Department of Health

Medicaid Program: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program

Report 2019-S-72 | April 2022

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health (Department) made improper payments for claims in violation of federal and State requirements related to ordering, prescribing, referring, or attending (OPRA) providers who were no longer participating in the Medicaid program. The audit covered the period from January 2015 through December 2019.

About the Program

The New York State Medicaid program provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled $68.1 billion.

The Affordable Care Act and implementing federal regulations mandated that state Medicaid agencies require all ordering and referring physicians and other professionals providing services through the Medicaid fee-for-service program to be enrolled as participating providers in the state Medicaid program. Accordingly, beginning January 1, 2014, New York's Medicaid program required that physicians and other health care professionals who order, prescribe, refer, or attend Medicaid services be appropriately screened and enrolled in Medicaid.

Through the screening and provider enrollment process, the Department gains a level of assurance over the OPRA provider's validity to provide Medicaid services. It also allows the Department to verify the provider's licensing and other credentials to furnish services. Additionally, the Department must verify that no providers are prohibited from participating in a Medicaid program by the federal government, which further enhances the safety of the Medicaid program and its members.

Key Findings

We identified system processing weaknesses in eMedNY, the Department's Medicaid claims processing system, which allowed improper payments for claims that reported a provider in a required OPRA field who was no longer actively enrolled in the Medicaid program at the time of the service (inactive provider). This resulted in $965 million in payments for claims that reported an inactive OPRA provider on the claim's order or service date, including $5.8 million for providers who were excluded from participating in Medicaid due to past misconduct.

The Department enhanced eMedNY claim edits in February 2018 and, subsequently, we found a significant drop in the amount of improper payments. However, additional actions are still needed. For the period March 2018 through December 2019, our audit identified about $45.6 million in claim payments for 135,476 services that reported an OPRA provider who was no longer actively enrolled in Medicaid. When inactive OPRA providers are included on Medicaid claims, the Department lacks assurance that the provider can furnish such services, and it increases the risk that excluded, or otherwise unqualified, providers are providing Medicaid services.

Key Recommendations

- Review the $965 million in payments to providers for Medicaid claims that reported inactive OPRA providers and determine an appropriate course of action.

- Enhance controls to prevent improper Medicaid payments for claims that do not report an active OPRA provider.
- Update guidelines to clarify OPRA billing requirements.

Office of the New York State Comptroller
Division of State Government Accountability

April 19, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Bassett:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program*. The audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
CMS	Centers for Medicare & Medicaid Services	*Federal Agency*
Department	Department of Health	*Auditee*
eMedNY	The Department's Medicaid claims processing and payment system	*System*
Facility	Clinic, hospital, group practice, or other health care facility	*Key Term*
Inactive provider	Provider who is not actively enrolled in the New York State Medicaid program	*Key Term*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*System*
NPI	National Provider Identifier	*Key Term*
NYCRR	New York Codes, Rules and Regulations	*Law*
OMIG	Office of the Medicaid Inspector General	*Agency*
OPRA	Ordering, prescribing, referring, or attending	*Key Term*
OPWDD	Office for People With Developmental Disabilities	*Agency*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $68.1 billion. The federal government funded about 56.5% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5%.

The federal Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid programs and issues regulations that set general parameters for states to follow. Each state must administer its Medicaid program in accordance with a CMS-approved Medicaid State Plan, which dictates the policies and procedures the state must follow. In New York State, the Medicaid program is administered by the Department of Health (Department).

The Affordable Care Act and implementing federal regulations mandated that, by January 1, 2011, state Medicaid agencies require all ordering and referring physicians and other professionals providing services through the Medicaid fee-for-service program to be enrolled as participating providers in the state Medicaid program. Beginning January 1, 2014, New York's Medicaid State Plan was amended to require that physicians and other health care professionals who order, prescribe, refer, or attend (OPRA) Medicaid services be appropriately screened and enrolled in Medicaid. Through the screening and provider enrollment process, the Department gains a level of assurance over a provider's validity to render Medicaid services as an OPRA provider. When providers who no longer participate in the Medicaid program serve as an OPRA provider, the Department lacks this assurance. Further, the OPRA provider application process allows the Department to verify the provider's licensing and other credentials to furnish services. In accordance with regulations, all providers are required to revalidate enrollment at least every 5 years. Additionally, the Department must verify that no providers are prohibited from participating in a Medicaid program by the federal government (e.g., by the Department of Health and Human Services Office of Inspector General), which further enhances the safety of the Medicaid program and its members.

