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Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New York Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the New York Medicaid Program. The MIG review team conducted the onsite portion of the review at the Office of Medicaid Inspector General (OMIG), and the Office of Health Insurance Programs (OHIP). The review team also conducted a phone interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the OMIG, which is responsible for Medicaid program integrity. This report describes 11 effective practices, 5 regulatory compliance issues, and 7 vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help New York improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of New York's Medicaid Program

The Department of Health (DOH) administers the New York Medicaid program. In January 2009, the program served 4,260,935 recipients. Of that total, 2,286,754 recipients were enrolled in 32 managed care organizations (MCOs), and the remaining 1,974,181 recipients were served on a fee-for-service (FFS) basis. The State had approximately 112,292 FFS enrolled providers and 312,200 MCO providers. During Federal fiscal year (FFY) 2008, New York State's Medicaid expenditures totaled approximately $47.5 billion, the most of any State. The Federal medical assistance percentage for New York in FFY 2008 was 50.00 percent.

Program Integrity Section

The OMIG, established by State statute in July 2006, is dedicated to the prevention, detection, and investigation of provider fraud and abuse. In addition, OMIG is responsible for coordinating program integrity activities with sister agencies and establishing cooperative relationships in order to accomplish its statutory mandate. At the time of the review, OMIG had 729 authorized full-time equivalent staff, with 592 positions encumbered. The authorized positions include auditors, investigators, nurses, data analysts, pharmacists, other clinical/medical professionals, program administrators/managers, and persons providing legal, technological, and clerical support. From calendar year (CY) 2006 through CY 2008, OMIG and OHIP staff conducted an annual average of 2,855 preliminary investigations and 1,342 full investigations. The table below presents the number of OMIG and OHIP initiated provider and beneficiary investigations and overpayments identified and collected for the past three CYs as a result of administrative

actions, such as fines, and program integrity (PI) activities, such as audits. It also includes data on the value of cost savings activities in New York State.

Table 1

CY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through PI Activities***	Overpayments Recovered Through PI Activities***	Value of Cost Savings Activities****
2006	2,656	1,077	$370,732,882	$333,292,548	$908,644,932
2007	2,627	1,596	$379,283,820	$315,566,251	$739,775,710
2008	3,281	1,352	$372,566,511	$321,785,915	$819,968,683

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The data include provider and beneficiary investigations.
** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
*** The number of investigations, overpayments identified, recoveries, and cost savings reflect various OMIG and OHIP program integrity initiatives.
**** Cost savings activities include claims processing edits that are used to prevent inappropriate payments, prepayment claims review, prior authorization initiatives, utilization initiatives designed to control over-utilization of prescription drugs, provider enrollment reviews that include a background check of the applicant and frequent on-site inspections, restricted recipient initiatives, exclusions, and terminations.

Methodology of the Review

In advance of the onsite visit, the review team requested that New York complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of October 19, 2009 the MIG review team visited the offices of OMIG and OHIP. The team conducted interviews with numerous officials from DOH and staff from the OHIP division responsible for procurements and contracts. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed Division of Managed Care (DMC) staff within OHIP. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of five MCOs. In addition, the team conducted sampling of provider enrollment applications, program integrity case files, and other primary data to validate New York's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of OMIG, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation. The Children's Health Insurance Program in New York operates as a stand-alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, OMIG provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that OMIG provided.

RESULTS OF THE REVIEW

Effective Practices

The OMIG has highlighted eight practices that demonstrate its commitment to program integrity. These include effective communication and collaboration with external and internal partners, large-scale service verification, a web-based exclusion database and a comprehensive provider tracking system, as well as provider self-disclosure protocols, enhanced monitoring of FFS and managed care providers, and additional initiatives to offer greater program transparency.

