Department of Health

Medicaid Program: Managed Care Payments to Unenrolled Providers

Report 2021-S-6 | June 2024

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

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid managed care organizations violated federal and State regulations by making payments to unenrolled providers. The audit covered the period from January 2018 through June 2022.

About the Program

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

Key Findings

Our audit found DOH does not monitor encounter claims to identify inappropriate managed care payments to providers who are not enrolled in Medicaid. Additionally, although DOH developed PNDS controls and error reports to assist MCOs in their compliance with the Act (such as notification of providers who are not enrolled), our audit found weaknesses in these controls. These problems led to over $1.5 billion in improper and questionable payments, as follows:

- We obtained PNDS submissions and encounter claims for a sample of five of the highest paid MCOs, which showed the MCOs made $916 million in payments to in-network providers whose identification numbers did not correspond to an identification number of a Medicaid-enrolled provider, according to DOH data.
- We identified $832.5 million in total MCO payments to providers (in-network and out-of-network) who had a Medicaid enrollment application that was either denied by the Office of the Medicaid Inspector General, withdrawn by DOH for not meeting Medicaid program standards, or automatically withdrawn by DOH's claims processing and payment system due to missing information. (Note: $212 million of this was included in the $916 million in payments made by the five MCOs.)
- We identified $9.6 million in improper MCO payments to providers (in-network and out-of-network) who were excluded from or otherwise ineligible for the Medicaid program. (Note: $548,184 of this was included in the $916 million in payments made by the five MCOs.)

Key Recommendations

- Review the $1.5 billion in Medicaid MCO payments to unenrolled in-network providers and providers who were denied Medicaid enrollment, and take appropriate corrective steps.
- Enhance monitoring over MCO compliance with the Act.

- Review the $9.6 million in Medicaid MCO payments to unenrolled providers who were excluded from receiving Medicaid payments or who should be further reviewed by DOH due to past misconduct, and recover payments where appropriate.

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

June 4, 2024

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

Dear Dr. McDonald:

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 *Managed Care Payments to Unenrolled Providers*. This 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.

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
DOH	Department of Health	*Auditee*
Act	21st Century Cures Act	*Law*
Billing provider ID	Identification number given to enrolled Medicaid providers	*Key Term*
BMCCS	Bureau of Managed Care Certification & Surveillance	*Key Term*
BMLTC	Bureau of Managed Long-Term Care	*Key Term*
CMS	Centers for Medicare & Medicaid Services	*Agency*
eMedNY	DOH's Medicaid claims processing and payment system	*System*
Encounter claim	Record of a health care service provided to a recipient	*Key Term*
FFS	Fee-for-service	*Key Term*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*System*
NEMT	Non-emergency medical transportation	*Key Term*
NPI	National Provider Identifier	*Key Term*
NPPES	National Plan and Provider Enumeration System	*System*
NYCRR	New York Codes, Rules and Regulations	*Law*
OASAS	Office of Addiction Services and Supports	*Agency*
OIG	U.S. Department of Health and Human Services Office of Inspector General	*Agency*
OMIG	Office of the Medicaid Inspector General	*Agency*
OPMC	DOH's Office of Professional Medical Conduct	*Agency*
Pended Listing	Medicaid Pended Provider Listing	*Key Term*
PHE	Public health emergency	*Key Term*
PNDS	Provider Network Data System	*System*
Unenrolled	Designates a billing provider whose NPI and/or provider ID reported on an encounter claim did not correspond to an enrolled Medicaid provider ID in the MDW	*Key Term*

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, 2023, New York's Medicaid program had approximately 8.4 million recipients and Medicaid claim costs totaled about $80.2 billion, comprising $30.2 billion in fee-for-service payments and $50 billion in managed care premium payments. The federal government funded about 56.9% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.1%. The federal Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid programs and issues regulations that set general parameters for states to follow.

The Department of Health (DOH) administers the Medicaid program in New York State. DOH uses two methods to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, DOH, through its Medicaid claims processing and payment system (eMedNY), pays Medicaid-enrolled providers directly for services delivered to Medicaid recipients. Under the managed care method, DOH makes monthly premium payments to managed care organizations (MCOs) for each enrolled Medicaid recipient and, in turn, the MCOs arrange for the provision of services and reimburse providers for those services. MCOs then submit claims that document those services (referred to as encounter claims) to DOH. Encounter claims are required to be accurate and timely and must include the billing provider's National Provider Identifier (NPI). NPIs are assigned through CMS' National Plan and Provider Enumeration System (NPPES), which also maintains and updates information about health care providers with NPIs.

Each MCO must maintain a provider network that is sufficient to deliver comprehensive services to their enrolled population. In December 1996, DOH implemented the Provider Network Data System (PNDS) to gather information about the providers and service networks contracting with MCOs operating in New York State. The primary purpose of the PNDS is to collect data needed to evaluate the provider networks and assess MCOs' compliance with adequacy standards pursuant to federal and State statutes and regulations. MCOs are required to submit their contracted provider information to the PNDS on a quarterly basis, as well as any interim changes to their networks (e.g., adding or terminating a provider) within 15 days of the change. The PNDS feeds the NYS Provider & Health Plan Look-Up website, which provides up-to-date provider information to enrollees. MCOs are also responsible for ensuring proper credentialing of their participating in-network providers (i.e., ensuring providers meet applicable licensing, certification, or qualification requirements). While enrollees are generally required to go to in-network providers for services, they may go out-of-network in certain situations (e.g., if there are no in-network providers who can offer the necessary skills or services).