According to the New York Codes, Rules and Regulations (NYCRR), prior to approving a provider for participation in the Medicaid program, the Department must consider several risk factors, including whether the provider has any previous or current suspension, exclusion, or involuntary withdrawal from participation in any state Medicaid program, private medical insurance, or other government program, such as Medicare or Workers' Compensation. The NYCRR also states that no payments will 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 participation in the Medicaid program. An individual excluded from participating in the Medicaid program cannot be involved in any activity relating to furnishing medical care, services, or supplies to Medicaid recipients.

The Department requires clinics, hospitals, group practices, or other health care facilities (facilities) to screen employees and contractors providing health care services, and states this should be done at the time of hiring and monthly thereafter. This screening process includes reviewing the Excluded Provider List issued by the Office of the Medicaid Inspector General (OMIG). OMIG is an independent entity created within the Department that conducts and coordinates the investigation, audit, and review of Medicaid providers to ensure their compliance with laws and regulations. When OMIG determines a provider is barred from participating in the Medicaid program due to unethical behavior, OMIG places the provider on its Excluded Provider List.

The Department does not require attending practitioners employed by a facility billing for Medicaid services to enroll in Medicaid as providers, but all facility services must be referred by an enrolled Medicaid provider. Facilities that bill for Medicaid services must register their attending practitioners' National Provider Identifier (NPI), license number, license profession code, licensing state, and effective date of the practitioner's affiliation with the facility with Medicaid through eMedNY, the Department's Medicaid claims processing and payment system. This enables the eMedNY system to validate the relationship between the attending practitioner and the billing facility. The attending practitioner NPI on the claim must be for an individual and not for a physician's group or other entity. If, at any time, the attending practitioner ceases to be affiliated with the facility, the facility must enter an end date for the affiliation in eMedNY. Facilities also have the option to delete affiliations; however, doing so effectively removes all evidence that the attending practitioner was ever affiliated with the facility.

The eMedNY system uses various automated controls, called edits, to determine whether claims are eligible for reimbursement, including verifying that OPRA providers are actively enrolled in Medicaid on the claim's date of service and preventing payment of claims that report an OPRA provider who is excluded from participating in the Medicaid program.

Audit Findings and Recommendations

When a provider who is not actively enrolled in the New York State Medicaid program (inactive provider) serves as an OPRA provider, the Department lacks assurance that the provider can furnish such services, and it increases the risk that excluded, or otherwise unqualified, providers are providing Medicaid services. For the period from January 2015 through December 2019, our audit identified $965 million in Medicaid payments for 2.3 million OPRA services by physicians and professionals who were no longer actively enrolled in Medicaid, as shown in Table 1.

Table 1 – Services by Inactive OPRA Providers

Inactive OPRA Provider	Service Count	Amount Paid
Referring/Ordering	1,690,708	$907,744,924
Prescribing	582,473	43,275,427
Attending	5,764	14,122,195
Totals	**2,278,945**	**$965,142,546**

Of the 2.3 million services we identified, 22,758 services totaling $5.8 million involved an OPRA provider who was excluded from participating in Medicaid. We also identified $10.3 million in Medicaid payments where the attending provider was not affiliated with the billing facility provider, as required (i.e., the attending provider was not registered with the facility in eMedNY; without this, the Department lacks assurance the attending provider was screened by the facility).

The Department implemented eMedNY system edits in 2014 to identify and prevent payments of Medicaid claims for services with an inactive OPRA provider. However, the edits were flawed and failed to check the provider's active status. Subsequent enhancements to the edits were made in February 2018, and our audit noted a significant decrease in improper Medicaid payments after the 2018 update. Furthermore, in response to this audit and our previous audit, *Improper Medicaid Payments for Claims Not in Compliance With Ordering, Prescribing, Referring, and Attending Requirements* (2019-S-2), the Department initiated Evolution Project 7008, Interagency OPRA Remediation Initiative. As part of this project, the Department established an internal work group to review all eMedNY edits associated with OPRA to ensure compliance, including edits that validate the provider was affiliated with the billing facility on the date of service.

Despite the implementation of eMedNY system changes, claim edits, and other recent efforts the Department has made to improve this area, Medicaid payments for claims billed without an actively enrolled OPRA provider continue. From March 2018 through December 2019, we identified $45.6 million paid for 135,476 services where the OPRA provider was not actively enrolled in Medicaid.

