Department of Health

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Executive Deputy Commissioner

October 1, 2018

Mr. Christopher Morris, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Mr. Morris:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2018-F-1 entitled, "Medicaid Managed Care Organization Fraud and Abuse Detection" (Report 2014-S-51).

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Donna Frescatore
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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2018-F-1 entitled, Medicaid Managed Care Organization Fraud and Abuse Detection

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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 2018-F-1 entitled, "Medicaid Managed Care Organization Fraud and Abuse Detection."

Recommendation #1

Review the MCO payments to ineligible providers that we identified and direct UHC and Amerigroup to recover the payments as appropriate.

Status – Partially Implemented

Agency Action – Our initial audit determined UHC and Amerigroup made improper payments totaling $1.1 million to providers who were excluded from the Medicaid program. In response to our initial audit, the Department agreed that payments to excluded providers should be recovered, and the Department indicated it would work with the MCOs to ensure that amounts paid to excluded providers were recovered and reported to the Department accordingly.

The Department shared our claim findings with Amerigroup and UHC and directed them to review and recover improper payments made to excluded providers. However, our initial audit concluded that the MCOs' excluded provider lists (that would be used to do the review) were incomplete. For example, we found that UHC and Amerigroup collectively reimbursed one pharmacy $43,217 during a period when the Office of the Medicaid Inspector General (OMIG) had excluded the pharmacy from participating in Medicaid due to abusive billing practices – such as billing Medicaid for prescription drugs that were not dispensed. Upon review of our audit findings, neither MCO determined its payments to this pharmacy were inappropriate. In fact, the MCOs' review found that only about $129,000 of the $1.1 million we identified was paid to excluded providers.

Therefore, in accordance with our recommendation, it is important that the Department complete its own review of the MCO payments to ineligible providers that we identified and make its own determination on the appropriateness of such payments.

Response #1

This recommendation has been implemented. In addition to the review being conducted by UHC and Amerigroup, the Department is conducting its own review to determine the providers eligibility status and whether MCO payments were appropriate.

Recommendation #2

Complete the review of the 7.2 million encounter claims, totaling over $445 million, that contained incomplete or otherwise untraceable provider information to determine if the MCOs made payments to ineligible providers, and instruct the MCOs to review and recover improper payments where appropriate.

Status – Partially Implemented

Agency Action – During our initial audit, we determined UHC and Amerigroup submitted over 6 million encounter claims (totaling $340 million of the $445 million) that lacked billing provider identification numbers (IDs) and/or provider names that could be used to determine if the MCOs made payments to ineligible providers. At the time of our initial audit, the Department reviewed these claims and, using National Provider Identifiers (NPIs), identified $5.5 million in questionable payments to excluded providers. The Department shared the files with Amerigroup and UHC after the initial audit and requested that the MCOs review the files and provide any additional information that would assist in establishing the billing providers' identity. However, during our follow-up review, the Department chose to restart its efforts using the findings from the initial audit and, as such, the review has not been completed.

Additionally, our initial audit identified over 1.2 million encounter claims (totaling $105 million of the $445 million) that contained generic billing provider IDs (such as one common billing ID generated for claims submitted by out-of-state pharmacies) and for which NPIs were unavailable. The Department provided the 1.2 million encounter claims to the MCOs and requested additional information to identify excluded providers. According to the Department, only UHC provided the necessary information. However, the Department did not analyze it. After the start of our follow-up review, the Department re-sent the original audit findings to the MCOs for review and instructed them to recover improper payments made to ineligible providers.

Response #2

As noted in discussions with OSC, the Department continues to work with both UHC and Amerigroup to fully identify the providers whose eligibility could not be determined during the initial audit. The Department will forward the results of this effort to OMIG for their review determination and subsequent recoupment of potential recoveries.

Recommendation #3

Determine the impact that UHC's and Amerigroup's recoveries have on the managed care premium calculations, and adjust the premium rates accordingly.