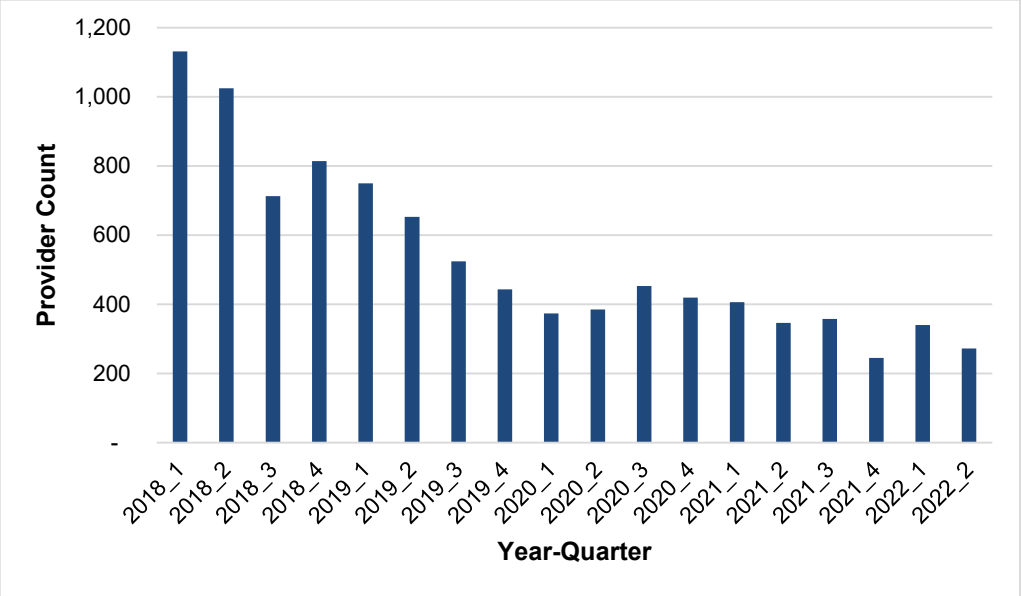
The 21st Century Cures Act (Act) and additional federal guidance mandated that, by January 1, 2018, all in-network managed care providers, with certain exceptions, must be enrolled as participating providers in the state Medicaid program. All providers must be screened when they initially apply to the Medicaid program, upon

re-enrollment in the Medicaid program, and at least once every 5 years to revalidate their enrollment. Through the screening and provider enrollment process, DOH gains a level of assurance over the provider's validity to provide Medicaid services. Further, the provider application process allows DOH to verify the provider's licensing and other credentials to furnish services. Additionally, DOH must verify that all providers are not prohibited from participating in a Medicaid program by the federal government (e.g., the Office of Inspector General), which further enhances the safety of the Medicaid program and its members. Effective September 1, 2022, MCOs are expected to deny payment for services by non-enrolled out-of-network providers servicing more than 10 members in the prior 180 days. Within DOH, the Office of the Medicaid Inspector General (OMIG) is responsible for conducting and coordinating the investigation, detection, audit, and review of Medicaid providers to ensure they are complying with the laws and regulations.

Audit Findings and Recommendations

Despite DOH taking steps since August 2017 to prepare MCOs for the Act's enrollment requirement, such as instructional presentations, guidance, and outreach, numerous factors, including the large volume of new provider enrollment applications and the onset of the COVID-19 public health emergency (PHE) came into play that stalled progress (as shown in the chart below for the five MCOs we sampled), increasing the risk that MCOs were making payments to unenrolled in-network providers.

Number of Unenrolled In-Network Billing Providers: 2018 Quarter 1 to 2022 Quarter 2



Although DOH resumed activities to bring MCOs into compliance with provider enrollment requirements as the PHE ended, the audit found that MCOs' encounter claims continued to include unenrolled in-network providers, accounting for significant inappropriate payments. We found DOH does not monitor encounter claims to identify improper payments to providers who are not enrolled or who are excluded from the Medicaid program. Although DOH developed PNDS controls and error reports to assist MCOs with compliance, our audit found weaknesses in these controls led to improper and questionable managed care payments.

For the period January 2018 through June 2022, we found $4.9 billion in MCO encounter claims that, based on provider information from DOH's Medicaid Data Warehouse (MDW), contained an unenrolled billing provider NPI and/or billing provider ID (both in-network and out-of-network). (For purposes of this report, "unenrolled" designates a billing provider whose NPI and/or provider ID reported on an encounter claim did not correspond to an enrolled Medicaid provider ID per provider information in the MDW.) Our audit found over $1.5 billion of the payments were questionable and improper, as follows:

- Five MCOs accounted for $2.6 billion (53%) of the $4.9 billion in encounter claim payments. We obtained the quarterly PNDS submissions for the five

MCOs and determined $916 million of their payments were made to in-network billing provider NPIs and/or billing provider IDs that did not correspond to a Medicaid-enrolled provider ID on the date of service, as required.

- Over $832.5 million of the total $4.9 billion in encounter payments were made to providers with a Medicaid enrollment application that was either denied by OMIG, withdrawn by DOH for not meeting Medicaid program standards, or automatically withdrawn by eMedNY due to missing information. (Note: $212 million was included in the $916 million in payments made by the five MCOs we reviewed.)
- Approximately $9.6 million in improper managed care payments were made to providers who were excluded from or otherwise ineligible to participate in the Medicaid program. (Note: $548,184 was included in the $916 million in payments made by the five MCOs we reviewed.)

DOH should review the payments identified in this report and determine an appropriate course of action, including recovery of improper payments. DOH should also enhance its monitoring, including a review of encounter payments, to ensure MCOs are complying with the provisions of the Act.

Managed Care Payments to Unenrolled Providers

Managed Care Network Providers

Effective January 1, 2018, all in-network managed care providers, with certain exceptions, must be enrolled in Medicaid. From January 2018 through April 2019, DOH directed MCOs to take steps to identify and reach out to providers who were not yet in compliance with the Act's enrollment requirement. However, due to various challenges that MCOs faced in implementing the requirement, DOH did not require MCOs to terminate providers not enrolled in Medicaid from their networks until May 2019. DOH continued to educate MCOs on Act requirements through presentations delivered from June 2019 through February 2020.