We recommend the Department review the findings identified in this report and determine an appropriate course of action, including recovery of improper payments, as appropriate. The Department should provide guidance to providers on OPRA billing requirements. In addition, the Department should enhance controls to prevent future improper Medicaid payments like the ones identified in this report.

Improper Payments for Services With an Inactive OPRA Provider

Federal regulations and the New York State Medicaid Plan require physicians and other health care professionals who provide OPRA Medicaid services to be appropriately screened and enrolled in Medicaid. These requirements also require practitioners prescribing pharmacy services for Medicaid recipients to be appropriately licensed and actively enrolled in Medicaid on the order date of a prescription. As shown in Table 2, the type of service designates which OPRA provider is required to be actively enrolled. From January 2015 through December 2019, we identified about 2.3 million services, totaling $965 million, that required an active OPRA provider but were instead provided by an inactive OPRA provider.

Table 2 – Services Provided by an Inactive OPRA Provider

Service Type	Required OPRA Provider	Service Count	Amount Paid
Nursing Home	Referring/Ordering	810,992	$628,491,917
Inpatient	Referring/Ordering or Attending*	35,080	221,604,562
Pharmacy	Prescribing	582,473	43,275,427
Clinic	Referring/Ordering or Attending*	443,461	38,619,037
Intermediate Care Facility for the Developmentally Disabled	Attending	4,656	13,936,608
Practitioner	Referring/Ordering	213,011	12,973,153
Durable Medical Equipment	Referring/Ordering	65,596	3,187,258
Referred Ambulatory	Referring/Ordering	13,556	1,404,344
Laboratory	Referring/Ordering	108,576	1,218,753
Home Health	Referring/Ordering or Attending*	1,544	431,487
Totals		**2,278,945**	**$965,142,546**

*Requirements vary within individual Medicaid programs and one OPRA provider requirement can be dependent on another. For example, in some cases, providers are not required to list the referring provider on the claim when there is an enrolled attending provider.

Medicaid providers may be assigned an inactive status for a variety of reasons, such as when their license or certification has expired or they are deceased. Additionally, prior to May 2017, managed care organizations (MCOs) could submit requests to add certain providers to Medicaid for reporting purposes (these providers are given a Medicaid identification number, e.g., for network reporting). However, providers added in this way were not screened or credentialed and, therefore, were not actively enrolled Medicaid providers. As shown in Table 3, the OPRA providers we identified were inactive on the date of service for a variety of reasons.

Table 3 – Reason for the Inactive Status of OPRA Providers on Date of Service

Reason for the Inactive Status	Service Count	Amount Paid
Added by MCO for Reporting Purposes Only	591,815	$314,312,572
Inactive for 2 Years With No Payment	734,605	236,574,784
License/Certification Expired	261,131	192,875,129
Termination by the State, Withdrawal (including death)	439,206	125,129,732
No Revalidation	225,718	89,707,693
Other	26,470	6,542,636
Totals	**2,278,945**	**$965,142,546**

According to the Department, there may be a lag in the process for updating a provider's status within eMedNY that perpetuates this issue. However, to ensure proper payment of Medicaid claims, providers' statuses should be updated promptly. Of the claims we identified, 81% of the services (over 1.8 million services) included an OPRA provider who was inactive for more than 1 year before the date of service. Furthermore, 286,321 of these services had an OPRA provider who became inactive prior to January 2000. For example, we identified a provider who became inactive in December 1996 but was the referring physician or prescriber on 706 services, totaling $1.4 million, between January 2015 and December 2019.

Although the Department issued additional guidance on OPRA requirements after the beginning of our audit, there was limited information available to providers prior to this point. In some instances, Department officials themselves were unaware of certain OPRA requirements. For example, Department officials stated that OPRA requirements for Office for People With Developmental Disabilities (OPWDD) services did not become effective until July 2019. However, OPWDD officials acknowledged OPRA requirements existed prior to July 2019; they were just unaware of them. In fact, CMS conducted a Payment Error Rate Measurement review in 2019 and flagged OPWDD claims for not having an active OPRA provider on the claims. Ultimately, CMS determined that the attending provider is required to be reported and actively enrolled on the date of service for claims pertaining to intermediate care facilities for the developmentally disabled. After the CMS review, OPWDD began enforcing this rule and made its provider community aware of the requirements. However, due to the initial lack of understanding and communication of OPRA requirements pertaining to these services, $13.9 million was improperly paid for such services from January 2015 through December 2019.

