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August 22, 2018

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

Re: Medicaid Managed Care Organization
Fraud and Abuse Detection
Report 2018-F-1

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Medicaid Managed Care Organization Fraud and Abuse Detection* (Report 2014-S-51).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. Through the Medicaid managed care program, the Department contracts with managed care organizations (MCOs) to coordinate the care of Medicaid beneficiaries. The Department pays MCOs a monthly premium payment for each enrolled beneficiary and MCOs pay claims from health care providers (referred to as encounter claims).

MCOs are responsible for ensuring they do not make payments to ineligible health care providers who have been excluded or terminated from the Medicaid program. In addition, MCOs are required to have effective compliance programs, including full-time Special Investigation Units (SIUs) dedicated solely to the prevention, detection, and investigation of fraud and abuse. State oversight of MCOs must ensure that only eligible health care providers participate in Medicaid.

We issued our initial audit report on July 15, 2016. The audit objective was to determine if United HealthCare (UHC) and Amerigroup made payments to ineligible health care providers

and whether these MCOs established and implemented adequate SIUs to detect, prevent, and follow up on instances of fraud and abuse. Our audit covered the period January 1, 2011 through December 31, 2014.

We determined that UHC and Amerigroup made improper and questionable payments totaling more than $6.6 million to providers who were excluded from the Medicaid program. Furthermore, recoveries of improper payments by UHC's and Amerigroup's SIUs were very limited. We also found that New York's Medicaid program had no specific requirements or criteria for SIU staffing levels, and there was a considerable risk that UHC and Amerigroup did not adequately staff their SIUs. With minimal staffing, the MCOs had limited ability to identify and recover fraudulent and improper payments, which increased the risk that Medicaid paid for improper claims. Lastly, we found the SIU staff at both MCOs received inadequate annual training.

We recommended that the Department ensure the improper MCO payments made to ineligible providers were recovered; strengthen steps to oversee and monitor MCOs to ensure that only eligible providers are reimbursed; and take steps to establish appropriate criteria for SIU staffing levels, adequate training requirements for the SIU staff, and a process for ensuring consistency and accuracy in reporting SIU activities and recoveries.

The objective of our follow-up was to assess the extent of implementation, as of August 7, 2018, of the 11 recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made some progress in addressing the problems we identified in the initial audit report. However, significant actions are still needed. With the Department's implementation of the 21st Century Cures Act, all MCO network providers are now required to enroll as a Medicaid provider and obtain a Medicaid ID. MCOs can access this enrollment information to help ensure only eligible (non-excluded) providers are included in their networks. However, a significant amount of the MCO payments to ineligible providers that we identified in the initial audit have not been recovered, and the Department has not developed a process to verify that all recoveries are reported to the Department to ensure that managed care premium payments are properly calculated. In addition, the Department has not established minimum MCO SIU staffing levels.

Of the initial report's 11 audit recommendations, 2 were implemented, 4 were partially implemented, and 5 were not implemented.

Follow-Up Observations

Recommendation 1

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

Status – Partially Implemented

Agency Action – Our initial audit determined UHC and Amerigroup made improper payments totaling $1.1 million to providers who were excluded from the Medicaid program. In response to our initial audit, the Department agreed that payments to excluded providers should be recovered, and the Department indicated it would work with the MCOs to ensure that amounts paid to excluded providers were recovered and reported to the Department accordingly.

The Department shared our claim findings with Amerigroup and UHC and directed them to review and recover improper payments made to excluded providers. However, our initial audit concluded that the MCOs' excluded provider lists (that would be used to do the review) were incomplete. For example, we found that UHC and Amerigroup collectively reimbursed one pharmacy $43,217 during a period when the Office of the Medicaid Inspector General (OMIG) had excluded the pharmacy from participating in Medicaid due to abusive billing practices – such as billing Medicaid for prescription drugs that were not dispensed. Upon review of our audit findings, neither MCO determined its payments to this pharmacy were inappropriate. In fact, the MCOs' review found that only about $129,000 of the $1.1 million we identified was paid to excluded providers.

Therefore, in accordance with our recommendation, it is important that the Department complete its own review of the MCO payments to ineligible providers that we identified and make its own determination on the appropriateness of such payments.

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.

Status – Partially Implemented

Agency Action – During our initial audit, we determined UHC and Amerigroup submitted over 6 million encounter claims (totaling $340 million of the $445 million) that lacked billing provider identification numbers (IDs) and/or provider names that could be used to determine if the MCOs made payments to ineligible providers. At the time of our initial audit, the Department reviewed these claims and, using National Provider Identifiers (NPIs), identified $5.5 million in questionable payments to excluded providers. The Department shared the files with Amerigroup and UHC after the initial audit and requested that the MCOs review the files and provide any additional information that would assist in establishing the billing providers' identity. However, during our follow-up review, the Department chose to restart its efforts using the findings from the initial audit and, as such, the review has not been completed.