With the onset of the COVID-19 PHE, and DOH resources redirected elsewhere, DOH efforts to ensure enrollment of in-network providers were halted. In March 2020, CMS approved a DOH waiver to temporarily cease revalidation of certain Medicaid providers until the end of the PHE (as stated previously, after providers are screened when they initially apply to the Medicaid program, they are screened upon re-enrollment in the program, and at least once every 5 years to revalidate their enrollment). As a result, from March 1, 2020 through the end of our audit scope in June 2022, a provider's enrollment in the Medicaid program would not be terminated for failure to revalidate. Officials from multiple MCOs informed us that they interpreted this guidance to mean providers should not be terminated for any reason, other than their being excluded from the program. While CMS granted waivers to make enrollments less cumbersome (e.g., allowing for provisional temporary provider enrollment) during the PHE, no waiver was granted to suspend the in-network provider enrollment requirements. As illustrated in the chart on page 8, progress enrolling in-network MCO providers stagnated until 2021 when DOH

began implementing additional PNDS-related procedures and re-issuing reminder publications.

We analyzed all MCO encounter claims (in-network and out-of-network) for the period January 2018 through June 2022, and found MCOs made $4.9 billion in payments to unenrolled providers. We obtained the PNDS quarterly submissions for five MCOs that accounted for $2.6 billion (53%) of these payments, and identified questionable payments of $916 million to unenrolled in-network providers. As of the PNDS June 2022 Quarter 2 submission file – the most recent submission file we reviewed – there were 272 unenrolled in-network providers on encounter claims of the five MCOs totaling over $52.7 million.

Providers Whose Medicaid Enrollment Application Was Denied or Withdrawn

DOH creates a publicly available data set of Medicaid-enrolled providers (Medicaid Enrolled Provider Listing) and a data set of providers who have applied to participate in Medicaid but whose enrollment is pending (Medicaid Pended Provider Listing [Pended Listing]). This information is, in part, meant to be used by MCOs to determine which of their network providers are enrolled in Medicaid and which providers are pending an enrollment decision by DOH. However, we identified deficiencies in DOH's procedures wherein MCOs may not be aware of providers whose pending application was denied or withdrawn, increasing the risk of improper payments to providers who are not enrolled in Medicaid.

Per CMS regulations, some providers are subject to greater screening during the credentialing process, such as site visits (which are conducted by OMIG in New York State) or certification by another agency (e.g., Office of Addiction Services and Supports [OASAS]). According to DOH officials, during our audit period, when provider applications were sent to another entity for review (such as OMIG), the provider would be removed from the Pended Listing, and their enrollment status would thus be unknown to MCOs. As a result of our audit, in September 2022, DOH implemented a process whereby providers under OMIG or other agency review will remain on the Pended Listing until that review is completed.

If DOH denies or withdraws a provider's Medicaid enrollment application, the provider is notified via letter, and they are removed from the Pended Listing. However, DOH does not communicate enrollment denials or withdrawals to the MCOs. We reviewed the $4.9 billion in encounter claims for all unenrolled providers in our population, and identified $832.5 million in payments that were made after the billing provider's Medicaid enrollment application was either denied by OMIG, withdrawn by DOH for not meeting Medicaid program standards, or automatically withdrawn by eMedNY due to missing information.

For example, we identified 17,081 claims totaling over $57.2 million (73% of which were in-network) that contained an unenrolled pharmacy provider who was denied enrollment by OMIG in 2016 and again in 2018. This provider was denied Medicaid enrollment by OMIG for reasons that included: unclean conditions, lack of proper

supporting documentation, and expired medications on pharmacy shelves. According to the Act, MCOs must immediately terminate a provider from their network when they are prohibited from participating in the Medicaid program by DOH. Although not all providers are denied for patient safety concerns (e.g., an out-of-state pharmacy provider can be denied enrollment if they primarily provide services via mail order/delivery and these services are readily available through existing in-State pharmacies), this example illustrates the importance of providing MCOs with a list of denied providers. In response to our audit, DOH officials stated they are developing procedures to ensure that MCOs regularly receive notification of providers whose enrollment has been denied or terminated. DOH should also incorporate a review of encounter data into its monitoring efforts to identify these improper payments.

Entities That Bill on Behalf of Servicing Providers

We found that MCOs may delegate certain business services to other entities in order to enhance their network as well as handle administrative functions such as provider credentialing (e.g., ensuring enrollment in Medicaid). For example, MCOs can contract with non-emergency medical transportation (NEMT) benefit brokers, who act as facilitators to provide transportation services to recipients. While these types of business entities do not need to enroll in Medicaid, any of their independent providers (e.g., individual practitioners, facilities, or transportation providers) who contract with an MCO and are in-network must enroll in Medicaid. Also, some business entities offer administrative services for providers by acting as fiscal intermediaries and submitting claims to the MCOs on the provider's behalf. In this case, the MCO pays the business entity and then submits the encounter claim to DOH. The encounter claim should contain the NPI of the business entity in the billing provider field and the NPI of the provider in the rendering provider field. The business entity then pays the provider who rendered the service.

For the period January 2018 through January 2022, we identified 1,007,656 encounter claims totaling $64.1 million (included in the $916 million in payments by the five MCOs to unenrolled in-network providers that we identified) where the NPI of the business entity was listed in both the billing provider and the rendering provider fields. We contacted one MCO, which accounted for over $56.6 million (88% of the $64.1 million) in payments submitted by an NEMT broker, to determine why the rendering provider field did not contain the NPI of the transportation provider who furnished the service. According to MCO officials, they do not require rendering provider information on claims submitted by this NEMT broker because the NEMT broker has the responsibility of ensuring that the rendering provider is enrolled. While MCOs can delegate this provider credentialing administrative function to these business entities, it ultimately remains DOH's and MCOs' responsibility to ensure in-network providers are appropriately enrolled. When encounter claims do not contain the rendering provider information, DOH and MCOs cannot be assured that services are being furnished by enrolled and properly credentialed providers.

Weaknesses in Monitoring MCO Compliance With the 21st Century Cures Act

DOH does not monitor encounter claims to identify in-network providers who aren't enrolled in Medicaid, but instead uses MCOs' PNDS submissions as the main control to monitor MCOs' compliance with the Act. DOH developed PNDS controls (i.e., edits) and error reports relating to both provider (individual) and ancillary (organization) submissions to identify providers not enrolled in Medicaid, inaccurate NPI and provider ID information, and providers with a pending Medicaid enrollment.