Additionally, admission to a nursing home requires physician approval and, under federal requirements, nursing home residents must be reassessed at least quarterly or whenever there is a change in condition. Further, under State requirements, a physician must maintain a schedule of visits at least every 30 days for the first 90 days, and at least every 60 days thereafter, to review the nursing home resident's total program of care and authenticate and date all orders. According to the Department, a portion of the 810,992 nursing home services we identified as having an inactive OPRA provider may have been paid appropriately if the provider was

active on the date of the quarterly reassessment. However, although Department officials stated the physician assessments should be documented in the medical records and made available upon survey, they do not have ready access to this information. Without this information, the Department has no way of knowing which provider is conducting the assessments and when they took place. Further, we determined that, for 92% of the nursing home services we identified as having an inactive OPRA provider, the provider had been inactive for more than 90 days prior to the service. As this exceeds the requirement for reassessment, it is unlikely these services were paid appropriately.

Department Efforts to Improve OPRA Compliance

On January 1, 2014, the Department implemented multiple eMedNY system edits in an effort to enforce OPRA requirements and verify the enrollment status of OPRA providers. These edits serve to identify claims that do not report an enrolled provider in the OPRA field. However, the Department determined these edits were not working as intended. Instead of checking the active status of the OPRA provider, the edits only checked to see if a Medicaid identification number existed for the NPI of the provider listed on the claim. As a result, Medicaid was still at risk of paying for services with an inactive OPRA provider because a provider can have a Medicaid identification number and be inactive. In February 2018, the Department updated the OPRA edits to ensure that the OPRA provider listed on the claim was actively enrolled in Medicaid on the date of service.

Further, although the Department implemented an eMedNY system edit in January 2014 to comply with regulations and deny pharmacy claims without an NPI of an enrolled provider in the prescribing field, the Department also implemented a system override option to allow providers time to adapt to the new regulations. The use of this override option, which allowed Medicaid claim payments for non-enrolled, licensed prescribers, was supposed to end in August 2014; however, we found the override was still in use for services billed during our audit period. The Department implemented a system change to fix this in May 2019.

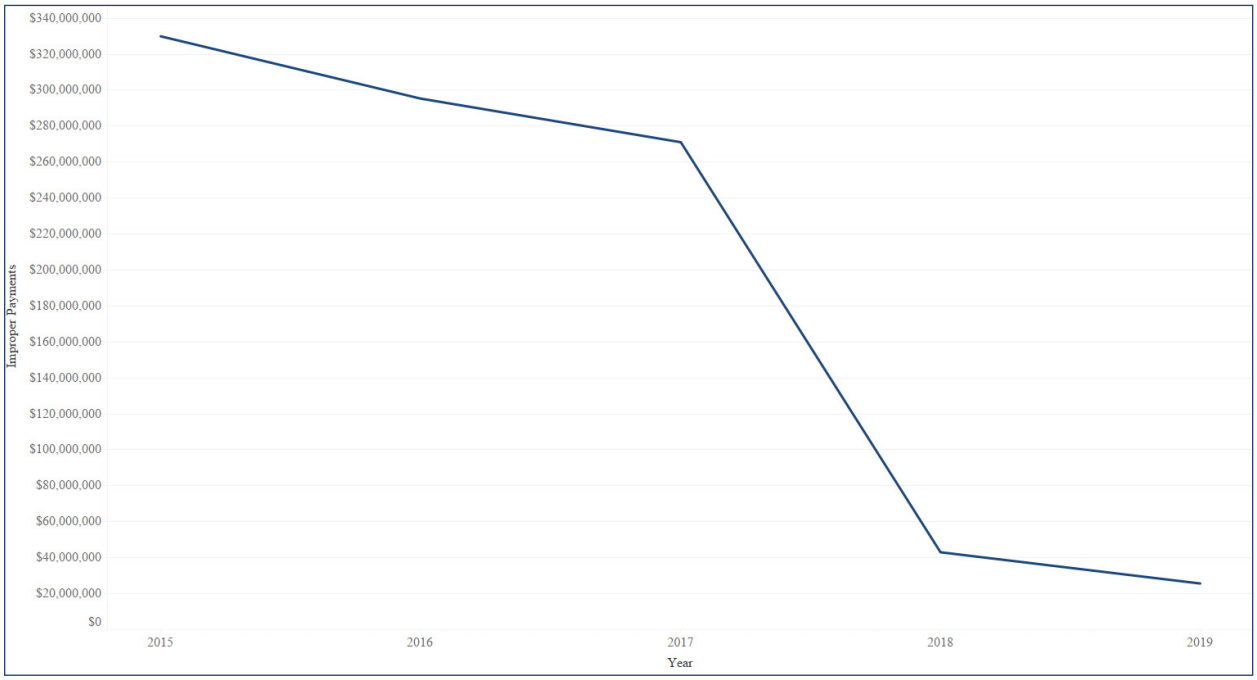
In response to our audit inquiries, and our prior audit, *Improper Medicaid Payments for Claims Not in Compliance With Ordering, Prescribing, Referring, and Attending Requirements* (2019-S-2), the Department has taken several actions to improve OPRA compliance, including: creating Evolution Project 7008, Interagency OPRA Remediation Initiative; updating provider manuals for certain programs; and publishing Medicaid Updates to reiterate OPRA enrollment requirements. As part of the Interagency OPRA Remediation Initiative, the Department established an internal work group to review all eMedNY edits associated with OPRA to ensure compliance, including edits that validate that the provider was affiliated with the billing facility on the date of service. The Department stated that it also provided training to its staff regarding OPRA requirements in April 2021.

