Thomas P. DiNapoli
State Comptroller

110 State Street
Albany, New York 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 3, 2024

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program
Report 2023-F-24

Dear Dr. McDonald:

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 (Department) to implement the recommendations contained in our initial audit report, *Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program* (Report 2019-S-72).

Background, Scope, and Objective

The Department administers New York's Medicaid program. The Affordable Care Act and implementing federal regulations mandated that state Medicaid agencies require all ordering and referring physicians and other professionals providing services through the Medicaid fee-for-service program to be enrolled as participating providers in the State Medicaid program. Accordingly, beginning January 1, 2014, New York's Medicaid program required that physicians and other health care professionals who order, prescribe, refer, or attend Medicaid services be appropriately screened and enrolled in Medicaid and have an "active" provider status. Through the screening and provider enrollment process, the Department gains a level of assurance over the ordering, prescribing, referring, or attending (OPRA) provider's validity to provide Medicaid services. It also allows the Department to verify the provider's licensing and other credentials to furnish services. Additionally, the Department must verify that no providers are prohibited from participating in a Medicaid program by the federal government, which further enhances the safety of the Medicaid program and its members.

The objective of our initial audit, issued April 19, 2022, was to determine whether the Department made improper payments for claims in violation of federal and State requirements related to OPRA providers who were no longer participating in the Medicaid program. The

audit covered the period from January 2015 through December 2019. The audit found that the Department's eMedNY claims processing system edits that were implemented in 2014 to prevent payments of Medicaid claims for services with an inactive OPRA provider were flawed and failed to check the provider's active status. As a result, the audit identified $965 million in Medicaid payments for 2.3 million OPRA services by physicians and professionals who were no longer actively enrolled in Medicaid.

The objective of our follow-up was to assess the extent of implementation, as of September 20, 2023, of the six recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made limited progress in addressing the problems we identified in the initial audit report and additional actions are still needed. For example, less than 1% of the $965 million had been recovered and, we note, the Office of the Medicaid Inspector General (OMIG) was unable to demonstrate that any of the recoveries were related to our audit's objective. In addition, the Department had not enhanced eMedNY system controls to more timely identify OPRA providers who were not actively enrolled in Medicaid and deny the related claims. Of the initial report's six audit recommendations, one was implemented and five were not implemented.

Follow-Up Observations

Recommendation 1

Review the $965 million in payments to providers for Medicaid services that did not meet federal and State OPRA regulations – particularly payments for services with an OPRA provider excluded from participating in the Medicaid program – and determine an appropriate course of action, including determining if any recoveries should be made.

Status – Not Implemented

Agency Action – Our initial audit found $965 million in Medicaid payments for claims that required an active OPRA provider on the claim's order or service date but were instead provided by an inactive OPRA provider, including $5.8 million for providers who were excluded from participating in Medicaid due to past misconduct. In response to our initial audit, Department officials stated they were collaborating with OMIG on a comprehensive strategy, including guidance and possible corrective actions for claims we identified. However, at the time of our follow-up, less than 1% of the $965 million had been recovered, and OMIG was unable to demonstrate that any of the recoveries were related to projects initiated in response to our initial audit. Additionally, according to OMIG, a portion of the claims are non-recoverable because they were used in recovery calculations associated with other OMIG audits. We note OMIG may have already lost the opportunity to recover nearly $838 million of the payments due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the improper payments we identified to prevent further loss of recoveries.

Recommendation 2

Review the $10.3 million payments to providers for Medicaid services where the attending provider on institutional claims was not affiliated with the billing facility, as required, and determine an appropriate course of action, including determining if any recoveries should be made.

Status – Not Implemented

Agency Action – Our initial audit found $10.3 million in Medicaid payments (most of which was part of the $965 million) where the attending provider was not affiliated with the billing facility provider in eMedNY, the Department's claims processing and payment system, as required. Without this, the Department lacks assurance that the attending provider was screened by the facility. In response to our initial audit, Department officials stated they were collaborating with OMIG on the development of a comprehensive strategy to identify improper payments and make recoveries. At the time of our follow-up, the Department and OMIG were unable to provide evidence that any of the claims identified by our initial audit had been reviewed or recovered.

Recommendation 3

Improve controls to more timely identify OPRA providers with an inactive status to prevent the types of improper Medicaid payments we identified after the enhancements to eMedNY edits were made in February 2018.

Status – Not Implemented

Agency Action – The Department enhanced eMedNY system controls in February 2018 that significantly reduced the number of improper claims billed with an inactive OPRA provider. However, improper payments continued. In response to our initial audit, the Department stated that an extensive project to review and remediate system edits and to improve provider compliance with State and federal OPRA requirements was in progress. However, at the time of our follow-up, the project was on hold and the Department had not made any additional improvements to controls.

Recommendation 4

Update and issue guidance clarifying OPRA billing requirements to providers, such as nursing home and home health, who have not yet received these communications.

Status – Not Implemented

Agency Action – Our initial audit found that the Department had issued guidance to certain providers to clarify OPRA requirements, such as pharmacy and intermediate care facilities for the developmentally disabled, but had not issued guidance related to nursing home or home health services (these services accounted for about $629 million of the $965 million in overpayments we identified, or 65%). In response to our initial audit, Department officials stated that they would update billing guidelines to clarify which OPRA fields are required when the associated eMedNY system projects were complete. However, since the eMedNY system projects were put on hold, the Department had not yet updated and issued the guidance.

Recommendation 5

Ensure providers who should be excluded from the Medicaid program are added to the provider sanction table in a timely manner.

Status – Not Implemented

Agency Action – The eMedNY provider sanction table contains information on excluded providers. If excluded providers are not in the provider sanction table, established system edits cannot prevent inappropriate claim payments for services provided by these individuals. Our initial audit identified 116 providers who were not on the provider sanction table but were on OMIG's Excluded Provider List or on the Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities. In response to our initial audit, OMIG stated that it implemented a process in January 2018 to confirm that eMedNY is updated accurately and timely in order to prevent claims from being paid when a provider was excluded. Upon our subsequent inquiry, OMIG confirmed that no updates had been made to this process since our initial audit. Because 16 of the 116 providers we identified were excluded after OMIG's 2018 process became effective, and the remaining 100 providers had still not been added to the provider sanction table at the time of the initial audit, we encourage the Department and OMIG to ensure providers who should be excluded from the Medicaid program are added to the provider sanction table in a timely manner.

Recommendation 6

Formally remind facilities not to delete affiliations with providers in eMedNY who are no longer affiliated with the facility in order to maintain a record of the affiliation.

Status – Implemented

Agency Action – The eMedNY system requires the attending provider on institutional claims, such as clinic and inpatient claims, to be affiliated with the billing facility on the date of service. According to the Department's guidance, if the attending provider is not affiliated with the facility on the date of service, the claim will be denied. If, at any time, the attending practitioner ceases to be affiliated with the facility, the facility must enter an end date for the affiliation in eMedNY. Our initial audit found that, although Department guidance instructed facilities to deactivate affiliations in order to maintain a record of the affiliation period, facilities also had the option to delete affiliations. However, deleting affiliations effectively removed all evidence that the attending practitioner was ever affiliated with the facility. In the August 2022 edition of the Medicaid Update (the Department's official publication for Medicaid providers), the Department informed providers they could no longer delete affiliations and instead must enter the end date of the affiliation.

Major contributors to this report were Thomas Sunkel, Emily Proulx, and Benjamin Buyer.

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 follow-up.

Sincerely,

Christopher Morris
Audit Manager

cc: Melissa Fiore, Department of Health
Frank T. Walsh, Jr., Office of the Medicaid Inspector General