The PNDS Part A error report identifies provider IDs submitted to the PNDS that are inactive. For organizations only, it also identifies instances where a provider ID's designated service – that is, the reported major health service that the provider contracted with the MCO to perform – doesn't match the provider's profession or service type reported in eMedNY (e.g., a provider who contracted with an MCO to perform home health services but who is enrolled in eMedNY as a skilled nursing home provider). The PNDS Part B error report identifies instances where a provider's NPI and corresponding provider ID reported in the PNDS do not match the NPI and provider ID on file with eMedNY. Also, where an error report identifies a provider with a pending enrollment, this will show as "pending" in the report and not as a Part A or a Part B error. In December 2021, DOH also established PNDS edit 1021, which rejects an MCO's entire PNDS submission file if certain provider types are reported with a provider ID field containing all 8s, 9s, or 0s, which MCOs would use to indicate no provider ID was available.

For the period January 2018 through June 2022, we identified 1,271 unenrolled in-network providers on encounter claims totaling over $144 million (of the $916 million paid by the five MCOs we reviewed) who were identified on a Part A and/or Part B error report in the PNDS submission quarter that corresponded with the claim date of service. For the remaining nearly $772 million, the payments were not captured on either report for reasons that included: the service date was prior to DOH's implementation of PNDS error reports discussed in this report or the designated provider type was not included in the Part A or B edit logic.

Despite DOH's PNDS edits and error reports to identify providers not enrolled in Medicaid, we found weaknesses in DOH's edit logic and monitoring processes that limit its ability to identify providers who are not enrolled and prevent inappropriate payments by MCOs, as discussed next.

Insufficient Monitoring of PNDS Edits

Our review of the PNDS submissions found that MCOs did not always take timely corrective action to address provider non-enrollment issues identified by the PNDS edits. Of the 1,271 providers identified by the edits, 370 providers, who received encounter payments totaling $92.1 million, were flagged on three or more consecutive PNDS quarterly submissions by the same MCO. For example, a physician was identified on 12 consecutive Part A error reports for one MCO (from

2018 Quarter 4 to 2021 Quarter 3). The MCOs' lack of responsiveness could be attributed, at least in part, to DOH's weak monitoring of MCOs' compliance and procedural deficiencies.

Within DOH, the Bureau of Managed Care Certification & Surveillance (BMCCS) has oversight of mainstream managed care plans, and the Bureau of Managed Long-Term Care (BMLTC) has oversight of managed long-term care plans. BMCCS written monitoring procedures require a review of Part A error reports only, and not Part B error reports. Beginning with 2021 Quarter 4 PNDS submissions, BMCCS procedures require a BMCCS Plan Manager to download the quarterly Part A errors and send the results to each MCO. Each MCO is required to respond within 15 days of receiving the report, delineating the action taken for each identified provider. The Plan Manager is required to follow up with MCOs on the status of providers identified and to conduct additional outreach where providers continue to be flagged on error reports after the next two quarters. According to DOH officials, BMLTC does not follow this process and does not require written responses from the MCOs it oversees.

We identified 48 unenrolled in-network providers, accounting for payments totaling $13.5 million, who were identified by the Part B error report (e.g., provider NPIs and corresponding provider IDs in the PNDS that don't match an identification number of an enrolled provider in eMedNY), but not the Part A error report (e.g., inactive provider IDs). For example, on one PNDS submission, an MCO wrongly reported all individual practitioner NPIs at one organizational provider in combination with the organization owner's individual provider ID, and we further determined that one of the practitioners was not enrolled. The unenrolled practitioner was not captured on the Part A error report due to the enrolled status of the owner's provider ID. The Part B error report flagged this item because, in eMedNY, the unenrolled practitioner's NPI was not associated with the owner's enrolled provider ID. If DOH monitored Part B errors, and required the MCO to correct the information, this unenrolled individual practitioner would have been identified by the Part A error report.

Weaknesses in Design and Implementation of PNDS Edits

When MCOs submit their provider information to the PNDS, they must associate each provider with a designated provider type code (e.g., pharmacy, hospital inpatient, physician, therapist). However, the PNDS designated provider type codes do not clearly align with provider type codes used by DOH in the enrollment process and identified in eMedNY, and there is no crosswalk between eMedNY and the PNDS. This may result in MCOs incorrectly reporting the wrong provider type, as confirmed by two MCOs that stated they continue to have issues matching their organizational providers to the correct PNDS designated provider type. Further, because the PNDS edits are designed for enrollable provider types, if an MCO incorrectly reports a provider under a PNDS designated provider type code that is not required to enroll in Medicaid (such as a Social Adult Day Care provider), the edits will be bypassed. (Note: providers impacted by this scenario would not be included in our audit findings because we used the provider type codes reported on the PNDS

submissions to identify providers required to enroll in Medicaid.) Furthermore, not all enrollable provider types are included in the PNDS edit logic.

For example, one MCO reported 14,147 encounters for 5,148 recipients, accounting for a total of $44.2 million in payments to an out-of-state in-network chemical dependency treatment provider with an unenrolled NPI. The MCO reported the provider on its PNDS submission, but the provider was not flagged by PNDS edits because the edit logic omitted inpatient chemical dependency provider types. Upon our inquiry, DOH officials were unable to explain why this provider type was excluded from the edit logic. In addition, out-of-state chemical dependency treatment providers are ineligible to enroll in New York's Medicaid program because OASAS does not endorse or consent to enrollment of or reimbursement to any out-of-state addiction service providers. In response, MCO officials told us that, without this out-of-state provider, they would not meet network adequacy standards, and removing the provider from their network would restrict their enrollees' access to care. MCO and DOH officials also stated that some recipients were court ordered to this out-of-state provider. We note that in 2019 a revision to Social Services Law Section 364-J(r) restricted court orders to OASAS-certified facilities; we determined that, of the 5,148 recipients, only 1,216 (24%) (with claims totaling $9.5 million) had claims for treatment prior to the date of this change.

