



Department of Health

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Executive Deputy Commissioner

May 29, 2026

Christopher Morris, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Christopher Morris:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report, 2025-F-21 entitled, "Department of Health/ Medicaid Program - Managed Care Payments to Unenrolled Providers (Follow Up to Report 2021-S-6)"

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in blue ink that reads "Johanne E. Morne".

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

cc: Frank Walsh
Amir Bassiri
Jacqueline McGovern
Amber Gentile
Brian Kiernan
Timothy Brown
James Dematteo
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**Department of Health Comments on the
Office of the State Comptroller’s
Follow-Up Audit Report 2025-F-21 entitled, “Managed Care Payments
to Unenrolled Providers” (Report 2021-S-6)**

The following are the Department of Health’s comments in response to the Office of the State Comptroller’s Follow-Up Audit Report 2025-F-21 entitled, “Managed Care Payments to Unenrolled Providers” (Report 2021-S-6). Included in the Department’s response is the Office of the Medicaid Inspector General’s (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

Below are definitions of the acronyms used in this audit response:

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| ○ Office of the State Comptroller | OSC |
| ○ Department of Health | DOH or Department |
| ○ Office of the Medicaid Inspector General | OMIG |
| ○ Medicaid Data Warehouse | MDW |
| ○ Management Care Organizations | MCOs |
| ○ National Provider Identifier | NPI |
| ○ Provider Network Data System | PNDS |
| ○ Office of Addiction Services and Supports | OASAS |
| ○ Provider Investigative Report | PIR |

Audit Recommendation Responses:

Recommendation #1

Review the Medicaid payments to unenrolled in-network providers (\$916 million) and providers who were denied Medicaid enrollment (\$832.5 million), and determine an appropriate course of corrective action—including prioritizing the payments to providers who were denied enrollment in Medicaid.

Status – Not Implemented

Agency Action – DOH did not provide any evidence of actions taken to address this recommendation.

Response #1

OMIG continuously performs audits of excluded providers in Managed Care. OMIG has verified voids of more than \$11.5 million of OSC-identified payments. OMIG continues to perform data analysis and is currently developing a process to address recoverable claims of the remaining specific OSC-identified payments. OMIG is also engaged with the Department to provide information regarding provider enrollment and contract oversight.

OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider’s right to due process.

Recommendation #2

Ensure MCOs took appropriate action on the 272 unenrolled in-network providers we identified from the June 2022 Quarter 2 PNDS submission file.

Status – Partially Implemented

Agency Action – The initial audit analyzed all MCO encounter claims (in-network and out-of-network) for the period January 2018 through June 2022, and determined that MCOs made over \$4.9 billion in payments that had an unenrolled billing provider National Provider Identifier (NPI) and/or billing provider ID. We obtained the PNDS quarterly submissions for five MCOs that accounted for \$2.6 billion (53%) of these payments. As of the PNDS June 2022 Quarter 2 submission file—the most recent submission file we reviewed—there were 272 unenrolled in-network providers on encounter claims for the five MCOs.

At the time of our follow-up, we found that 102 of the 272 providers were actively enrolled. We reviewed the 2025 Quarter 2 PNDS submission files and found that, of the remaining 170 providers who were still not enrolled, 118 were no longer in-network with the MCOs from the initial audit, while 52 remained unenrolled and in-network with the same MCOs.

Response #2

The Department analyzed outstanding providers and has reached out to the MCOs requiring they ensure enrollment or remove un-enrolled providers, as necessary, from the Medicaid Managed Care Plan networks. An updated review will be completed with the first quarter PNDS submissions.

Recommendation #3

Develop a process to notify MCOs of providers who have been denied or withdrawn enrollment in the Medicaid program.

Status – Partially Implemented

Agency Action – DOH provides a publicly available data set of providers who have applied to participate in Medicaid and whose enrollment is pending. However, the initial audit identified deficiencies in DOH's procedures that may leave MCOs unaware of providers whose pending applications were denied or withdrawn, increasing the risk of improper payments to providers who are not enrolled in Medicaid.

At the time of our follow-up, DOH was developing a procedure to notify MCOs of providers terminated for cause pursuant to State regulations. This process includes denied providers as a subset of terminated providers. According to DOH officials, they are unable to identify providers who have withdrawn enrollment.

