NEW YORK STATE | Department of Health

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Andrea Inman
Audit Director
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NYS Office of the State Comptroller
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Dear Andrea Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2021-S-6 entitled, "Medicaid Program: Managed Care Payment to Unenrolled Providers."

Should you have any questions, please feel free to contact Nichole Katz, Acting Assistant Commissioner for Governmental Affairs, at (518) 473-1124 or Nichole.katz@health.ny.gov.

Sincerely,

Johanne E Morne

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

Enclosure

cc: Nichole Katz

Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2021-S-6 entitled, "Medicaid Program: Managed Care Payments to Unenrolled Providers"

The following are the Department of Health's (the Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2021-S-6 entitled, "Medicaid Program: Managed Care Payments to Unenrolled Providers." Included in the Department's response are the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

General Comments:

The Department requires the submission of encounters via an Encounter Intake System, and also requires the submission of certain network information to confirm Managed Care Organization network adequacy via Provider Network Data System. Both systems were designed before the requirements for managed care network provider enrollment, and therefore cannot support systematic reviews at this time.

The eMedNY Provider Enrollment system is designed to collect information to support fee-for-service billing and has been expanded to collect data on managed care providers as well. System improvements and further refinement of data requirements are needed to integrate the data from these distinct systems.

Encounter data is submitted by health plans using information submitted by health care providers on a claim. Encounter data documents both the clinical conditions as well as the services and items delivered to beneficiaries to treat these conditions. The provider data rules on encounters are based on claim submission rules. Claims have used a unique 10-digit National Provider Identifier assigned to the provider as the provider ID in many cases.

The primary purpose of the Provider Network Data System is to capture the Managed Care Organization's provider network and determine if the Managed Care Organization's network meets adequacy requirements pursuant to SSL 364 or 365, PHL 4403(5), 10 NYCRR 98-1.16(j) and 42 CFR 438.58. Network adequacy refers to a Managed Care Organization's ability through its contracted providers to deliver services and benefits as necessary to assure reasonable access to enough in-network primary care and specialty physicians, and all health care services defined in the Medicaid Model contract.

Provider networks submitted to the Provider Network Data System are a "snapshot" of what the network looks like at a particular point in time. Provider networks are fluid whereby multiple changes occur ahead of, and post submission on a quarterly basis in accordance with the Provider Network Data System submission schedule. The Provider Network Data System is intended to be a measure of Managed Care Organization compliance with established network adequacy standards and in no shape or form is connected to eMedNY and the Department's

claims processing and payment system.

The eMedNY Provider Enrollment system, on the other hand, is utilized to process and enroll Medicaid providers in a variety of enrollable categories of service for the purpose of ensuring that ordering, prescribing, service rendering, and billing providers are enrolled with the NYS Medicaid program for the purpose of claims payment, and their information is verified across several exclusionary databases, as necessary, to assure Medicaid program integrity. The Federal 21st Century Cures Act mandated that all providers in a Managed Care Organization's network for enrollable categories of services be enrolled in the State's Medicaid program. Accordingly, the Department began by issuing directives and guidance to Managed Care Organizations to identify and enroll providers in their network that were not enrolled prior to such a law. The Department further established pending and enrolled provider listings and published them on its website to allow Managed Care Organizations to monitor and ensure enrollment of their network providers pursuant to this law and the Department's enrollment procedures.

As noted above, since the three systems were designed before the requirements for managed care network provider enrollment, and as such cannot support systematic reviews, OSC's analysis used to determine provider enrollment status is systematically flawed.

State Comptroller's Comment – DOH acknowledged it has not developed an efficient mechanism to systematically review Managed Care Organizations' compliance with the 21st Century Cures Act, which requires in-network providers to enroll in Medicaid. Despite this—and the fact that the Encounter Intake System, the Provider Network Data System, and eMedNY (DOH's Medicaid claims processing system) were built before the 21st Century Cures Act's requirements—various information exists in these sources that DOH could have used in its oversight role, including encounter claims that show Managed Care Organization payments to unenrolled providers. However, rather than use all the available information, DOH relies on Provider Network Data System controls to monitor Managed Care Organization compliance, even though DOH officials acknowledge the Provider Network Data System was not created for this purpose.

Our auditors used information from the various sources and identified over $1.5 billion in improper and questionable Managed Care Organization payments to unenrolled providers. For instance, approximately $832 million of this amount was found to be associated with payments after provider enrollment applications were either denied by OMIG, withdrawn by DOH for not meeting Medicaid program standards, or automatically withdrawn by eMedNY due to missing information. To illustrate, one unenrolled pharmacy that had been denied enrollment by OMIG due to unclean conditions, lack of proper supporting documentation, and expired medications on pharmacy shelves received over $57 million in Managed Care Organization payments.

Because of DOH's ineffective administration of the 21st Century Cures Act's requirements, Medicaid patients and taxpayers have been put at risk, and DOH's response appears to be a tactic to deflect from the significance of the issue. We also remind DOH that the audit reviewed a sample of five Managed Care Organizations—approximately 50% of the claims indicating payments to unenrolled providers—not the entire managed care population and, therefore, the issue is bigger than we reported, giving even more importance to the need for DOH to take corrective actions in response to the audit and its recommendations.