Effective communication and collaboration with external and internal partners

Since its establishment in July 2006, OMIG has routinely collaborated with New York's neighboring States of New Jersey and Connecticut. It has also communicated with other States such as Georgia, Florida, California, Pennsylvania, Massachusetts, Minnesota, Oregon, Maryland, and Arizona in order to discuss pre-payment review information, ways of targeting providers, and other issues dealing with data mining. In addition, OMIG began in June 2009 collaborating quarterly with California, Texas, and Florida in the Quad State Initiative. These meetings provide a forum in which the country's four largest State Medicaid programs can discuss common concerns, such as fraud detection tools, MFCU referrals, surveillance and utilization review (SUR) issues, and the Medi-Medi program. They also provide an opportunity to discuss case studies and suggestions for improved fraud and abuse detection.

To meet the requirements of State law, OMIG likewise collaborates with departments providing specialized services to disadvantaged populations. These include the New York State Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and Office of Alcoholism and Substance Abuse. Representatives of each agency meet monthly to discuss issues relating to fraud and abuse prevention and detection, audits, and investigations. Additionally, each agency meets separately with OMIG on a quarterly basis to discuss providers targeted through SUR activity as outliers and to develop edits to address systems issues identified through audits and investigations.

As several other effective practices below suggest, in general the OMIG has established a good working relationship with different parts of the Medicaid agency in New York since its creation.

Large-scale verification of billed services with recipients

In an effort to verify that services billed by providers have actually been furnished, the State Medicaid agency sends out approximately 5,000 targeted and random Explanations

of Medical Benefits (EOMBs) to Medicaid recipients per month. This is consistent with the requirements of Federal regulations at 42 CFR § 455.20, but is undertaken on a much larger scale than in most States. The OMIG opened 38 investigations in SFY 2008 based on EOMB responses.

Web-based exclusion database

The OHIP maintains a web-based exclusion database of individuals and entities that have been excluded by the Federal government and/or the State of New York. The OMIG sends a list of the monthly changes from the Medicare Exclusion Database (MED) file via email to both the FFS and Rate-Based Enrollment Units. The two units upload the information to the sanction file within the State's Medicaid Management Information System (MMIS). All provider applications are run against this file. This practice was identified as effective during a CMS program integrity review of New York State in 2005 and continues to be utilized.

Enhanced post-enrollment measures

Once a FFS provider has been enrolled, OHIP uses a number of enhanced measures to ensure the most current information is available in the provider file. For example, OHIP receives daily automated license updates from the New York State Education Department, which can update the provider file and also initiate disenrollment from the Medicaid program as needed. The OHIP also terminates inactive providers with no claims activity for the previous two years. It likewise receives monthly death match reports from the Office of Vital Statistics which ensure that all deceased in-state providers are identified and terminated in a timely manner from the Medicaid program.

Interactive real-time fraud and abuse tracking database

The OMIG uses a comprehensive provider case tracking system that has many applications and is accessible to a wide variety of essential users. The Fraud Activity Comprehensive Tracking System (FACTS) tracks both fraud investigations and audit activities. It captures current and historical information on all audit and investigation activities involving Medicaid providers. Investigators can limit access to cases on a need-to-know basis. For example, qui tam cases can be set for restricted viewing by only the investigator(s) assigned to the case as opposed to allowing open access for all FACTS users. The application is web-based and offers real-time access to over 1,200 users in four State agencies across New York. It allows a complete history of questionable prior provider or recipient activity to be compiled in one place and makes it immediately available to auditors and investigators. Users can collaborate on assignments, and managers can keep up with the status of audits and investigations in real time.

Large-scale data mining and auditing activity and provider self-disclosure protocols

The OMIG Division of Medicaid Audit has over 250 auditors who monitor the cost-effective delivery of Medicaid services through audit initiatives which look at the medical necessity and appropriateness of services billed to the State and the accuracy of payments. During SFY 2005 through 2008, the State completed an annual average of 1,963 audits. They included provider audits, rate-based audits, and managed care audits.

Approximately 10 to 14 percent of these were performed in the field, rather than desk audits. In SFYs 2006 and 2007, OMIG reports that its audit activities generated an average of approximately $20 million per year in overpayment collections from non-institutional and $85 million from institutional providers, respectively.