Additionally, our initial audit identified over 1.2 million encounter claims (totaling $105 million of the $445 million) that contained generic billing provider IDs (such as one common billing ID generated for claims submitted by out-of-state pharmacies) and for which NPIs were unavailable. The Department provided the 1.2 million encounter claims to the MCOs and requested additional information to identify excluded providers. According to the Department, only UHC provided the necessary information. However, the Department did not analyze it. After the start of our follow-up review, the Department re-sent the original audit findings to the MCOs for review and instructed them to recover improper payments made to ineligible providers.

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.

Status – Not Implemented

Agency Action – MCOs are required to report recoveries of improper payments on the Medicaid Managed Care Operating Reports (MMCORs), which are filed with the Department. Such recoveries are factored into the premium calculations (for example, large recoveries could decrease premium payments). Recoveries are reported as an aggregate amount on the MMCORs. Therefore, the Department cannot use this report exclusively to determine if the improper payments we identified during our initial audit were recovered, or to determine the impact these recoveries, if made, had on premium calculations.

At the time of our follow-up review, the Department had not taken any steps to verify what amount, if any, of the improper payments we identified in our initial audit were reported on UHC's or Amerigroup's MMCORs and what impact that had on the premium calculations.

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).*

Status – Implemented

Agency Action – At the time of our initial audit, the Department monitored MCO provider networks through the Department's Comprehensive Operational Surveys, which included reviews of MCO policies and procedures and compared MCO provider networks with certain exclusion lists. During the initial audit, we identified flaws in this oversight process. We found that the Department did not use the Enrollment Status File to monitor MCO provider networks and, as a result, the Department did not notify MCOs of all ineligible providers that should be excluded from the MCOs' networks. The Enrollment Status File, located in the Department's Medicaid claims processing system (eMedNY), is a comprehensive file (populated from various sources) of excluded fee-for-service (FFS) Medicaid providers. We concluded the Department's oversight process would be enhanced if it used the Enrollment Status File to help monitor the MCOs. During our follow-up review, the Department stated they now use the Enrollment Status File to monitor MCO provider networks. The Department identifies ineligible providers and notifies the MCOs accordingly.

During the initial audit, we also determined the MCOs did not have access to the Enrollment Status File. Rather, the MCOs used various listings of excluded providers to determine which providers should be excluded from their networks. However, based on the exceptions we identified during our initial audit, we concluded the MCOs did not use the multiple sources adequately. We found that the Department's Enrollment Status File would help the MCOs identify ineligible providers that were not identified by the MCOs' other reviews. We also determined the Enrollment Status File (which identified excluded FFS providers) should be updated to include all providers within the MCOs' provider networks, including those who did not have a Medicaid ID.

After our initial audit, as a result of the implementation of the 21st Century Cures Act, in 2018, all MCO network providers are now required to enroll, and maintain active enrollment, in the Medicaid FFS program (accordingly, all MCO network providers now have a Medicaid ID). The new "active" provider enrollment file is a comprehensive list of eligible Medicaid FFS and MCO network providers. The active provider enrollment file reflects the information in the Enrollment Status File. According to Department officials, MCOs have access to the active provider enrollment file to monitor whether any of their network providers are ineligible providers.

Recommendation 5

Establish appropriate criteria for SIU staffing levels.

Status – Not Implemented

Agency Action – Our initial audit determined that, in the absence of any managed care contractual requirements or State regulations mandating specific SIU staffing levels, MCOs may not always maintain adequate staffing levels to effectively prevent, detect, and investigate Medicaid fraud and abuse. We found this to be the case with both UHC and Amerigroup,

which are among the larger MCOs in the State's Medicaid program.

Although the Department agrees that adequate staffing is critical to the success of SIU activities, the Department has not established criteria for SIU staffing levels. In 2017, the federal Centers for Medicare & Medicaid Services (CMS) recommended that the Department mandate a minimum number of SIU staff to ensure adequate program integrity oversight of network providers. However, according to Department officials, without guidance from CMS or widely accepted standards for staffing criteria, a minimum SIU staffing size cannot be mandated.

Inadequate SIU staffing levels may lead to inadequate fraud and abuse prevention, detection, and investigation efforts and can result in care being provided by unqualified or unethical providers, which could potentially impact the health and safety of Medicaid MCO enrollees. Furthermore, MCOs report medical expense payments made on behalf of enrollees to the Department, and the Department uses this information to establish MCO premiums. As a result, inadequate SIU staffing levels increase the risk that Medicaid may pay fraudulent or unnecessary claims, which may result in inflated premiums to MCOs.

Recommendation 6

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

Status – Not Implemented

Agency Action – As specified previously in the Agency Action section of Recommendation 5, the Department did not establish criteria for SIU staffing levels. Therefore, the Department did not revise the managed care model contract language to require that MCOs meet an established criteria for SIU staffing levels.

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 premium rates as appropriate.