OSC, defines "unenrolled" as "…a billing provider whose National Provider Identifier and/or provider ID reported on an encounter claim did not correspond to an enrolled Medicaid provider ID in the Medicaid Data Warehouse." However, such mismatch between the MMIS ID (unique provider number assigned by eMedNY enrollment) and National Provider Identifier is not conclusive evidence that a provider is unenrolled.

These data systems have different data rules which interfere with cross-system data-matching. There is no one-to-one relationship in terms of the data collected by each system, resulting in the inability to crosswalk data from one system to the other. There can be mismatches between the MMIS ID and National Provider Identifier which may vary based on whether it is assigned to a provider group or an individual. Additionally, there is a variety of atypical providers that do not meet the definition of a health care provider as defined in 45 CFR 160.103 and may not apply for a National Provider Identifier. Such entities include billing services, value-added networks, re-prices, health plans, health care clearinghouses, non-emergency transportation services, and others.

State Comptroller's Comment – We agree DOH has not developed the infrastructure to systematically review Managed Care Organizations' compliance with the 21st Century Cures Act's requirements. Accordingly, our audit included a comprehensive review of various DOH systems (Provider Network Data System, Medicaid Data Warehouse [which collects Encounter Intake System information], eMedNY, etc.) to identify unenrolled in-network providers.

DOH's response focuses on cross-system data matching and atypical provider issues, and it inappropriately applies these DOH problems to the entirety of the audit findings. We made these issues abundantly clear to DOH during the audit. We also made clear to DOH that we considered findings related to these issues to be questionable payments because of these limitations (for instance, we identified $306 million of the $1.5 billion to DOH as questionable for these reasons). Specifically, DOH doesn't require National Provider Identifiers for atypical providers or add them to eMedNY provider enrollment files, even when a National Provider Identifier is entered on a provider's Medicaid enrollment application (exacerbating DOH's oversight limitations), which could result in data matching limitations. We reported these scenarios to DOH as questionable because, without extensive manual review, a definitive conclusion on enrollment status could not be reached. Furthermore, our audit report and recommendations addressed these issues.

Unfortunately, because of DOH's lax oversight of Managed Care Organizations' compliance with the 21st Century Cures Act, it does not know which of this high-risk subset conclusively represents unenrolled providers. Exacerbating the matter, because DOH had not developed a mechanism to efficiently, systematically, and comprehensively review Managed Care Organization provider enrollment statuses, a manual review of all providers would be a next step, however unrealistic due to the intensive manual comparison of various data sources needed. As a result, DOH is left knowing that a significant number of unenrolled providers are in this subset, but it can't systematically process and vet these unenrolled and, in some cases, excluded providers who are doing business with the State.

The Department strongly believes that if OSC had performed a more focused and detailed review comparing MMIS ID and National Provider Identifier mismatches, results like the examples we provided under separate cover, would have been evident to the auditors. The

Department reviewed many of the providers OSC identified in its analysis as being unenrolled and in many of these scenarios, the Department drew a different conclusion. The analysis the Department performed indicated that providers deemed by OSC as unenrolled included providers that were in fact enrolled in NYS Medicaid. These National Provider Identifiers were identified as having a corresponding enrolled provider ID on the Provider Network Data System submission and were enrolled in NYS Medicaid.

State Comptroller's Comment – DOH stated it "reviewed many of the providers OSC identified in its analysis as being unenrolled and in many of these scenarios, the Department drew a different conclusion." We obtained DOH's review and it consisted of eight providers (out of 2,691 in-network providers identified in our report). Additionally, DOH incorrectly selected the providers from a preliminary file (not our final results) of providers.

Our analysis of DOH's sample follows. One of the eight providers in DOH's review is a pharmacy that was not enrolled in Medicaid—it was on a DOH Provider Network Data System error report for at least eight consecutive quarters for three different Managed Care Organizations, indicating the provider ID was inactive. Further, two of the eight providers were not included in our final audit results. The remaining five providers are personal care service providers that we brought to DOH's attention during the audit as a subset of questionable payments (because of limitations addressed in our prior State Comptroller's Comment) and, therefore, would need a manual review of additional information because DOH had not developed a proper automated mechanism to accurately identify Managed Care Organization provider enrollment statuses.

Department Responses to the Audit Recommendations:

Recommendation #1:

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

Response #1:

The Office of the Medicaid Inspector General (OMIG) routinely performs audits of excluded providers in Managed Care. OMIG continues to perform data analysis to evaluate if changes are needed to address the OSC-identified claims. OMIG is also engaged with the Department to provide information regarding provider enrollment and contract oversight.