Response #3

The Department has developed a process that identifies providers whose enrollment has been denied and terminated. Beginning in December 2025, a report of these providers is sent to the MCOs quarterly.

Recommendation #4

Issue guidance to MCOs to ensure that encounter claims contain the NPI of the provider who rendered the service, as required.

Status – Implemented

Agency Action – In April 2024, DOH issued guidance to MCOs clarifying its expectations for encounter claims to include the rendering provider's NPI.

Response #4

The Department confirms agreement with this recommendation status.

Recommendation #5

Enhance monitoring over MCO compliance with 21st Century Cures Act provisions. Such enhancements should include, but not be limited to:

- *Reviewing encounter claims to identify payments to unenrolled providers.*
- *Ensuring MCOs take appropriate, timely action on providers identified on all PNDS error reports.*
- *Creating a crosswalk or other reference tool to assist MCOs in ensuring in-network providers are submitted on the PNDS with the appropriate designated provider type code.*
- *Ensuring that PNDS edit controls encompass all enrollable provider type codes.*
- *Implementing a process to track MCO actions on provider records that trigger the PNDS 1021 edit.*

Status – Partially Implemented

Agency Action – DOH has taken steps to enhance monitoring of MCO compliance with the Act provisions. For example, DOH officials provided auditors with a draft of internal guidance DOH was developing to assist in identifying unenrolled in-network MCO providers. Officials also provided a letter addressed to an MCO notifying it that certain providers in its network may be providing services to Medicaid members without being enrolled as Medicaid providers. Furthermore, DOH officials indicated that they are working with the PNDS contractor on a system solution to address the issue in which MCOs intentionally bypassed edit 1021 by removing providers from their PNDS submission or by altering the indicator from in-network to out-of-network.

However, DOH has not reviewed encounter claims to identify payments to unenrolled providers. According to DOH officials, reviewing encounter claims to identify payments to unenrolled providers is currently too time-intensive given their limited resources. Further, DOH has not created a crosswalk or other reference tool to assist MCOs in ensuring that providers are

submitted on the PNDS with the appropriate provider type code. Lastly, we found that DOH's PNDS edit logic continues to exclude some provider type codes identified in the initial audit.

Response #5

The Department continues to investigate the best practices and data tools that could be employed to enhance monitoring of MCO compliance with the 21st Century Cures Act provisions.

Recommendation #6

Collaborate with the MCO identified in this report in connection with the unenrolled out-of-state chemical dependency treatment provider to determine the appropriate course of action to ensure enrollees have sufficient access to chemical dependency services from properly credentialed providers.

Status – Partially Implemented

Agency Action – The initial audit found that one MCO made \$44.2 million in payments to an out-of-state in-network chemical dependency treatment provider with an unenrolled NPI. The provider is ineligible to enroll in New York's Medicaid program because the Office of Addiction Services and Supports does not endorse or consent to the enrollment or reimbursement of any out-of-state addiction service providers.

Since our initial audit, for the period July 2022 through November 2025, we identified encounter payments totaling over \$47 million to this provider, primarily from the same MCO identified in the initial audit. In December 2025, after our follow-up was initiated, DOH reached out to MCOs to have the provider removed from their networks and provided them with a list of alternative, in-state providers. We encourage DOH to continue working with the MCOs to ensure enrollees have sufficient access to chemical dependency services from properly credentialed providers.

Response #6

As provided to OSC, the Department has directed the Managed Care Organizations to terminate contracts with the unenrolled out-of-state chemical dependency treatment provider. The Department received confirmation from all six Managed Care Organizations that there is no current contract with the out-of-state provider. The Department continues to work with Office of Addiction Services and Supports (OASAS) to address situations in accordance with OASAS policies and service needs.

Recommendation #7

Review the \$9.6 million in encounter payments to providers who were excluded from the Medicaid program or who should be further reviewed by DOH due to past misconduct, and ensure recoveries are made where appropriate.

Status – Partially Implemented

Agency Action – The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper payments on behalf of DOH. At the time of the follow-up, more than \$2.3

million (24%) of the encounter payments we identified had been recovered. We note that OMIG may have already lost the opportunity to recover about \$2.6 million of the remaining payments due to regulatory lookback provisions. We encourage DOH and OMIG to take prompt action to review the remaining payments to prevent further loss of recoveries.