We commend the Department's efforts in this area and encourage officials to continue taking steps to improve compliance with OPRA requirements, as improvements are still needed. Although there has been a significant decrease in

paid services with an inactive OPRA provider since the updates to edits in February 2018, improper claims continue. Additional guidance to Medicaid providers is still necessary. For example, while the Department has issued guidance for certain providers to clarify OPRA requirements, such as pharmacy and intermediate care facilities for the developmentally disabled, no guidance has been provided regarding nursing home or home health services.

Improper Payments for Services With an Inactive OPRA Provider From March 2018 to December 2019

After the Department updated the OPRA eMedNY edits in February 2018, we found significantly fewer paid claims with an inactive OPRA provider. However, as illustrated in the figure below, Medicaid is still at risk of making improper payments. From March 2018 through December 2019, $45.6 million was paid for 135,476 services where the OPRA provider was not actively enrolled in Medicaid.



Per the Department, the improper services we identified after February 2018 occurred because of retroactive adjustments to the providers' statuses (i.e., the inactive status of a provider was updated after the payment of the claim). However, although a brief lag may be expected in some circumstances, such as when a provider dies, we found that 65% of the services (totaling $15 million) we identified after the edits were updated had an OPRA provider who was inactive for more than 1 year from the date of service.

We also found most of these services had an OPRA provider with an inactive status that would not appear to require retroactive updates, such as inactivity within the Medicaid program. This status is assigned to providers who do not have any Medicaid payment activity over a 2-year period. For example, we identified a provider who became inactive, beginning in February 2000, due to not receiving a Medicaid payment for 2 years. Despite this, the Department paid $488,476 for 280 services occurring between March 2018 and December 2019 where this provider was listed as an OPRA provider. Additionally, we determined that eMedNY system edits that would deny claims without the required OPRA provider were not applied to Medicare crossover claims (claims for Medicaid recipients who also have Medicare coverage) until July 2021, allowing these claims to be paid during our audit period.

Improper Payments for Services With Excluded OPRA Providers

According to the NYCRR, prior to approving a provider for participation in the Medicaid program, the Department must consider several risk factors, including whether the provider has any previous or current suspension, exclusion, or involuntary withdrawal from participation in the Medicaid program from any state, private medical insurance, or other government program, such as Medicare or Workers' Compensation. The NYCRR also states that no payments will 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 participation in the Medicaid program. An individual excluded from participating in the Medicaid program cannot be involved in any activity relating to furnishing medical care, services, or supplies to Medicaid recipients. Thus, these providers cannot be OPRA providers.