Besides its audit program, OMIG has a self-disclosure program which encourages and rewards providers who investigate and report matters that involve possible fraud, waste, abuse, and inappropriate payments. The OMIG has made a concerted effort to recognize providers who find problems within their own organizations, reveal those issues to the OMIG, and return any inappropriate payments. As part of the self-disclosure program, the OMIG assists providers who request help in developing audit protocols and drawing a statistical sample. The OMIG conducts active outreach with various provider associations, professional societies, other State agencies and the New York State Bar Association to encourage providers to come forward when internal issues of fraud, waste, abuse, and billing errors are identified. Under certain circumstances, as a result of OMIG data mining, provider self-audits are also required. In documentation submitted prior to the MIG's onsite review, the OMIG indicated that in SFY 2008, one county voided over $130,000 in improper preschool speech therapy claims following such a mandatory self-audit. The amount of overpayments identified as a result of self-disclosure has increased on a yearly basis over the past few years.

The OMIG is able to effectively target providers both for external audit and required self-audits because of its ability to perform equally large-scale and continuous data mining and data match activities. The Bureau of Business Intelligence (BBI) within OMIG uses the State's Medicaid data warehouse, which stores five years of Medicaid claims with payments exceeding $200 billion, to support audit initiatives by targeting problem provider behaviors, conducting pre-audit analyses, and selecting audit samples. In addition, the BBI performs system matches which are based on algorithms designed with specific knowledge of various provider types and the guidelines that govern their claims submissions. When such matches identify potentially incorrect payments, OMIG requires providers to substantiate the payment received or return the overpayment.

Enhanced managed care monitoring

The DMC evaluates MCO quarterly and annual fraud and abuse reports and collaborates with OMIG in following up on cases of suspected fraud and abuse. To be more sensitive to program integrity issues in the managed care setting, DMC has also added a fraud and abuse monitoring section to its MCO survey and performance evaluation tool.

Transparency initiatives

The OMIG has undertaken a number of transparency initiatives tailored to both external and internal audiences. These initiatives include the posting of information on the OMIG website, such as the excluded persons list, as well as OMIG's final audit and annual reports. The OMIG also posts its annual audit plan on the website, which serves as a roadmap for all activities across New York State. The audit plan communicates risk areas to providers and explains the agency's focus for that SFY. The plan's availability

gives providers an opportunity to self-audit and take any necessary corrective action in accordance with the audit concerns identified. The OMIG also makes its audit protocols available to trade associations.

Additionally, the MIG review team identified three practices that are particularly noteworthy. The CMS recognizes New York's efforts in the use of point-of-service controls, a special screening process for high-risk provider types, and the adoption of mandatory provider compliance plans.

Use of point-of-service controls

The OMIG has a Point-of-Service Controls Unit within the Division of Technology and Business Automation. This unit is responsible for implementing and monitoring the use of controls at the point of service to ensure that the Medicaid recipient is present for the service. The unit currently implements and monitors two programs: the Cardswipe program and the Post & Clear program.

The Cardswipe program verifies a recipient's presence at the point of service by requiring that the recipient's benefit card be swiped at the time the recipient presents for a Medicaid service. This program is monitored at the provider level, with the expectation that providers meet established thresholds for the proportion of their transactions that are swiped. The OMIG designates providers based on various criteria to become mandatory "swipers" as part of the Cardswipe program. At the end of December 2008, 821 providers were so designated.

The Post & Clear program was noted during CMS' 2005 program integrity review of New York. It continues to be an effective means that other States should consider for using technology to match provider claims against service authorization requests by ordering physicians. The Post & Clear program is a set of enhanced controls designed to ensure that Medicaid claims for services are actually ordered by the provider indicated on each claim. The Post & Clear program requires selected providers ordering services (e.g., a physician ordering a prescription) to post their orders to the MMIS electronically before the claiming provider (e.g., pharmacy) can clear (process and bill) the transaction. This establishes a record of the care, services, or supplies ordered by the provider, and enables OMIG to verify that the order has been requested by the ordering physician before paying the claim. At the end of calendar year 2008, 363 providers were designated as "posters". An additional 26 providers were designated as both card "swipers and posters". For calendar year 2008, New York reports that both programs generated cost savings totaling $93.4 million.