Status – Not Implemented

Agency Action – MCOs are required to report recoveries of improper payments on the Medicaid Managed Care Operating Reports (MMCORs), which are filed with the Department. Such recoveries are factored into the premium calculations (for example, large recoveries could decrease premium payments). Recoveries are reported as an aggregate amount on the MMCORs. Therefore, the Department cannot use this report exclusively to determine if the improper payments we identified during our initial audit were recovered, or to determine the impact these recoveries, if made, had on premium calculations.

At the time of our follow-up review, the Department had not taken any steps to verify what amount, if any, of the improper payments we identified in our initial audit were reported on UHC's or Amerigroup's MMCORs and what impact that had on the premium calculations.

Response #3

OMIG and the Department will be collaborating to accurately capture MCO recoveries and overpayments for the purpose of premium rate setting.

Recommendation #4

Strengthen steps to oversee and monitor MCOs to ensure that providers who are not eligible for reimbursement are removed from MCO provider networks so that only eligible Medicaid providers are reimbursed. These steps should include (but not be limited to):

- Utilizing all available eMedNY information, including information contained on the Enrollment Status File;
- Sharing the Enrollment Status File information with the MCOs;
- Updating the Enrollment Status File to include all providers within MCOs' provider networks, including those who do not have a Medicaid ID; and
- Continuing pursuit of changes to Medicaid regulations that would require the State to enroll all MCO network providers in Medicaid (thereby requiring network providers to have Medicaid IDs).

Status – Implemented

Agency Action – At the time of our initial audit, the Department monitored MCO provider networks through the Department's Comprehensive Operational Surveys, which included reviews of MCO policies and procedures and compared MCO provider networks with certain exclusion lists. During the initial audit, we identified flaws in this oversight process. We found that the Department did not use the Enrollment Status File to monitor MCO provider networks and, as a result, the Department did not notify MCOs of all ineligible providers that should be excluded from the MCOs' networks. The Enrollment Status File, located in the Department's Medicaid claims processing system (eMedNY), is a comprehensive file (populated from various sources) of excluded fee-for-service (FFS) Medicaid providers. We concluded the Department's oversight process would be enhanced if it used the Enrollment Status File to help monitor the MCOs. During our follow-up review, the Department stated they now use the Enrollment Status File to monitor MCO provider networks. The Department identifies ineligible providers and notifies the MCOs accordingly.

During the initial audit, we also determined the MCOs did not have access to the Enrollment Status File. Rather, the MCOs used various listings of excluded providers to determine which providers should be excluded from their networks. However, based on the exceptions we identified during our initial audit, we concluded the MCOs did not use the multiple sources adequately. We found that the Department's Enrollment Status File would help the MCOs identify ineligible providers that were not identified by the MCOs' other reviews. We also determined the Enrollment Status File (which identified excluded FFS providers) should be updated to include all providers within the MCOs' provider networks, including those who did not have a Medicaid ID.

After our initial audit, as a result of the implementation of the 21st Century Cures Act, in 2018, all MCO network providers are now required to enroll, and maintain active enrollment, in the Medicaid FFS program (accordingly, all MCO network providers now have a Medicaid ID). The new "active" provider enrollment file is a comprehensive list of eligible Medicaid FFS and MCO network providers. The active provider enrollment file reflects the information in the Enrollment

Status File. According to Department officials, MCOs have access to the active provider enrollment file to monitor whether any of their network providers are ineligible providers.

Response #4

The Department confirms our agreement with this report.

Recommendation #5

Establish appropriate criteria for SIU staffing levels.

Status – Not Implemented

Agency Action – Our initial audit determined that, in the absence of any managed care contractual requirements or State regulations mandating specific SIU staffing levels, MCOs may not always maintain adequate staffing levels to effectively prevent, detect, and investigate Medicaid fraud and abuse. We found this to be the case with both UHC and Amerigroup, which are among the larger MCOs in the State's Medicaid program.

