 Q4)	51	74	81	206
Number of ineligible providers MCO paid following notification (CY 2016)	0	1	6	7
Improper Payments	**$0**	**$3,566**	**$21,620**	**$25,186**

In an additional test, we reviewed the notification letters sent to the three MCOs for the fourth quarter of 2015, and identified a total of 21 providers from the Sanction Provider Report that were not included in the notifications. This resulted in questionable payments by the three MCOs totaling more than $3.6 million, as detailed in Table 2.

Table 2 – MCO Payments to Ineligible Providers

	Healthfirst	Fidelis	UHC	Totals
Number of ineligible providers in Sanction Provider Report (2015 Q4) but not in MCO notification	5	6	10	21
Resulting payments to ineligible providers by MCO (CY 2016)	**$1,291,396**	**$1,562,146**	**$795,718**	**$3,649,260**

When questioned why they did not notify Healthfirst about the five providers that were on the Sanction Provider Reports, BMCCS officials explained that the providers were not included on Healthfirst's PNDS submission. (Note: the providers were included on other MCOs' PNDS submissions. Additionally, our review of encounter payments by the MCOs that reported these five providers in PNDS found no payments after the fourth quarter of 2015.)

DHPCO's Sanction Provider Reports contain valuable, but underutilized data. We identified two procedural refinements that could improve the Department's process and prevent more improper payments:

- Notify each MCO of all ineligible providers identified in the Sanction Provider Reports.
- Send notifications to MCOs more frequently than twice a year.

In response, Department officials stated that, under the Model Contract, MCOs are required to review requisite exclusionary databases as part of their initial credentialing and re-credentialing processes. We maintain that MCOs are making inappropriate payments to ineligible providers despite these requirements, and a universal notification of ineligible providers to all MCOs would enhance MCOs' ability to detect and prevent these payments. Officials also stated that, upon implementation of the new PNDS, they will explore options for more frequent notification of MCOs regarding ineligible provider matches.

Department Reviews of Encounter Claims

According to Department procedures, data from PNDS is used to identify and facilitate the recovery of payments made to ineligible providers. However, neither DHPCO nor BMCCS perform any matching of PNDS data with encounter claims data for this purpose. Performing such matches would provide an indication of whether the Department's process for removing ineligible providers from MCO networks is working, and would also identify inappropriate payments that still need to be recovered. We also found that BMCCS does not inform OMIG, which is responsible for identifying and collecting overpayments to Medicaid providers, including MCOs, of the providers identified as ineligible to participate in Medicaid managed care. We believe OMIG should be informed of the identified providers so it can review and identify improper payments on a regular basis. OMIG officials stated they regularly review encounter claims to identify ineligible providers. However, we found that these reviews are not comprehensive since OMIG does not use all available exclusion databases.

We obtained a report of one such OMIG review from one of the MCOs we selected for analysis. For the same period covered by the OMIG audit, and using the OMIG, OIG, OPMC, and eMedNY exclusion data sets, we found additional questionable payments to pharmacies where the prescriber was excluded from the Medicaid program or otherwise ineligible to receive Medicaid payments. For example, the OMIG match did not identify 2,822 claims totaling $119,930 for prescriptions written by six ineligible prescribers, since OMIG's list of ineligible providers did not include these prescribers. The six ineligible prescribers included three who had been disciplined by State medical boards and had their licenses surrendered/revoked. In another example, the OMIG match did not identify 185 claims totaling $21,076 for two deceased prescribers, as reported in eMedNY.

Need for Historical Exclusion Information

Historical provider exclusion information provides an important audit trail that enables the Department to more effectively identify inappropriate payments. The Department maintains historical provider exclusion information, including exclusion begin and end dates, in eMedNY for fee-for-service providers, but not for MCO network providers. To ensure inappropriate payments are identified and recovered, the Department should maintain this information for MCO network providers as well and share it with MCOs.

MCOs are not contractually required to maintain comprehensive or historical files. Therefore, such an audit trail would expand their capability for preventing improper payments by enabling them to determine whether improper payments were erroneously made to ineligible providers retrospectively. According to officials at both Healthfirst and Emblem, they perform prospective computer matching against exclusion databases on a monthly basis and, once they identify ineligible providers, they stop processing claims for those providers. However, this process may not capture retroactive provider exclusions. For example, we found instances where the effective date of termination as recorded by one MCO was later than the date in the State and federal databases. In situations such as this, where providers were excluded retroactively, MCOs should perform routine reviews to recoup these improper payments. Officials at both MCOs stated they do not keep historical data of ineligible providers since they are not contractually required to do so.

According to Department officials, the issue of historical files will be addressed with the implementation of the 21st Century Cures Act. Specifically, by January 1, 2018, all network providers in Medicaid MCOs will be required to enroll, and maintain active enrollment, in the Medicaid Fee-for-Service (FFS) Program, and the providers' historical enrollment status will be maintained in eMedNY. Department officials stated MCOs will have access to the FFS active provider enrollment file.

Recommendations

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).

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.

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.

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

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

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.

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

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

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether the Department and MCOs have adequate processes in place to prevent payments to ineligible providers and whether improper payments were made to ineligible providers. Our audit covered the period January 1, 2012 to December 31, 2016.