Special screening process for high-risk provider types

The OMIG has set up a special unit, the Enrollment and Audit Review (EAR) Unit, for identifying high-risk providers and provider types at the time of enrollment. The OHIP initially reviews all provider types for Medicaid participation. Applications from certain categories of high-risk provider types, such as transportation providers, pharmacies, durable medical equipment (DME) suppliers, and labs are forwarded to the EAR Unit for

a more intensive review that often includes site visits and visits by undercover investigators known as secret shoppers. In New York, the OMIG conducts onsite reviews of 100 percent of all new DME enrollment applications and the majority of pharmacies and transportation providers. In addition, OHIP maintains a list of the categories of services and enrollment types that are sent to the EAR Unit for special review and also meets with the Unit quarterly to review and update the list as needed. The OHIP, in conjunction with OMIG, has the ability to overturn a denial decision through its participation on the appeal committee which reviews provider denials. In addition, all notices of exclusions/terminations are sent to OHIP for review before they are mailed to the provider. The EAR Unit denied enrollment to 212 high-risk providers during calendar years 2007 and 2008.

State mandated provider compliance plans
In 2009, OMIG implemented prior State legislation and additional regulations that require providers operating pursuant to Articles 28 and 36 of the Public Health Law, Articles 16 and 31 of the Mental Hygiene Law, and all providers who order, provide, or bill more than $500,000 annually in claims, to adopt and implement effective compliance programs and submit to OMIG, on an annual basis, an attestation that they maintain an effective compliance program. The compliance program, including a written compliance plan, must address how the provider proposes to mitigate the risk of fraud or abuse in key areas of activity, such as billing, payments, medical necessity and quality of care, governance, mandatory reporting, credentialing, and other risk areas identified by provider due diligence. Per the regulations, the new compliance plan requirements went into effect on October 1, 2009. The OMIG believes that requiring larger providers to develop compliance plans will be an effective tool in increasing claims accuracy and preventing or identifying inappropriate conduct.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations mandating certain disclosures, referrals, and notification activities.

The OMIG does not refer cases of suspected recipient fraud to appropriate law enforcement authorities.
The Federal regulation at 42 CFR § 455.15(b) requires State Medicaid agencies to refer suspected cases of recipient fraud to an appropriate law enforcement agency.

New York State law requires OMIG to send all cases of suspected recipient fraud to the Local Departments of Social Services (LDSSs), which are county intake offices, for disposition. To comply with State law, OMIG only refers certain recipient cases directly to law enforcement that fall outside the scope of the statute, such as cases of abuse and neglect. The OMIG indicated in interviews that District Attorneys in many counties will not prosecute cases of suspected recipient fraud unless the dollar amount in question is at least $5,000. The reluctance of local law enforcement to accept such cases and the relationship of many LDSSs with local law enforcement have made it difficult for OMIG to alter its policy of referring suspected recipient

fraud cases to the county offices after conducting preliminary investigations. While such referrals are acceptable in cases of recipient behavior that do not rise to the level of fraud, Federal regulations require that likely cases of recipient fraud be referred directly to law enforcement.

Recommendation: Develop and implement procedures for reporting all cases of suspected recipient fraud to appropriate law enforcement authorities.

New York's notice of payment withholding does not include all required information.
The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation.

The notice of withholding letter that OMIG utilizes in cases of fraud and willful misrepresentation does not meet the requirements of 42 CFR § 455.23 because it contains no reference to the Federal regulation. During the post-onsite exit conference, the OMIG Director indicated that this change had been made.

Recommendation: Modify the withholding letter to include language that references 42 CFR § 455.23 as required by the regulation.

The OHIP does not capture all required ownership, control, and relationship information from the fiscal agent.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The OHIP does not collect the full range of ownership and control information from its fiscal agent as required under 42 CFR § 455.104(c). The OHIP officials indicated that they did not think it was necessary to obtain such information during the Request for Proposals (RFP) process since New York's Medicaid fiscal agent is a publicly traded company. Because this information is not collected, it is impossible for the State to monitor changes in the fiscal agent's ownership

or to check for excluded persons with ownership or control interests prior to contracting and periodically thereafter.