Although the Department agrees that adequate staffing is critical to the success of SIU activities, the Department has not established criteria for SIU staffing levels. In 2017, the federal Centers for Medicare & Medicaid Services (CMS) recommended that the Department mandate a minimum number of SIU staff to ensure adequate program integrity oversight of network providers. However, according to Department officials, without guidance from CMS or widely accepted standards for staffing criteria, a minimum SIU staffing size cannot be mandated.

Inadequate SIU staffing levels may lead to inadequate fraud and abuse prevention, detection, and investigation efforts and can result in care being provided by unqualified or unethical providers, which could potentially impact the health and safety of Medicaid MCO enrollees. Furthermore, MCOs report medical expense payments made on behalf of enrollees to the Department, and the Department uses this information to establish MCO premiums. As a result, inadequate SIU staffing levels increase the risk that Medicaid may pay fraudulent or unnecessary claims, which may result in inflated premiums to MCOs.

Response #5

The Department continues to assert adequate Special Investigation Unit (SIU) staffing levels are critical to the success of SIU activities, which is reflected in New York State's regulatory requirement that MCOs with enrolled populations larger than 10,000 create a Fraud and Abuse Prevention Plan (FAPP) that includes a rationale justifying the staffing size of their SIUs.

Recommendation #6

Revise the managed care model contract language to require that MCOs meet the established criteria for SIU staffing levels.

Status – Not Implemented

Agency Action – As specified previously in the Agency Action section of Recommendation 5, the Department did not establish criteria for SIU staffing levels. Therefore, the Department did not revise the managed care model contract language to require that MCOs meet an established criteria for SIU staffing levels.

Response #6

Until the Department receives guidance from CMS or widely accepted standards for staffing criteria has been established for minimum SIU staffing levels, the managed care model contract cannot be revised to include this requirement.

Recommendation #7

Identify the actual recoveries by UHC and Amerigroup, determine if there is any impact on the monthly managed care premium rates, and adjust the premium rates as appropriate.

Status – Not Implemented

Agency Action – MCOs are required to report recoveries of improper payments on the MMCORs they file with the Department (recoveries offset MCO expenses in the premium calculations). In addition, the MCOs file an annual Fraud and Abuse Prevention Plan (FAPP) report with the Department that provides detail of SIU-related fraud and abuse recoveries. Our initial audit analyzed the recoveries reported on UHC's and Amerigroup's MMCORs and FAPP reports and found underreporting of recoveries on both the MMCORs and the FAPPs during the audit period.

At the time of our follow-up review, the Department had not verified the actual recoveries by UHC and Amerigroup for the audit period and determined if there was any impact on the monthly premium rates.

Response #7

Any recoveries by the Amerigroup and UHC are reported in the Incurred But Not Reported tables in the Operating Cost report. These tables reflect all claim adjustments (including fraud, recoveries, errors etc.) and are part of the rate setting process whereby all adjustments are accounted for and included in the premium rate development.

Recommendation #8

Instruct MCOs on how to properly report SIU activities to help ensure consistency in SIU reporting activities.

Status – Partially Implemented

Agency Action – MCOs report recoveries on three different reports: the MMCOR, the FAPP, and (as of 2016) the Annual Program Integrity (API) report. These reports serve different functions. The MMCOR is used to facilitate premium rate setting, and the FAPP and API reports are used to evaluate MCO SIU activities. Our initial audit identified numerous problems in the way MCOs accounted for SIU activities on the MMCORs and FAPP reports filed with the Department. For example, we found numerous instances of underreporting of recoveries on UHC's and Amerigroup's MMCORs. We also reviewed the 2011 FAPP reports filed by Amerigroup and UHC

and found: Amerigroup presented its SIU recovery data as estimated amounts rather than actual recoveries; UHC omitted seven cases of recoveries totaling $139,854; and both MCOs omitted information about their fraud and abuse cases.