To accomplish our audit objectives, and assess relevant internal controls, we interviewed officials from the Department and two MCOs (Healthfirst and Emblem), and analyzed the Department's quarterly Sanction Provider Reports, federal and State Ineligible Lists, and other available excluded provider data. In using the Sanction Provider Reports, we did not consider any payments to be improper if they occurred during the quarter the provider was initially excluded because the Sanction Provider Reports did not have an exact date of exclusion. For the pharmacy claims where the prescribing physicians were excluded, we considered payments to be improper when the service dates were more than 60 days after the dates of termination, based on OMIG practices. Based on our preliminary audit findings and subsequent discussions with Department officials, we worked with Department and OMIG officials to remove from our analysis any providers that were inactive, disciplined, or sanctioned, which would not prohibit payment of Medicaid dollars. In addition, any exception claims that resulted from more than one data set that we used to identify exception claims were removed from the final findings (see "Remove Duplicate Claims" in the Exhibit). We used the OMIG, OIG, and OPMC Ineligible Lists as of June 2016 to match against MCOs' encounter claims paid during the period from January 1, 2012 through June 30, 2016. We also performed a similar match with encounter claims paid during the period July 1, 2016 through December 31, 2016 using the OMIG and OIG files as of December 2016.

We reviewed the Department's Model Contracts with MCOs and analyzed encounter claims that MCOs reported as paid. To assess the accuracy of pertinent eMedNY data, as well as the propriety of payments made by the MCOs, we judgmentally selected several samples from our exception files for review by the Department, OMIG, and the two selected MCOs. In addition, we matched the dates of death from eMedNY with information obtained from an independent third-party service that maintains information from the SSA Death Master File.

Note: Our ability to identify all improper payments to ineligible providers during our audit period

was limited due to incomplete data. For example, the MCO did not always indicate the provider was active on its quarterly network provider submission. Also, irregular or inconsistent data layouts in some exclusion lists prevented us from performing complete data matches. However, based on our analysis, we determined that the data was sufficiently reliable for the purposes of this report.

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 to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these 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 the report. In their response, Department officials generally concurred with the audit 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.

Contributors to This Report

Andrea Inman, Audit Director
Dennis Buckley, Audit Manager
Christopher Morris, Audit Manager
Sal D'Amato, Audit Supervisor
Mostafa Kamal, Examiner-in-Charge
Misty Daiyan, Senior Examiner
Aissata Niangadou, Staff Examiner
Mary McCoy, Senior Editor

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.state.ny.us

Ken Shulman, Assistant Comptroller
518-473-0334, kshulman@osc.state.ny.us

Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews, and evaluations of New York State and New York City taxpayer-financed programs.

Exhibit

Summary of Improper Payments

Improper Payment Category	Claims Paid to Ineligible Providers		Pharmacy Claims Paid Where Prescribers Were Ineligible	
Ineligible Providers	**Claims**	**Amount**	**Claims**	**Amount**
DHPCO Quarterly Reports	112,765	$8,809,013	102,737	$5,782,588
OMIG/OIG/OPMC Lists	44,789	3,035,061	43,543	3,324,251
eMedNY Enrollment Status File	72,851	3,709,543	63,621	4,210,889
Deactivated NPIs	177,831	24,852,238	11,915	1,550,931
Subtotals	**408,236**	**$40,405,855**	**221,816**	**$14,868,659**
Less: Duplicate Claims	28,475	2,824,026	23,301	2,143,445
Ineligible Provider Totals	**379,761**	**$37,581,829**	**198,515**	**$12,725,214**
Ineligible Providers That Lacked IDs	**951**	**$82,943**	**1,320**	**$295,635**
Totals	**380,712**	**$37,664,772**	**199,835**	**$13,020,849**

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

December 27, 2017

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 comments on the Office of the State Comptroller's Draft Audit Report 2016-S-59 entitled, "Managed Care Organizations: Payments to Ineligible Providers."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
Dennis Rosen
Erin Ives
Brian Kiernan
Timothy Brown
Elizabeth Misa
Geza Hrazdina
Jeffrey Hammond
Jill Montag
James Dematteo
James Cataldo
Diane Christensen
Lori Conway
OHIP Audit SM

Department of Health
Comments on the
Office of the State Comptroller's
Draft 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) Draft 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 (MCO) with instructions to recover improper payments where appropriate. The MCOs will be further instructed to provide a reconciliation which will be shared with OMIG. 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. As such, we defer to OSC for an acceptable way the MCOs can provide proof of their recoupment efforts. OMIG has MMCOR audits in various stages of the audit process. As part of the OMIG's MMCOR audits, OMIG reviews claim data to ensure that recoveries are appropriately reported on the MMCORs.

* Comment 1

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.

* See State Comptroller's Comments, Page 24.

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. As there are multiple MCOs impacted by this recommendation, response files have been received from the MCOs regarding this request, and are now being compiled into a single file. This file will be turned over to OMIG for review and determination on whether improper payments have occurred. The Department anticipates turning this information over to the OMIG by the end of 2017. OMIG will perform analysis and 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 will require 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 will 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 Department's 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 sanctioned providers and remove them from the MCO's networks. Plans are notified of such matches and are notified by the Department to remove a 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 audits 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 will be 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.

* Comment 2

Recommendation #8

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

Response #8

Pending final approval of the revised mainstream managed care model contract, currently under Centers for Medicare and Medicaid Services (CMS) review, OMIG will monitor the adequacy of MCOs' retrospective analyses and recoupment of ineligible provider payments.

State Comptroller's Comments

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