As mentioned previously, DOH's PNDS edit 1021 will reject an MCO's entire PNDS submission file if certain provider types are reported with a provider ID field containing all 8s, 9s, or 0s. (Prior to this edit, MCOs would use these numbers to indicate that there was no provider ID available.) To bypass the rejections, MCOs can remove the provider from their PNDS submission or change the indicator from in-network to out-of-network. However, with either of these actions, the provider will no longer be identified as an in-network provider on DOH's NYS Provider & Health Plan Look-Up website, which enrollees use to find a provider. Four of the five MCOs we interviewed admitted to taking these steps in lieu of ensuring that the provider enrolled in Medicaid, updating the provider information, or terminating the provider from their network – including one MCO that told us it removes provider records that trigger this edit even though they consider those providers to still be in their network. DOH does not monitor the rejected submissions to track MCO actions on the provider records that trigger edit 1021, and was thus unaware that MCOs were taking these actions. In response, DOH officials stated they will explore options to determine whether an exception report can be created to identify MCO submissions that trigger edit 1021. We note that MCOs' strategy for avoiding edit 1021 may impact our findings, as providers removed from the PNDS submissions would not have been considered in-network for our analysis.

Excluded or Improper Providers

Pursuant to the New York Codes, Rules and Regulations (NYCRR), no payments may be made to or on behalf of any person for medical care, services, or supplies furnished by or under the supervision of a person excluded from participating in the Medicaid program. A provider who has been excluded from the Medicaid program

cannot be involved in activity related to furnishing medical care, services, or supplies to Medicaid recipients. Furthermore, according to the Medicaid Managed Care Model Contract, MCOs must routinely check various federal and State databases to ensure their enrollees are not receiving services from excluded persons. According to federal regulations, encounter claims must include the billing provider's NPI (with limited exceptions). NPIs are assigned and maintained by CMS through the NPPES. CMS may deactivate NPIs for reasons such as provider death, disbandment, or fraud.

As part of its monitoring efforts, DOH developed PNDS edits intended to identify excluded providers within an MCO's network. The edits include a check against the U.S. Department of Health and Human Services Office of Inspector General's (OIG) List of Excluded Individuals/Entities, OMIG's List of Restricted and Excluded Providers, DOH's Office of Professional Medical Conduct (OPMC) List of Sanctioned Providers, and the NPPES database. DOH generates a Sanctioned Provider report for MCOs' review and follow-up corrective action. However, out-of-network providers are not included in these efforts.

We identified 63,733 encounters totaling approximately $9.6 million (of the $4.9 billion) in payments to 366 excluded billing NPIs or to improper NPIs that should be further reviewed by DOH (see following table).

Breakdown of Encounters and Payments to Excluded Billing NPIs or Improper NPIs

Source	Number of Excluded or Improper NPIs	Number of Encounter Claims	Encounter Claim Amount
CMS' National Plan and Provider Enumeration System	308	44,523	$6,254,988
OMIG's List of Restricted and Excluded Providers	57	19,209	3,301,458
OIG's List of Excluded Individuals/Entities	7	11	473
OPMC's List of Sanctioned Providers	1	196	17,425
Totals – With Duplicates	**373***	**63,939***	**$9,574,344***
Totals – Without Duplicates	**366**	**63,733**	**$9,556,456**

*Amount includes duplicates where providers were identified by more than one source.

Exclusion Edit Logic Error

We determined encounters totaling $6.4 million (of the $9.6 million in improper payments) were made by one of the five MCOs included in our analysis, and $548,184 were billed by in-network providers after they were excluded or while their NPI was not considered active. For example, 126 encounters, totaling $28,571, were billed by the in-network provider after the provider was excluded by OMIG in August 2018 for fraudulent billing. DOH's PNDS edits failed to identify this provider as excluded and the provider was therefore not included on a Sanctioned Provider report to the MCO. After a press release regarding the provider's conviction was issued in July 2022, the MCO's investigative unit recommended the provider for termination from its network and submitted a self-disclosure to OMIG. However, the MCO's provider credentialing department did not become aware of the provider's

exclusion until our inquiry on August 5, 2022, at which time the MCO removed the provider from its network. Up until that time, the provider remained listed as a participating practitioner on the NYS Provider & Health Plan Look-Up website, placing enrollees at risk of receiving services from an excluded provider. As a result of our audit work, DOH officials identified an error in the "OMIG exclusion edit" logic and stated they were working on implementing a solution.

Failure by MCOs to Check Status of Out-of-Network Providers

Out-of-network providers are not included on PNDS submissions and therefore not subject to edits meant to identify improper providers. However, MCOs are still required to check the exclusion status of out-of-network providers upon first payment and on a routine basis thereafter, including checking the NPPES and various exclusion lists. We determined that the five MCOs included in our analysis accounted for over $5.8 million (of the $9.6 million) in improper payments made to excluded or improper out-of-network billing provider NPIs. About $3.2 million (of the $9.6 million in improper payments) were paid by an MCO other than one of the five we analyzed during the audit and therefore we did not determine the network status of the providers.

No Monitoring of MCOs' Corrective Actions

We also determined that OMIG doesn't monitor encounter claim data to ensure MCOs take the appropriate corrective action on MCO self-disclosures or fraud referrals to OMIG. For example, we found one MCO paid $377,982 to a provider after the provider was excluded from Medicaid in March 2021. The MCO self-disclosed only $238,372 of that amount to OMIG officials, who instructed the MCO to recover the self-disclosed amount. Subsequently, we confirmed with the MCO that the amount paid to the excluded provider was, in fact, $377,982. Because OMIG relied upon the MCO's self-disclosure and did not review the encounter claim data, an additional $139,610 ($377,982 – $238,372) wasn't sought for repayment. Furthermore, the provider didn't respond to the MCO's requests for repayment of the $238,372 and the MCO decided not to pursue further action. As a result, none of these claims have been voided and the full $377,982 remains unrecovered. According to OMIG officials, the MCO would eventually have to pay back the State if they did not obtain recoveries; however, there is no time frame or process to ensure this occurs.