According to the Department, a monthly report is run using OMIG's Excluded Provider List and the Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities to ensure the Department's list of excluded providers is up to date. This report is supposed to ensure providers are monitored from the time of enrollment through revalidation so excluded providers are not actively enrolled in Medicaid and cannot be involved in any activity relating to furnishing medical care, services, or supplies to Medicaid recipients. However, we reviewed these exclusion lists for our audit period and identified 164 excluded OPRA providers on 22,758 services, totaling $5.8 million. For example, we identified one provider who was excluded in February 2015 for the illegal sale of prescription painkillers. Although the Department updated the providers' status to indicate they were inactive due to the exclusion, this provider was the OPRA provider on about 7,000 services, totaling more than $4.9 million, between February 2015 and December 2018.

Further, 116 of the 164 providers did not appear on the eMedNY provider sanction table, which contains information on excluded providers. If excluded providers are not in the provider sanction table, established system edits cannot prevent inappropriate claim payments for services provided by these individuals.

Improper Payments for Services With Non-Affiliated OPRA Providers

In addition to the OPRA-specific requirements and edits, the Department has other eMedNY system processing requirements and corresponding edits to ensure proper claim payment. One such requirement for certain Medicaid services is that the attending provider on institutional claims, such as clinic and inpatient, must be affiliated with the billing facility on the date of service. The Department includes guidance on this requirement in documents disseminated to providers.

According to the guidance, if the attending provider is not affiliated with the facility on the date of service, the claim will be denied. However, the Department does not review facility affiliations because the attending providers are not required to enroll in Medicaid. Therefore, the Department relies on facilities to appropriately screen their affiliated attending practitioners and enter this information in eMedNY. If, at any time, the attending practitioner ceases to be affiliated with the facility, the facility must enter an end date for the affiliation in eMedNY. Although Department guidance instructs facilities to deactivate affiliations in order to maintain a record of the affiliation period, facilities also have the option to delete affiliations. However, doing so effectively removes all evidence that the attending practitioner was ever affiliated with the facility.

We reviewed clinic and inpatient claims paid during our audit period to determine if the attending provider was affiliated with the billing facility on the date of service, as required. We found 12,265 services, totaling $10.3 million, had an attending provider who was not affiliated with the facility on the date of service. For example, we identified 125 services, totaling $789,454, submitted for payment by one facility between October 2015 and March 2016 where the attending provider was not affiliated with the facility. According to information available to us in eMedNY, this provider had never been affiliated with the facility. However, as previously mentioned, the facility may have deleted prior affiliations, removing the evidence of affiliation. Of note, 10,830 of the 12,265 services, totaling $10.2 million, are also included in the $965 million referenced earlier in this report, indicating that the required OPRA providers for these services were also not active providers.

Recommendations

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

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

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

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

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

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

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department made improper Medicaid payments for claims in violation of federal and State requirements related to OPRA providers who were no longer participating in the Medicaid program. The audit covered the period from January 2015 through December 2019.

To accomplish our objective and assess related internal controls, we interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures as well as applicable federal and State requirements. We interviewed officials from OMIG, the Office of Mental Health, OPWDD, and eMedNY to gain an understanding of their processes and procedures regarding Medicaid and OPRA provider enrollment. We used the Department's Medicaid Data Warehouse (MDW) and eMedNY to identify instances where the OPRA provider was not actively enrolled on the date of service or order date, as required, and calculated improper payments made during the audit period. We judgmentally selected specific claim types to review based on total payments, and OPRA requirements, including clinic, durable medical equipment, intermediate care facility for the developmentally disabled, inpatient, nursing home, home health, practitioner, pharmacy, referred ambulatory, and laboratory services.

We obtained data from federal and State databases and compared this data with the inactive OPRA providers in our population to determine if Medicaid paid for services involving improper or excluded providers, such as providers found to have a history of misconduct.

We judgmentally selected 94 claims, totaling over $4.2 million, and reviewed them for accuracy. We used a risk-based approach to judgmentally select claims based on a high dollar amount of potential improper payments, as well as the service date, type of service, and reason for the inactive status of the OPRA provider. Because we selected a judgmental sample, our results cannot be projected to the population as a whole. We shared our methodology and claim findings with the Department and OMIG during the audit for their review.

We found the information used to be generally reliable and point out a limitation with our analyses involving practitioner–facility affiliations. As discussed in the Background, facilities can delete affiliations from eMedNY, which effectively eliminates any record of the affiliation from the MDW. Identifying deleted practitioner–facility affiliation requires obtaining a download of the audit history table (not available in the MDW) for each facility provider. It was not feasible for us to obtain this information for each facility in our audit, and our analyses, therefore, necessarily present only a partial picture of improper claim payments involving affiliated providers.