In response to our initial audit, the Department updated the MMCOR instructions related to reporting recoveries. However, additional improvements are needed. The updated MMCOR instructions for reporting cost recoveries instruct MCOs to match the dollars reported on their FAPP reports. However, the FAPP instructions require MCOs to include payment denials (i.e., claims not paid due to SIU activity), not just actual cost recoveries. As a result, MCOs may report amounts on the MMCOR that were not actually recovered, which could cause inaccuracies in the premium rate setting process.

Response #8

The Department will issue guidance to all MCOs on proper reporting of SIU activities.

Recommendation #9

Establish an oversight process to help ensure MCOs properly report all recoveries resulting from fraud, waste, and abuse investigations on their MMCORs and on the annual reports that detail the MCOs' Compliance Plans.

Status – Not Implemented

Agency Action – In our initial audit, we determined the Department did not exercise proper oversight over the recoveries reported on the MMCORs or the accuracy of SIU fraud and abuse investigation recoveries reported on the MCOs' annual Compliance Plans (i.e., the MCOs' annual FAPP reports).

During our follow-up, we selected four MCOs and compared the data reported on their 2016 MMCORs and FAPP and API reports. The following table illustrates the significant differences in reported recoveries from the various reports. These differences were not reconciled by the Department.

2016 Reported Recoveries

MCO Name	MMCOR	FAPP	API
HealthPlus/Empire (Amerigroup)	$176,029	$2	$1,178,386
MetroPlus	117,974	4,098,376	267,970
UHC	11,131	Not Available	733,645
Wellcare	Not Reported	124,512	343

According to Department officials, the three reports serve different purposes and were not designed to be reconciled. However, during our follow-up review, Department and OMIG officials agreed to collaborate to determine if the reports could also be used to monitor recovery amounts reported on the MMCORs.

Response #9

The Department and the OMIG will collaborate to develop an oversight process that ensures proper reporting.

Recommendation #10

Formally review Compliance Plan information submitted by the MCOs to assess whether they contain appropriate and specific minimum training requirements for SIU staff.

Status – Partially Implemented

Agency Action – In our initial audit, we found that while MCOs submitted information on staff trainings in their annual FAPP reports (i.e., the Compliance Plans), these reports did not contain specific details, such as the number of training hours provided, the title or content of the training, or attendees.

After our initial report was issued, OMIG began requiring MCOs to complete an API report, which identifies specific SIU training requirements. However, we found that the results of the report were not shared with the Department, even though the Department is responsible for ensuring SIU training requirements are appropriate.

Additionally, during our follow-up, we reviewed the 2016 and 2017 API reports submitted by four MCOs and found that the SIU staff training was not uniformly reported. For example:

- UHC reported the training for all SIU employees, the title of each training for each individual, and their respective durations.
- Amerigroup reported information only for new SIU hires.
- MetroPlus and Wellcare did not document the employees, titles of trainings, or the training durations.

During our follow-up, OMIG officials agreed to look into sharing the results of the API reports with the Department.

Response #10

The Department will expand compliance plan reviews to ensure training requirements for SIU staff are contained therein. MCOs will now be required to provide specific details regarding staff trainings in their annual FAPP reports, including the number of training hours provided, the title and content of the training, and attendees. Furthermore, the results of the API reports submitted to OMIG are now being shared with the Department.

Recommendation #11

Actively monitor MCO SIU staff training to ensure training requirements are met.

Status – Implemented

Agency Action – Our initial audit determined that UHC's and Amerigroup's investigators did not always meet their own mandatory core and specialized training program requirements for SIU employees. The Department conducts operational surveys of MCOs every two years, which include a review of staff training. Non-compliant MCOs must submit a Plan of Correction to the Department. According to Department officials, they will then conduct a targeted survey, typically within one year following the full operational survey, to review the MCO's compliance with its Plan of Correction.

During our follow-up, we obtained and reviewed the Department's 2016 operational surveys of UHC and Amerigroup. Both MCOs were found to be compliant. According to Department officials, MCOs are required to show annual and quarterly training documentation (i.e., training logs and attendance sheets) and demonstrate training requirements were met through Department interviews with SIU staff.

Response #11

The Department confirms our agreement with this report.