NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

October 11, 2019

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 Follow-Up Audit Report 2019-F-2 entitled, "Managed Care Organizations: Payments to Ineligible Providers." (2016-S-59)

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the Office of the State Comptroller's Follow-Up Audit Report 2019-F-2 entitled, Managed Care Organizations: Payments to Ineligible Providers (Report 2016-S-59)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2019-F-2 entitled, "Managed Care Organizations: Payments to Ineligible Providers."

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).

Status – Partially Implemented

Agency Action – Our initial audit found that MCOs made $50.3 million in payments to providers who were excluded from the Medicaid program or were otherwise ineligible to receive Medicaid payments. At the conclusion of our initial audit, we provided the Department with the claim details supporting our findings.

In April 2019, after we initiated our follow-up review, the Department distributed the finding data to the MCOs for review. The Department is in the process of compiling the responses from the MCOs and plans to forward the information to OMIG for review and to ensure the MCOs report the recoveries on their MMCORs. We note that, of the $50.3 million in audit findings, $7.2 million of the improper payments (14 percent) represented dates of services between January 1, 2012 and June 30, 2013. Due to federal look-back provisions, these payments may no longer be recoverable. We encourage the Department to take prompt action to avoid any loss of recoveries.

Response #1:

In conjunction with the Department, per Model Contract language, the Office of the Medicaid Inspector General (OMIG) will utilize the Provider Investigative Report to monitor Managed Care Organizations (MCOs) recoupment of inappropriate payments made to ineligible providers.

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.

Status – Partially Implemented

Agency Action – Our initial audit identified 22.5 million MCO encounter claims that lacked the provider IDs needed to assess the propriety of payments. Department officials stated they obtained the provider IDs for 19.3 million encounter claims and, in March 2018, sent the information to OMIG to facilitate its review of the appropriateness of these payments. OMIG is still working on this review and was unable to provide a timeline for completion. The Department also

explained that the MCOs were unable to provide information for the remaining 3.2 million encounter claims because some encounters were associated with MCOs that were no longer in business, and some provider ID numbers were not consistently maintained in the MCOs' claims systems prior to the 2015 implementation of the All-Payer Database.

Response #2:

In conjunction with the Department, OMIG is performing an analysis on the 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.

Status – Partially Implemented

Agency Action – In our original audit, we found MCOs did not use certain State and federal databases for ineligible provider reviews because they were not explicitly required to do so by the Model Contract.

Following our initial audit, implementation of the 21st Century Cures Act requires Medicaid MCO network providers to undergo monthly sanction checks against mandated federal and State databases. Providers found in any of these databases are subsequently removed from the active Medicaid provider enrollment file. This file is published bimonthly on Open Data NY and is accessible to all MCOs to verify the status of providers in their networks and identify any corresponding improper payments. However, the Department was unable to demonstrate what steps it has taken to ensure MCOs utilize Open Data NY or the other federal and State databases.

In addition, our follow-up review found limitations with Open Data NY that could allow payments to ineligible providers. For example, we compared the provider listing on Open Data NY as of April 15, 2019 to the April 9, 2019 federal deactivated NPI list disseminated by CMS. We found 83 providers active in Open Data NY that had deactivated NPIs per the federal list, and two MCOs made combined payments of $21,310 to one of the deactivated providers.

Response #3:

The Department enhanced the Medicaid Enrolled Provider Listing found on Health Data NY in September 2019, whereby such list is updated weekly and adds additional data elements to enhance the MCO's ability to match their network providers. The Department has hosted monthly webinars to instruct MCOs to utilize this data set for verifying Medicaid enrollment. During operational surveys, Department staff confirms, by reviewing a sample of provider credentialing files, that plans are checking required exclusionary databases and terminating providers in accordance with the above directives. Department staff also reviews policies and procedures to assure the MCO is performing activities in accordance with these requirements.

The Department receives a list of deactivated providers from the federal government's National Plan and Provider Enumeration System monthly. The Centers for Medicare and Medicaid Services provides up to 60 days for a State Medicaid Agency to act on exclusions on this list.

Such State action will be reflected in the weekly Health Data NY update which provides MCOs with timely information as to the enrollment status of their network providers. The Health Data NY is a tool, combined with the requirement of monthly exclusion checks by MCOs, which allows MCOs to react timely to exclusions. Relating to OSC's example, the Department was not able to locate a six-calendar day standard limitation turnaround from federal exclusion notification to MCO network termination.

Recommendation #4:

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

Status – Implemented

Agency Action – In our initial audit, we identified Medicaid payments to providers listed on the Department's Sanction Provider Report. We found that the Department would only notify an MCO about a provider on the Sanction Provider Report if that MCO had included that provider on its quarterly PNDS submission. After our initial audit, the Department started sharing all the results of the Sanction Provider Reports produced from all MCOs' PNDS submissions with all MCOs.

Response #4:

The Department confirms agreement with this report.

Recommendation #5:

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

Status – Implemented

Agency Action – In response to our audit, in the second quarter of 2017, the Department increased the frequency of the BMCCS notifications to the MCOs from semiannually to quarterly.

Response #5:

The Department confirms agreement with this report.

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.

Status – Not Implemented

Agency Action – In our original audit, we found that OMIG's review of encounter claims for one of two MCOs we selected did not identify certain excluded prescribers on OPMC lists and two deceased prescribers reported in eMedNY. As part of our follow-up review, we determined that OMIG did not have any ongoing or recently finalized audits with the objective of identifying payments to ineligible providers.

Response #6:

OMIG is finalizing the process to 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.

Status – Partially implemented

Agency Action – According to Department officials, beginning in the fourth quarter of 2018, the Department started retaining quarterly Sanction Provider Reports from PNDS submissions for historical purposes. However, as described in our original report, use of the Sanction Provider Report for the purposes of identifying improper payments to excluded providers is limited. OMIG also maintains an exclusion list, which is updated daily, on its website. However, the exclusion list does not contain all historical provider exclusion information. For example, if a health care provider is subsequently removed from OMIG's exclusion list (i.e., the exclusion was temporary), the historical information about the provider's exclusion is no longer listed. According to OMIG officials, historical provider exclusion information can be provided to MCOs on a case-by-case basis, upon request. However, this level of accessibility is inadequate for MCOs to use for comprehensive reviews of the appropriateness of payments to providers.

Response #7:

OMIG maintains a current provider 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.

Status – Partially Implemented

Agency Action – After our initial audit, the Model Contract was updated and now requires MCOs to submit a quarterly Provider Investigative Report (PIR) to OMIG. According to OMIG officials, they use the PIR to monitor the adequacy of MCOs' retrospective analyses and recoupment of inappropriate payments made to ineligible providers. However, the PIR is currently used to report Medicaid overpayment recoveries in general, not just payments made to excluded providers. According to OMIG officials, the report is currently being updated to make the data more useful for monitoring MCO recoupments from ineligible providers.

Response #8:

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.