Effective December 28, 2022, NYCRR Title 18, Part 521 was amended to implement statutory changes updating MCO self-disclosure requirements to report, explain, and return overpayments. In January 2023, OMIG issued guidance stating MCOs must develop a process for providers to report, explain, and return any identified overpayments within 60 days of identification. The procedure for providers to self-disclose must be published on each MCO's website. Any reported self-disclosures an MCO receives from a provider must be reported on the MCO's Medicaid Managed Care Operating Report to DOH and the monthly Provider

Investigative Report to DOH and OMIG. The amended NYCRR also authorizes penalties for failure to report, explain, and return overpayments. In light of the amended NYCRR, DOH and OMIG should ensure all appropriate recoveries are made pertaining to MCO self-disclosures during the audit period.

Recommendations

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.
2. Ensure MCOs took appropriate action on the 272 unenrolled in-network providers we identified from the June 2022 Quarter 2 PNDS submission file.
3. Develop a process to notify MCOs of providers who have been denied or withdrawn enrollment in the Medicaid program.
4. Issue guidance to MCOs to ensure that encounter claims contain the NPI of the provider who rendered the service, as required.
5. Enhance monitoring over MCO compliance with 21st Century Cures Act provisions. Such enhancements should include, but not be limited to:
    - Reviewing encounter claims to identify payments to unenrolled providers.
    - Ensuring MCOs take appropriate, timely action on providers identified on all PNDS error reports.
    - Creating a crosswalk or other reference tool to assist MCOs in ensuring in-network providers are submitted on the PNDS with the appropriate designated provider type code.
    - Ensuring that PNDS edit controls encompass all enrollable provider type codes.
    - Implementing a process to track MCO actions on provider records that trigger the PNDS 1021 edit.
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.
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.
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.

9. Ensure the error in the “OMIG exclusion edit” logic is corrected.
10. Enhance procedures to include a review of MCO encounters to ensure MCO self-disclosures, fraud referrals, and corresponding recoveries are complete and timely.

Audit Scope, Objective, and Methodology

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

To accomplish our objective and assess related internal controls, we interviewed DOH, OMIG, and MCO officials and examined DOH's relevant Medicaid policies and procedures as well as applicable federal and State laws. We analyzed encounter claims from DOH's MDW to identify MCO payments that reported billing provider NPIs and/or billing provider IDs that did not correspond to a Medicaid-enrolled provider ID (per provider information contained in the MDW) on the date of service. This totaled $4.9 billion in encounter claim payments to in-network and out-of-network providers. We then obtained the quarterly PNDS network data for our scope period for five MCOs and compared the PNDS in-network data to those encounter claims to identify payments to in-network billing provider NPIs and/or billing provider IDs that did not correspond to a Medicaid-enrolled provider ID in the MDW on the date of service. We also obtained data from federal and State databases and compared this data to the $4.9 billion in encounter payments to determine if Medicaid made improper payments to excluded providers or providers who required further review by DOH due to past misconduct.

We used a non-statistical sampling approach to provide conclusions on our audit objectives. We selected a judgmental sample for this work. Because we used a non-statistical sampling approach, we cannot project the results to the population. Our sample, which is discussed in detail in the body of our report, comprised $2.6 billion in encounter payments from a population of $4.9 billion in payments.

- We selected a judgmental sample of five MCOs and obtained the MCOs' PNDS quarterly network submission files and related edit error reports to test whether the billing provider on encounters were reported as in-network. The five MCOs reviewed accounted for $2.6 billion of the $4.9 billion. MCOs were selected based on: highest dollar amount for managed long-term care plans; highest dollar amount for mainstream managed care plans; and highest dollar amount paid to OMIG-excluded providers.
- We obtained documentation from the MCOs' claim systems, the MCOs' provider network agreements and credentialing files, and the corresponding providers' Medicaid records to test whether documentation supported the provider identified on the encounter claim. To do this, we picked a judgmental sample of 54 encounters (from the $2.6 billion) totaling $152,147 and representing 26 distinct billing providers from the five MCOs. Encounters were selected based on: exclusion status, dollar amount, identified network status, date of service, and the PNDS error report identification status.

We relied on data from the MDW, eMedNY, and the PNDS that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit. However, we point out a limitation with our analyses involving the PNDS submission files. As detailed in our report, MCOs may not always report providers under the correct designated provider type, and MCOs may not always correctly report all network providers on their PNDS submissions. Our audit would not have assessed the

Medicaid enrollment status of providers impacted by these limitations. We also relied on data obtained from CMS, OIG, OMIG, and OPMC, which are recognized as appropriate sources and we used this data for widely accepted purposes. Therefore, this data is sufficiently reliable for the purposes of this report without requiring additional testing.

We shared our methodology and claim findings with DOH and OMIG during the audit for their review. We took their comments into consideration and adjusted our analysis as appropriate.

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 judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight of Medicaid managed care payments to unenrolled providers.

Reporting Requirements

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

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.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

April 11, 2024

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 Andrea Inman:

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

Thank you for the opportunity to comment.

Sincerely,

Johanne E. Morne

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

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Andrea Martin
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Rohan
Michael Atwood
OHIP Audit
DOH Audit

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

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

The following are the Department of Health's (the Department) comments in response to the Office of the State Comptroller's (OSC) Draft 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 (EIS), and also requires the submission of certain network information to confirm Managed Care Organization (MCO) network adequacy via Provider Network Data system (PNDS). 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 (NPI) assigned to the provider as the provider ID in many cases.

The primary purpose of the PNDS is to capture the MCO's provider network and determine if the MCO'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 an MCO'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 PNDS 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 PNDS submission schedule. The PNDS is intended to be a measure of MCO 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 an MCO'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 MCOs 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 MCOs 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 MCOs' compliance with the 21st Century Cures Act (Act), which requires in-network providers to enroll in Medicaid. Despite this – and the fact that the Encounter Intake System (EIS), the PNDS, and eMedNY (DOH's Medicaid claims processing system) were built before the Act's requirements – various information exists in these sources that DOH could have used in its oversight role, including encounter claims that show MCO payments to unenrolled providers. However, rather than use all the available information, DOH relies on PNDS controls to monitor MCO compliance, even though DOH officials acknowledge PNDS was not created for this purpose.