Statutory Requirements

Authority

The audit was performed 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 conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgement, these functions do not affect our ability to conduct independent audits of the Department's oversight of the Medicaid program.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments, which are embedded in the Department's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Agency Comments and State Comptroller's Comments

NEW YORK STATE OF OPPORTUNITY. | Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

March 2, 2022

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2019-S-72 entitled, "Department of Health- Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program."

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Frank Walsh
Amir Bassiri
Brett Friedman
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Jill Montag
Brian Kiernan
Timothy Brown
Amber Rohan
Melissa Fiore
Michael Atwood
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Department of Health Comments to Draft Audit Report 2019-S-72 entitled, "Medicaid Program: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2019-S-72 entitled, "Medicaid Program: Improper Payments for Services Related to Ordering, Prescribing, Referring, or Attending Providers No Longer Participating in the Medicaid Program" by the Office of the State Comptroller (OSC).

Recommendation #1:

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

Response #1:

The Department is collaborating with OMIG on the development of a comprehensive strategy, including guidance and possible corrective actions for claims identified by OSC, to identify and make appropriate recoveries where services delivered by providers were not ordered, referred, or provided by eligible OPRA practitioners on the date of service, to the extent applicable. OMIG is performing data analysis on the 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. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

The Department reviewed a sample of the claims in question and related federal OPRA policy. The Department disagrees that the claims reviews were paid inappropriately. Below is the rationale supporting our position:

- OSC stated that an actively enrolled referring provider ID is required to be entered on all referred ambulatory claims, clinic claims, laboratory claims, and practitioner claims. However, federal regulations state that the State Medicaid Agency must require all claims for payment for items and services ***that were ordered or referred*** to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. The claim must contain the NPI of an ordering/referring professional only if those services that were furnished required an order/referral. The Department reviewed a sample of the clinic and practitioner claims identified by OSC during this audit and found that many services had an attending provider such as a physician, physician assistant, nurse practitioner, midwife, psychologist, optometrist, dentist, or podiatrist and do not require an order or referral. Professional services provided by these practitioners do not require an order or referral. Since no order is required for professional services furnished by these provider types, an actively enrolled referring provider is not required to be entered on the

claim. The Department requests that any claims that do not require an order or referral be removed from this audit report.

State Comptroller's Comment – None of the claims the Department reviewed were included in the final scope of the audit and, therefore, are not in the audit findings. Furthermore, we disagree with the Department's conclusion that professional services provided by the practitioner types listed in its response do not require an order/referral. In fact, subsequent to the Department's review of the claims referenced in its response, we provided the Department with specific examples of claims for clinic services where the attending provider was one of the professions listed, such as physician. The Department, OPWDD, and other related agencies confirmed that the claim examples we provided did not comply with OPRA requirements.

- OSC states that the referring provider must be actively enrolled on the date of service. However, in some instances, even when the referring provider is not actively enrolled on the date of service, the claim may still be paid appropriately. The referral is valid when written, as long as the provider has a valid Medicaid provider enrollment at the time that the services were ordered. If, on the date of service, the referring provider is not actively enrolled, the claim can still be paid, if the referral was written when the referring practitioner was actively enrolled.

  State Comptroller's Comment – The Department's response contradicts previous guidance it issued to providers. According to the Department's own December 2013 Medicaid Update, "It is the billing provider's responsibility to ensure that all required documentation is in place prior to submission of a Medicaid claim, including checking the status of the ordering provider, who must be enrolled on the date of service." Further, the date a referral is written is not known during claims processing and therefore not considered as part of claim edit controls. If the issued guidance is inaccurate, the Department needs to update it with accurate information.

- The Department notes that the number of claims cited in the OSC audit report is overstated. The OSC is counting individual claim lines as unique encounters, claims, or patient visits. A single medical visit with a provider may have multiple procedures/claim lines reported for a single encounter. A count of unique Transaction Control Numbers would provide a more accurate representation of the number of claims reviewed during the scope of the audit.

  State Comptroller's Comment – The Department's response is inaccurate. Our findings are clearly summarized throughout the report by a count of the number of services provided (including in each of the three tables), not by the number of claims.

- The Department also notes that there are still retroactive adjustments added by the Department regarding provider terminations. Some of this may be due to timeliness of ascertaining that information and applying it systematically.