Status – Not Implemented

Agency Action – MCOs are required to report recoveries of improper payments on the MMCORs they file with the Department (recoveries offset MCO expenses in the premium calculations). In addition, the MCOs file an annual Fraud and Abuse Prevention Plan (FAPP) report with the Department that provides detail of SIU-related fraud and abuse recoveries. Our initial audit analyzed the recoveries reported on UHC's and Amerigroup's MMCORs and FAPP reports and found underreporting of recoveries on both the MMCORs and the FAPPs during the audit period.

At the time of our follow-up review, the Department had not verified the actual recoveries by UHC and Amerigroup for the audit period and determined if there was any impact on the monthly premium rates.

Recommendation 8

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

Status – Partially Implemented

Agency Action – MCOs report recoveries on three different reports: the MMCOR, the FAPP, and (as of 2016) the Annual Program Integrity (API) report. These reports serve different functions. The MMCOR is used to facilitate premium rate setting, and the FAPP and API reports are used to evaluate MCO SIU activities. Our initial audit identified numerous problems in the way MCOs accounted for SIU activities on the MMCORs and FAPP reports filed with the Department. For example, we found numerous instances of underreporting of recoveries on UHC's and Amerigroup's MMCORs. We also reviewed the 2011 FAPP reports filed by Amerigroup and UHC and found: Amerigroup presented its SIU recovery data as estimated amounts rather than actual recoveries; UHC omitted seven cases of recoveries totaling $139,854; and both MCOs omitted information about their fraud and abuse cases.

In response to our initial audit, the Department updated the MMCOR instructions related to reporting recoveries. However, additional improvements are needed. The updated MMCOR instructions for reporting cost recoveries instruct MCOs to match the dollars reported on their FAPP reports. However, the FAPP instructions require MCOs to include payment denials (i.e., claims not paid due to SIU activity), not just actual cost recoveries. As a result, MCOs may report amounts on the MMCOR that were not actually recovered, which could cause inaccuracies in the premium rate setting process.

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.

Status – Not Implemented

Agency Action – In our initial audit, we determined the Department did not exercise proper oversight over the recoveries reported on the MMCORs or the accuracy of SIU fraud and abuse investigation recoveries reported on the MCOs' annual Compliance Plans (i.e., the MCOs' annual FAPP reports).

During our follow-up, we selected four MCOs and compared the data reported on their

2016 MMCORs and FAPP and API reports. The following table illustrates the significant differences in reported recoveries from the various reports. These differences were not reconciled by the Department.

2016 Reported Recoveries

MCO Name	MMCOR	FAPP	API
HealthPlus/Empire (Amerigroup)	$176,029	$2	$1,178,386
MetroPlus	117,974	4,098,376	267,970
UHC	11,131	Not Available	733,645
Wellcare	Not Reported	124,512	343

According to Department officials, the three reports serve different purposes and were not designed to be reconciled. However, during our follow-up review, Department and OMIG officials agreed to collaborate to determine if the reports could also be used to monitor recovery amounts reported on the MMCORs.

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.

Status – Partially Implemented

Agency Action – In our initial audit, we found that while MCOs submitted information on staff trainings in their annual FAPP reports (i.e., the Compliance Plans), these reports did not contain specific details, such as the number of training hours provided, the title or content of the training, or attendees.

After our initial report was issued, OMIG began requiring MCOs to complete an API report, which identifies specific SIU training requirements. However, we found that the results of the report were not shared with the Department, even though the Department is responsible for ensuring SIU training requirements are appropriate.

Additionally, during our follow-up, we reviewed the 2016 and 2017 API reports submitted by four MCOs and found that the SIU staff training was not uniformly reported. For example:

- UHC reported the training for all SIU employees, the title of each training for each individual, and their respective durations.
- Amerigroup reported information only for new SIU hires.
- MetroPlus and Wellcare did not document the employees, titles of trainings, or the training durations.

During our follow-up, OMIG officials agreed to look into sharing the results of the API reports with the Department.

Recommendation 11

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

Status – Implemented

Agency Action – Our initial audit determined that UHC's and Amerigroup's investigators did not always meet their own mandatory core and specialized training program requirements for SIU employees. The Department conducts operational surveys of MCOs every two years, which include a review of staff training. Non-compliant MCOs must submit a Plan of Correction to the Department. According to Department officials, they will then conduct a targeted survey, typically within one year following the full operational survey, to review the MCO's compliance with its Plan of Correction.

During our follow-up, we obtained and reviewed the Department's 2016 operational surveys of UHC and Amerigroup. Both MCOs were found to be compliant. According to Department officials, MCOs are required to show annual and quarterly training documentation (i.e., training logs and attendance sheets) and demonstrate training requirements were met through Department interviews with SIU staff.

Major contributors to this report were David Schaeffer, Jasbinder Singh, Edward Reynoso, Laura Singh, and Kevin Fung.

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

Very truly yours,

Christopher Morris
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General