Recommendation: Develop and implement policies and procedures to obtain the required ownership, control, and relationship disclosures from the fiscal agent.

The OHIP does not require MCOs to disclose required business transaction information.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health & Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

Non-compliance with 42 CFR § 455.105 was a finding during CMS' 2005 program integrity review of New York State. Although OHIP has addressed this in its FFS provider enrollment process, compliance issues remain in the managed care program. While the State's MCO contracts contain some financial reporting provisions, they do not obligate the MCOs to provide the business transaction information on request as specified in 42 CFR § 455.105. The regulation also states that providers must submit business information within 35 days of the date on a request by the Secretary or the Medicaid agency. New York's managed care contracts do not require the MCOs to provide the requested information within the specified time frame.

Recommendation: Modify the MCO contracts to require disclosure upon request of the business transaction information specified in 42 CFR § 455.105.

The OHIP does not collect all required health care-related criminal conviction information from FFS providers and MCOs.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

This is also a partial repeat finding from the 2005 CMS review. Although OHIP has addressed the regulatory requirements in most of its forms, the individual FFS provider enrollment application does not contain space to record health care-related criminal convictions for agents or managing employees of the provider. In addition, the DMC contracts with MCOs do not require all the parties specified in the regulation, such as managing employees, to disclose health care-related criminal convictions. Based on managed care staff responses during interviews, there is also no indication that complete disclosure information for all required parties was collected during the procurement process and passed on to the DMC as part of the pre-contracting RFP process. Because these disclosures are not collected, the State is not in a position to send them to the HHS-OIG, as required by the regulation.

Recommendations: Modify the FFS provider enrollment application, MCO contract, and RFP process to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement a procedure to report applicable criminal convictions to HHS-OIG within 20 working days.

Vulnerabilities

The review team identified seven areas of vulnerability in the State's program integrity practices. These involved the failure of MCOs to verify billed services with recipients, capture managing employee information, collect required disclosure information from network providers, notify HHS-OIG of adverse actions taken on enrollment applications, and conduct complete searches for excluded individuals and entities within their networks.

Not verifying with MCO recipients whether services billed by providers were received.

While New York meets the requirements of 42 CFR § 455.20 by sending EOMBs to FFS recipients, the DMC contract with MCOs does not require this. During interviews, several MCOs reported that they utilize National Committee on Quality Assurance standards for sending surveys to enrollees. Such surveys are designed for assessing general satisfaction, not the actual receipt of services. The MCOs indicated that they only send an EOMB when services are denied. To assess the appropriateness of services rendered, they review medical records. However, some method of verifying the actual provision of services that providers claim to have furnished is not employed.

Recommendation: Require MCOs to develop and implement a method for verifying with recipients whether billed services were received.

Not capturing managing employee information on FFS provider applications and managed care credentialing forms.

Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." Neither the State nor its MCOs solicit managing employee information on FFS provider enrollment and managed care credentialing forms, respectively. Thus, the State would have no way of knowing if excluded providers are working for health care entities in such positions as billing managers and department heads.

Recommendation: Modify the State's FFS provider applications and managed care credentialing packages to require information on the full range of managing employees. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not collecting all required ownership and control disclosure information from MCO network providers.
Neither OHIP's MCO umbrella contract nor DMC's existing policies and procedures require the MCOs to collect the full range of ownership and control disclosures from MCO network providers that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. In their internal credentialing process, the MCOs use the Council for Affordable Quality Healthcare (CAQH) provider application form which does not ask for information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships among persons with ownership and control and subcontractors. In addition, the MCOs do not capture the name of any other Medicaid provider in which there is an ownership or control interest. This leaves MCOs vulnerable to paying Medicaid dollars to network providers with excluded parties in ownership and control positions.

Recommendation: Modify the managed care contracts to require the disclosure of complete ownership, control, and relationship information from all MCO network providers.

Not requiring MCO network providers to disclose business transaction information upon request.
Neither the OHIP umbrella contract with MCOs nor the MCO provider agreements require network providers to disclose the business transaction information, upon request, that is stipulated in 42 CFR § 455.105.