Response #7

OMIG has recovered more than \$2.5 million of the OSC-identified payments. OMIG continuously performs audits of excluded providers in Managed Care. OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #8

Enhance processes to identify and recover managed care payments to providers who are excluded or who otherwise require further review by DOH due to past misconduct.

Status – Not Implemented

Agency Action – Pursuant to New York Codes, Rules and Regulations, no payments may be made to or on behalf of any person for medical care, services, or supplies furnished by or under the supervision of a person excluded from participating in the Medicaid program. As part of its monitoring efforts, DOH developed PNDS edits intended to identify excluded providers within an MCO's network by checking submissions against federal and State databases. DOH generates a report for MCOs' review and follow-up corrective action. The initial audit found weaknesses in DOH's process that prevented the identification of MCO payments to excluded providers.

In response to our follow-up, OMIG explained that it has an audit presence in this area, with its most recent audit issued in January 2024. However, neither DOH nor OMIG indicated that any of their processes have been enhanced since the initial audit. We analyzed encounter claims for service dates after the initial audit period for billing providers whose NPIs were excluded or required further review by DOH at the time of service. For the period July 2022 through November 2025, we identified 24 NPIs on 5,197 encounter claims totaling \$733,292 that also appeared on OMIG's List of Restricted and Excluded Providers. We also identified 323 NPIs on 33,145 encounter claims, totaling over \$10.8 million, that were invalid or deactivated on the service date, according to the federal Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System NPI dataset. We encourage DOH and OMIG to enhance their process to identify and recover improper payments to excluded providers.

Response #8

OMIG continuously performs audits of excluded providers in Managed Care and has recovered more than \$3.2 million prior to and during the scope period of this OSC audit. OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm

the accuracy of the claims detail for use in OMIG audit activities. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #9

Ensure the error in the "OMIG exclusion edit" logic is corrected.

Status – Implemented

Agency Action – As a result of our initial audit, DOH identified an error in its PNDS edit logic that prevented the identification of an excluded provider, even though the provider was in-network with an MCO. As of April 2023, the edit logic has been corrected.

Response #9

The Department confirms agreement with this recommendation status. For clarification, the edit logic error was not an OMIG exclusion edit. The edit is on the PNDS reporting, which is not in the Medicaid claims processing system.

Recommendation #10

Enhance procedures to include a review of MCO encounters to ensure MCO self-disclosures, fraud referrals, and corresponding recoveries are complete and timely.

Status – Not Implemented

Agency Action – The initial audit determined that OMIG did not monitor encounter claims data to ensure MCOs took appropriate corrective action on self-disclosures and fraud referrals. For example, we found one MCO self-disclosed only \$238,372 out of \$377,982 in payments made to a provider after they were excluded from Medicaid. OMIG officials instructed the MCO to recover the self-disclosed amount. However, because OMIG did not review the encounter claims data, the additional \$139,610 (\$377,982 - \$238,372) was not identified and pursued for repayment.

Although OMIG published review matrices for MCO program integrity compliance that added a section on guidance for complete and timely self-disclosure of overpayments, OMIG has not enhanced its procedures to include a review of encounters.

Response #10

OMIG continues its process of enhancing procedures related to Medicaid Managed Care, which includes reviewing the data submitted by the MCOs on the Provider Investigative Report (PIR). Additionally, OMIG actively reviews current regulation, policy, and model contract language to identify opportunities for recommending language changes to improve and strengthen MCO requirements.

OMIG processes MCO self-disclosures of overpaid capitation payments. However, OMIG does not process overpayments made by MCOs to network providers, as these self-disclosures must be made by the network provider to their contracted MCO; it is the MCO's responsibility to process the overpayment and accurately report all self-disclosure recoveries on the PIR. OMIG has updated the self-disclosure guidance on the OMIG website ([Self-Disclosure | Office of the Medicaid Inspector General](#)) to make this more clear and has participated in several engagements with the MCOs specifically regarding MCO requirements under the Self-Disclosure Program.

OMIG also conducts reviews of MCOs to evaluate their compliance with program integrity sections of the respective Model Contract. The Matrix of Contract Obligations and Performance Standards identifies the contract sections OMIG will review, the performance standards and how performance shall be measured. OMIG areas of review include assessing whether MCOs are meeting their obligation to adjust and report payments made to excluded or terminated providers, and whether MCOs have procedures for their providers to report, return, and explain overpayments. ([Medicaid Managed Care Program Integrity Reviews | Office of the Medicaid Inspector General](#)).