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OFFICE OF THE STATE COMPTROLLER

March 31, 2026

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

Re: Managed Care Payments to  
Unenrolled Providers  
Report 2025-F-21

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 (DOH) to implement the recommendations contained in our initial audit report, *Medicaid Program – Managed Care Payments to Unenrolled Providers* (Report [2021-S-6](#)).

**Background, Scope, and Objective**

DOH uses two methods to pay for Medicaid services: fee-for-service and managed care. Under the managed care method, DOH makes monthly premium payments to managed care organizations (MCOs) for each enrolled Medicaid member and, in turn, the MCOs arrange for the provision of services and reimburse providers for those services. MCOs are required to submit encounter claims data to DOH detailing each service provided.

MCOs establish provider networks by contracting with physicians, hospitals, and other health care providers to provide medical care to their members. The 21st Century Cures Act (Act) mandated that all managed care in-network providers, with certain exceptions, enroll as participating providers in the state Medicaid program by January 1, 2018. Through the screening and provider enrollment process, DOH gains some assurance over the provider's validity to provide Medicaid services. Additionally, DOH must verify that the federal government has not prohibited providers from participating in Medicaid. DOH's Provider Network Data System (PNDS) maintains information about providers and service networks contracting with MCOs. MCOs are required to submit their contracted provider information to the PNDS quarterly. MCOs also separately submit encounter claims to DOH, which detail member health care services and payments to providers.

The objective of our initial audit, issued on June 4, 2024, was to determine whether Medicaid MCOs violated federal and State regulations by making payments to unenrolled providers. The audit covered the period from January 2018 through June 2022. The audit found

that DOH did not monitor encounter claims to identify inappropriate managed care payments to providers who were not enrolled in Medicaid. Additionally, although DOH developed PNDS controls and error reports to assist MCOs in complying with the Act, the audit found weaknesses in these controls. These problems led to over \$1.5 billion in improper and questionable payments.

The objective of our follow-up was to assess the extent of implementation, as of February 3, 2026, of the 10 recommendations included in our initial audit report.

### **Summary Conclusions and Status of Audit Recommendations**

DOH officials made some progress in addressing the problems we identified in the initial audit report. For example, DOH improved monitoring of MCO compliance with the provisions of the Act and resolved a system error that had been preventing the identification of inappropriate providers. However, further action is still necessary. DOH has not utilized encounter data to identify payments made to unenrolled providers and has not enhanced 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. Of the initial report's 10 audit recommendations, two were implemented, five were partially implemented, and three were not implemented.

### **Follow-Up Observations**

#### **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.

#### **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.

### **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.

### **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.

### **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.

### **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.

### **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.

### **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.

### **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.

### **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.

Major contributors to this report were Wendy Matson, Justine Maloy, Reid Vogel, and Kyle Matsen.

DOH officials are requested, but not required, to provide information about any actions planned to address the unresolved issues discussed in this follow-up within 30 days of the report's issuance. We thank the management and staff of DOH for the courtesies and cooperation extended to our auditors during this follow-up.

Sincerely,

Thomas Sunkel  
Audit Manager

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