Recommendation: Modify the MCO contracts and MCO network provider agreements to require disclosure upon request of the required business transaction information.

Not requiring the disclosure of health care-related criminal conviction information from MCO-affiliated parties during the MCO credentialing process.
The OHIP contract with the MCOs does not require relevant persons other than MCO providers to disclose the health care-related criminal conviction information which Federal regulations at 42 CFR § 455.106 would otherwise require in the FFS program. The CAQH application used by the MCOs during provider credentialing does not contain language with sufficient breadth to meet the regulatory requirement. Section 8 of the CAQH provider application asks if the practitioner has been convicted of any felony or pled guilty or nolo contendere to a misdemeanor for any civil offense that is reasonably related to qualifications, competence, functions, or duties as a medical professional or for fraud. While this meets the requirement for providers, the application does not ask for similar disclosures about owners, directors, agents, and managing employees.

Recommendation: Modify the MCO contracts to require the collection and reporting of health care-related criminal conviction disclosure information from all MCO-affiliated parties as specified in 42 CFR § 455.106.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
Although the State's model contract does not require MCOs to report network provider terminations, during interviews, the MCOs indicated that they are reporting terminations to DMC. However, the MCOs are not reporting adverse actions taken on provider applications for participation in the MCO Medicaid network. This may make it easier for problem providers to find a way into other MCOs and the FFS program undetected. The failure of MCOs to notify the Medicaid agency of adverse actions taken for program integrity reasons also precludes the Medicaid agency from reporting such actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

Recommendations: Require contracted MCOs to notify the State agency when they deny providers credentialing for program integrity-related reasons. Develop and implement procedures for reporting these adverse actions to HHS-OIG.

Not conducting complete searches of individuals and entities excluded from participating in Medicaid.
On June 12, 2008, CMS issued a State Medicaid Directors Letter (SMDL #08-003) providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers to screen their own staff and subcontractors for excluded parties.

In OHIP, provider enrollment is handled by the FFS and Rate-Based Units which are organizationally separate. While each unit processes applications and conducts exclusion checks for most provider types, the applications do not request information on agents and managing employees. Failure to collect this information means that agents and managing employees cannot be checked against HHS-OIG's List of Excluded Individuals and Entities (LEIE) or the MED file during the enrollment process. This in turn leaves the State vulnerable to allowing into the program excluded individuals who may work for providers in responsible positions.

During the managed care credentialing process, owners and managing employees likewise are not always checked for exclusions at or after enrollment because the information is not disclosed as part of the credentialing process.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information to ensure that FFS provider enrollment staff and contracted MCOs conduct complete exclusion searches using the LEIE or MED at the time of provider enrollment, re-enrollment, and at least monthly thereafter. Instruct FFS and MCO network providers to do the same with their own employees. Refer for guidance as needed to SMDLs #08-003 and #09-001, which can be found on the CMS website.

CONCLUSION

The State of New York applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- effective communication and collaboration with external and internal partners,
- large-scale verification of billed services with recipients,
- web-based exclusion database,
- enhanced post-enrollment measures,
- interactive real-time fraud and abuse tracking database,
- large-scale data mining, auditing, and provider self-disclosure protocols,
- enhanced managed care monitoring,
- transparency initiatives,
- use of point-of-service controls,
- special screening process for high-risk provider types, and
- State mandated provider compliance plans.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, seven areas of vulnerability were identified. The CMS encourages the State to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require the State to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of New York will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If New York has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

Although not directly related to findings or vulnerabilities identified in this review, the MIG notes that internal State oversight reports as recently as the fall of 2009 have expressed concern about issues relating to improper claims payments in New York. For example, one report noted that the periodic turning off of claims processing edits has allowed significant amounts of improper payments to be processed, while another analysis raised the issue of duplicate payments to MCOs based on delays at the county level in the processing of Medicaid recipient residency changes. While these concerns need not be addressed in the requested corrective

action plan, the MIG recommends that OMIG exercise closer oversight of problem areas within the framework of existing partnerships.

The Medicaid Integrity Group looks forward to working with the State of New York on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.