Our auditors used information from the various sources and identified over $1.5 billion in improper and questionable MCO 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 who 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 MCO payments.

Because of DOH's ineffective administration of the 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 MCOs – 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 NPI and/or provider ID reported on an encounter claim did not correspond to an enrolled Medicaid provider ID in the MDW." However, such mismatch between the MMIS ID (unique provider number assigned by eMedNY enrollment) and NPI 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 NPI 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 an NPI. 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 MCOs' compliance with the Act's requirements. Accordingly, our audit included a comprehensive review of various DOH systems (PNDS, MDW [which collects EIS 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 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 NPIs for atypical providers or add them to eMedNY provider enrollment files even when an NPI 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 MCOs' compliance with the 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 MCO 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 NPI 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 NPIs were identified as having a corresponding enrolled provider ID on the PNDS 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 PNDS error report for at least eight consecutive quarters for three different MCOs, 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 MCO 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) is currently performing data analysis on the OSC-identified claims, to determine an appropriate course of action.

Recommendation #2:

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

Response #2:

The PNDS is not the appropriate system to use when determining the enrollment status of in-network providers. The PNDS is designed to monitor adequacy of the MCOs 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; MCOs 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 NPIs for each specialty and/or affiliations to which the provider is associated.

State Comptroller's Comment – DOH's response does not address the audit's findings or Recommendation 2. As detailed on page 19 of the audit report, we used quarterly PNDS network data to identify in-network providers and the MDW to determine the enrollment status of those providers. We also note that, while DOH asserts that PNDS is not designed to monitor

in-network provider/ancillary facility's enrollment status, DOH nonetheless relies on PNDS controls to monitor this MCO compliance and to identify providers not enrolled in Medicaid, inaccurate NPI and provider ID information, and providers with a pending Medicaid enrollment. We encourage DOH to ensure MCOs take appropriate action on the 272 unenrolled in-network providers we identified.

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 MCOs to frequently, no less than monthly, review such pending and enrolled provider lists. The Department has a process in place to notify MCOs of the cause for terminations. The Department is reviewing the feasibility of developing a process of notifying MCOs of denied or withdrawn enrollments, however there are no funding opportunities or resources identified at this time.

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 NPI. Specifically, the Department requires NPIs to be included on all encounters submitted to the EIS. Although the Department has transitioned from the EIS to the Original Source Data Submitter (OSDS) system, this same guidance continues to apply. The Department is currently working on updating this guidance with language specific to the OSDS 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 PNDS and encompassed within the PNDS 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 PNDS 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 PNDS, 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 PNDS 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 PNDS, to create an exemption report capturing submissions that trigger the 1021 edit. Such exemption reports will be shared with MCOs.

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, will work with the MCOs to identify the appropriate course of action necessary to ensure enrollees have sufficient access to chemical dependency services from properly credentialed in-state providers.

Recommendation #7:

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

Response #7:

OMIG has recovered more than $2.2 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 MDW 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 MDW 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 PNDS 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 includes 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 MCOs. OMIG continues to update guidance on its website, according to the recent rulemaking in 18 NYCRR Part 521.

Missing NPI on Encounters

Provider Identifier Requirements

Provider Identifier Requirements on Encounters:

- Provider Identifier Requirements – NCPDP
- Provider Identifier Requirements – X12
  - 298 Professional
  - 299 Institutional
  - 300 Dental

NEW YORK STATE | Department of Health

Provider Identifier Requirements – NCPDP Encounters

- All providers who have a National Provider Identifier (NPI) are expected to include this number on NCPDP encounters, specifically the appropriate NPI that was identified during the NYS Medicaid Provider Enrollment process.
  - This includes all providers, including those authorized to prescribe or dispense drugs.
    - CMS NPI Standard
- Managed Care Plans should be reporting NPIs for providers, pharmacies, and prescribers:
  - See NCPDP 4.2 Implementation Guide and EIS Standard Companion Guide – NCPDP for requirements.
    - Field 201-B1, Service Provider ID (Mandatory)
    - Field 411-DB, Prescriber ID (Situational)
    - Field 421-DL, Primary Care Provider ID (Situational)
      - *Exceptions: In the cases where the Issuer does not receive the NPI on member submitted claims, Plan Specific (14) should be entered. Examples:*
        - ✓ *Emergency Contraception*
        - ✓ *COVID related services*

NEW YORK STATE | Department of Health

Provider Identifier Requirements – X12

- All providers who have a National Provider Identifier (NPI) are expected to include this number on X12 encounters, specifically the appropriate NPI that was identified during the NYS Medicaid Provider Enrollment process.
  - This includes all providers, including those authorized to prescribe or dispense drugs.
    - CMS NPI Standard
- Note: There are exceptions where an alternative provider identifier would be appropriate:
  - Some providers may not have an NPI. For example, providers who don't prescribe but order/bill may not have an NPI. This would be an exception where an alternative identifier is acceptable *(This exception would not be valid for medical drug claims).*
  - Another exception would be for Fiscal Intermediaries (FIs). For the Consumer Directed Personal Assistant Program (CDPAS), the Department expects the MMIS ID of the FIs in the appropriate Loop's REF Segment: REF02 = Secondary Identifier in addition to the NPI reported in the appropriate NM1 provider segment, where NM109 = NPI.