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

Recommendation #2:

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

Response #2:

The Provider Network Data System is not the appropriate system to use when determining the enrollment status of in- network providers. The Provider Network Data System is designed to monitor adequacy of the Managed Care Organization's networks, and it is not designed to monitor in-network provider/ancillary facility's enrollment status. Moreover, the Department publishes pended and enrolled provider listings; Managed Care Organizations are required to check such listings prior to submitting their quarterly network submissions. Lastly, providers in an enrollable category of service can receive only a single MMIS ID from the Department upon enrollment into the Medicaid Program. However, that same provider can obtain multiple National Provider Identifiers for each specialty and/or affiliations to which the provider is associated.

The Department will review the list of 272 unenrolled in-network providers identified by this OSC audit against the most recent provider network data. The Department will work with the Managed Care Organizations to remove un-enrolled providers, as necessary, from the plan networks, and where appropriate, engage OMIG for recovery efforts.

Recommendation #3:

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

Response #3:

The Department administers the second largest Medicaid program in the nation and provides care and services to over seven million members. To serve these members, over 250,000 providers and practitioners are enrolled annually by the Department into over 100 unique categories of service. All providers are required to revalidate their enrollments every five years as a condition for ongoing participation in the Medicaid program. The Department already publishes pending and active provider lists on its website and requires Managed Care Organizations to frequently, no less than monthly, review such pending and enrolled provider lists. The Department has a process in place to notify s of the cause for terminations. The Department is reviewing the feasibility of developing a process of notifying Managed Care Organizations of denied or withdrawn enrollments.

The Department has engaged a new vendor to modernize the current paper-based provider enrollment process, by transitioning to a full digital system This initiative will streamline the enrollment process for providers, and the Department, and is anticipated to provide enhanced reporting capabilities. The Department will thoroughly explore the new portal's ability to generate and publish comprehensive reports, including those detailing denied or withdrawn provider applications.

Recommendation #4:

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

Response #4:

The Department distributed guidance (see attached) in September of 2022, clarifying its expectations for encounter claims containing the National Provider Identifier. Specifically, the Department requires National Provider Identifiers to be included on all encounters submitted to the Encounter Intake System. Although the Department has transitioned from the Encounter Intake System to the Original Source Data Submitter System, this same guidance continues to apply. The Department is currently working on updating this guidance with language specific to the Original Source Data Submitter System.

Recommendation #5:

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

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

Response #5:

The Department has developed and employed an internal process to ensure all newly enrollable categories of service or enrollable types of providers are incorporated into the Provider Network Data System and encompassed within the Provider Network Data System edit logic, when appropriate, in a manner that is as timely as practicable. The Department is also updating its internal policies and procedures to assure timely action on providers identified by Provider Network Data System error reports.

The Department is exploring the barriers to identify when an encounter includes an inappropriately non-enrolled provider, including differences in provider identification rules. The Department will review the codes used for the Provider Network Data System, which are used to ensure network adequacy, and the codes used for designated provider type, to determine whether improvements in reporting are appropriate and possible.

The Provider Network Data System 1021 edit is a hard edit whereby providers that trigger the edit are prevented from being accepted as part of the network submission. The Department is exploring options, with the State contractor managing Provider Network Data System, to create an exemption report capturing submissions that trigger the 1021 edit. Such exemption reports will be shared with Managed Care Organizations.

The Department continues to collaborate on the best practices and research tools that could be employed in monitoring Managed Care Organizations compliance with the 21st Century Cures Act provisions.

Recommendation #6:

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

Response #6:

The Department, in collaboration with the Office of Addiction Services and Supports (OASAS), will work with the Managed Care Organizations to identify the appropriate course of action necessary to ensure enrollees have sufficient access to chemical dependency services from properly credentialed in-state providers.

OASAS' Criminal Justice Division works closely with the courts to ensure that enrollees have sufficient access to substance use disorder (chemical dependency) services from properly credentialed in-state providers. The following Local Service Bulletin: Working with Criminal Justice Entities | Office of Addiction Services and Supports (ny.gov) states *that "OASAS continues to work closely with the New York State Office of Court Administration and State Criminal Justice (CJ) agencies to advance understanding of the differing but critically important roles played by chemical dependence (CD) treatment providers and CJ agencies to ensure quality of care for those served,* " and that *"Persons may be referred to an OASAS certified program as an alternative to incarceration, enrollment in a drug court, or as a required referral to treatment as a result of a DWI arrest. These referrals may be as a result of a plea agreement, condition of probation/parole, or a part of an alternative to incarceration program."*

Recommendation #7:

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

Response #7:

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

Recommendation #8:

Enhance processes to identify and recover managed care payments to providers who are

excluded or who otherwise require further review by DOH due to past misconduct.

Response #8:

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

Recommendation #9:

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

Response #9:

For clarification, the edit logic error is not an OMIG exclusion edit. The edit is on the Provider Network Data System reporting, which is not in the Medicaid claims processing system. The Department has implemented a fix, effective April 2023, that rectified issues with this edit logic error.

Recommendation #10:

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

Response #10:

OMIG is in the process of enhancing procedures, which include reviewing the data submitted by the MCOs on the Program Integrity Report. OMIG has updated the self-disclosure documents on the OMIG website and has been communicating those updates with the Managed Care Organizations. OMIG continues to update guidance on its website, according to the recent rulemaking in 18 NYCRR Part 521.