- Furthermore, the Department did a special input to adjust pharmacy reimbursement due to a Centers for Medicare & Medicaid Services (CMS) requirement which changed our pricing methodology. This project entailed repricing the pharmacy claims retroactively. During this process edits were turned down to effectuate the adjustment of the previously adjudicated claim to correct the reimbursed amount.

As OSC states, the volume of providers excluded from participating in the Medicaid program dropped significantly after eMedNY claims edits were enhanced in February 2018. This enhancement to the edit addressed the majority of claims in the audit report.

To further enhance eMedNY, the Department has established an internal workgroup to support DOH executive leadership and staffed by subject matter experts dedicated to assisting all interagency policy owners – including but not limited to various DOH divisions, the Office of Mental Health (OMH), the Office of Alcohol and Substance Abuse Services (OASAS), the Office of Persons with Developmental Disabilities (OPWDD), and the Office of Children and Family Services (OCFS) – with their holistic review of all eMedNY edits associated with OPRA. Additionally, the workgroup is examining all edits to ensure compliance with federal OPRA and HIPAA X.12 reporting requirements. This ongoing review is anticipated to result in phased modifications to eMedNY as determined by executive leadership as necessary and appropriate. This holistic agile-based mitigation endeavor, otherwise known as Evolution Project 7008 entitled "*Interagency OPRA Remediation Initiative*," remains a significant and resource-intensive undertaking for all involved agencies and is expected to remain so throughout the course of the project's lifecycle.

Recommendation #2:

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

Response #2:

The Department is collaborating with OMIG on the development of a comprehensive strategy, including guidance and possible corrective actions for claims identified by OSC, to identify and make appropriate recoveries where services delivered by providers were not ordered, referred, or provided by eligible OPRA practitioners on the date of service, to the extent applicable. OMIG is performing data analysis on the 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. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

In addition, the Department has established an internal workgroup to support DOH executive leadership and staffed by subject matter experts dedicated to assisting all interagency policy owners – including but not limited to various DOH divisions, OMH, OASAS, OPWDD, and OCFS – with their holistic review of all eMedNY edits associated with OPRA, including edits which will prevent the payment of institutional claims where the attending provider does not have an active affiliation with the billing facility. Additionally, the workgroup is examining all edits to ensure compliance with federal OPRA and HIPAA X.12 reporting requirements. This ongoing review is anticipated to result in phased modifications to eMedNY as determined by executive leadership as necessary and appropriate. This holistic agile-based mitigation endeavor, otherwise known as Evolution Project 7008 entitled "*Interagency OPRA Remediation Initiative*," remains a significant and resource-intensive undertaking for all involved agencies and is expected to remain so throughout the course of the project's lifecycle.

Recommendation #3:

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

Response #3:

The Department is continuously reviewing processes on an ongoing basis to identify areas for improvement. The Department notes that the Department is required to enroll OPRA providers to comply with the 21st Century Cures Act. By design, OPRA providers cannot bill and, therefore, don't receive payment. It would defeat the purpose of enrolling OPRA providers if the Department were to inactivate them for not receiving a Medicaid payment during a two-year timeframe, as these providers would no longer be able to order, prescribe, refer or attend within the Medicaid program. Prior to the 21st Century Cures Act, there was a code used for the reason indicated. The Department periodically ran a report to determine who had not billed in two years and then request to apply the enrollment code. However, since the 21st Century Cures Act, the code has not been used for providers that have not billed in two years and instead has been repurposed for various other reasons.

State Comptroller's Comment – The inactive status code associated with many of the providers in our audit findings after February 2018 is "Inactive: two years no payment activity." The Department should update the description of this code if it no longer accurately reflects the reason a provider was deemed to be inactive so the information can be used to improve controls and prevent improper payments.

Recommendation #4:

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

Response #4:

The Department is updating its billing guidelines to providers to clarify which OPRA fields are required when the associated eMedNY system projects are complete.

Recommendation #5:

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

Response #5:

Data entry and system controls currently exist. OMIG has a process in place to confirm that eMedNY is updated accurately and timely, in order to prevent claims from being paid when a provider was excluded. OMIG is currently working with the Department to automate the eMedNY updates of NYS Medicaid excluded entities.

Recommendation #6:

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

Response #6:

The Department is developing guidance to remind facilities not to delete affiliations with providers in eMedNY via an upcoming Medicaid Update article. In addition, the Department is exploring whether the delete function for affiliations can be removed from enrollment systems without impacting other processes.

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