NEW YORK STATE | Department of Health

Provider Identifier Requirements – X12 298 Professional Encounters

- Managed Care Plans should be reporting NPIs for providers on X12 298 Professional encounters:
  - See X12 298 Professional Implementation Guide and EIS Standard Companion Guide – X12 for requirements:
    - Loop 2010AA, Segment NM1 – Bill Provider Name (Required)
    - Loop 2310A, Segment NM1 – Referring Provider Name (Situational)
    - Loop 2310B, Segment NM1 – Rendering Provider Name (Situational)
    - Loop 2310D, Segment NM1 – Supervising Provider Name (Situational)
    - Loop 2420A, Segment NM1 – Rendering Provider Name (Situational)
    - Loop 2420B, Segment NM1 – Purchased Service Provider Name (Situational)
    - Loop 2420D, Segment NM1 – Supervising Provider Name (Situational)
    - Loop 2420E, Segment NM1 – Ordering Provider Name (Situational)
    - Loop 2420F, Segment NM1 – Referring Provider Name (Situational)
      - For all listed NM1 provider segments, NM109 = NPI
- If a provider does not have an NPI, a secondary provider identifier can be submitted in the appropriate Loop's REF Segment:
  - REF02 = Secondary Identifier, as applicable in the EIS Standard Companion Guide – X12.

NEW YORK STATE | Department of Health

Provider Identifier Requirements – X12 299 Institutional Encounters

- Managed Care Plans should be reporting NPIs for providers on X12 299 Institutional encounters:
  - See X12 299 Institutional Implementation Guide and EIS Standard Companion Guide – X12 for requirements:
    - Loop 2010AA, Segment NM1 – Billing Provider Name (Required)
    - Loop 2310A, Segment NM1 – Attending Provider Name (Situational)
    - Loop 2310B, Segment NM1 – Operating Physician Name (Situational)
    - Loop 2310C, Segment NM1 – Other Operating Physician Name (Situational)
    - Loop 2310D, Segment NM1 – Rendering Provider Name (Situational)
    - Loop 2310F, Segment NM1 – Referring Provider Name (Situational)
    - Loop 2420A, Segment NM1 – Operating Physician Name (Situational)
    - Loop 2420B, Segment NM1 – Other Operating Physician Name (Situational)
    - Loop 2420C, Segment NM1 – Rendering Provider Name (Situational)
    - Loop 2420D, Segment NM1 – Referring Provider Name (Situational)
      - For all listed NM1 provider segments, NM109 = NPI
- If a provider does not have an NPI, a secondary provider identifier can be submitted in the appropriate Loop's REF Segment:
  - REF02 = Secondary Identifier, as applicable in the EIS Standard Companion Guide – X12.

NEW YORK STATE | Department of Health

Provider Identifier Requirements – X12 300 Dental Encounters

- Managed Care Plans should be reporting NPIs for providers on X12 300 Dental encounters:
  - See X12 300 Dental Implementation Guide and EIS Standard Companion Guide – X12 for requirements:
    - Loop 2010AA, Segment NM1 – Billing Provider Name (Required)
    - Loop 2310A, Segment NM1 – Referring Provider Name (Situational)
    - Loop 2310B, Segment NM1 – Rendering Provider Name (Situational)
    - Loop 2310E, Segment NM1 – Supervising Provider Name (Situational)
    - Loop 2420A, Segment NM1 – Rendering Provider Name (Situational)
    - Loop 2420C, Segment NM1 – Supervising Provider Name (Situational)
      - For all listed NM1 provider segments, NM109 = NPI
- If a provider does not have an NPI, a secondary provider identifier can be submitted in the appropriate Loop's REF Segment:
  - REF02 = Secondary Identifier, as applicable in the EIS Standard Companion Guide – X12.

NEW YORK STATE | Department of Health

Provider Identifier Requirements – Examples of Non-Compliance

- **For X12 Encounters**:
  - If the rendering and ordering/prescribing provider is the same (which should be the case for professional drug claims), please submit the NPI in both locations.
  - Submit the NPI in the **primary field** rather than the secondary billing provider field. We have found that some issuers are submitting in just the secondary field which is incorrect and causing a data integrity issue within our dataset.

src	ENCOUNTER-TYPE	NM109_BILL_PROV_NPI	REF01_1_BILL_PROV_SCNDRY_QUAL	REF02_1_BILL_PROV_SCNDRY_ID
apd	Institutional	[NULL]	G2	1053441907

- **For NCPDP Encounters**:
  - If the rendering and ordering/prescribing provider is the same (which should be the case for professional drug claims), please submit the NPI in both locations.
  - Submit a **valid NPI** which can be found in NPPES. An NPI is a **ten-digit**, unique numeric identifier for healthcare providers. We do not want other types of numbers such as NABP numbers, etc. submitted in the servicing provider field - 2Ø1-B1 (SERVICE PROVIDER ID).

NEW YORK STATE | Department of Health

Provider Identifier Requirements – Next Steps

- Issuers' encounter teams should evaluate encounter data regarding missing/invalid NPI numbers.
- If Issuers do not follow the NCPDP V4.2, X12 298 Professional, X12 299 Institutional, X12 300 Dental Implementation Guides or the APD EIS Guidance Manuals and submit an NPI where NYS DOH is expecting the provider's NPI on encounters, the Department may reject encounters and/or issue Statements of Deficiency if an Issuer's error volume does not decline.
- The Department will continue to monitor going forward and will consider updating Provider Identifier Requirements where necessary.
- If there are any questions, please contact the Managed Care Encounter Compliance Team:

ManagedCareEncounterCompliance@health.ny.gov

NEW YORK STATE | Department of Health

Contributors to Report

Executive Team

Andrea C. Miller - *Executive Deputy Comptroller*

Tina Kim - *Deputy Comptroller*

Stephen C. Lynch - *Assistant Comptroller*

Audit Team

Andrea Inman - *Audit Director*

Christopher Morris - *Audit Manager*

Rebecca Chromey - *Audit Supervisor*

Daniel Rossi - *Audit Supervisor*

Justine Maloy - *Examiner-in-Charge*

Lindsey Winter - *Examiner-in-Charge*

Jeanne Hui - *Senior Examiner*

Eric Spence - *Program Research Specialist*

Mary McCoy - *Supervising Editor*

Contact Information
(518) 474-3271
StateGovernmentAccountability@osc.ny.gov
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

For more audits or information, please visit: www.osc.state.ny.us/state-agencies/audits