Department of Health

Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers

Report 2023-S-18 | November 2024

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

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health (DOH) provided adequate oversight to ensure managed care recipients in the Recipient Restriction Program received services from the appropriate providers. The audit covered the period from July 2018 through May 2023.

About the Program

DOH administers the New York State Medicaid program. Under federal authorization, the Recipient Restriction Program (Restriction Program) was created to reduce the cost of inappropriate utilization by identifying Medicaid recipients who demonstrate a pattern of misusing and abusing the Medicaid program. Medicaid recipients in the Restriction Program must receive certain care through only their designated health care providers or via referral from those providers. Generally, claims for non-emergency services submitted for a restricted recipient should not be paid if the service is not provided or referred by the designated providers. The Office of the Medicaid Inspector General (OMIG) is responsible for administering and monitoring the Restriction Program. Managed care organizations (MCOs) are contractually required to continue OMIG's efforts by administering recipient restrictions, identifying recipients who should be placed in the program, and ensuring restricted services are provided or referred by the designated providers.

Key Findings

- A lack of oversight by DOH and OMIG led to MCOs paying approximately $117 million for clinic, inpatient, practitioner, laboratory, and durable medical equipment services on behalf of Medicaid recipients who had designated Restriction Program providers on file in eMedNY, yet received services that were not furnished or referred by the designated providers.
- MCOs did not consistently implement Restriction Program requirements and did not have effective mechanisms in place to ensure recipients received restricted services from designated providers or that designated providers made referrals as required.
  - One MCO had its Restriction Program claims processing controls turned off for over 3 years and paid $23.4 million (of the $117 million) for 96,397 claims between March 2020 and May 2023 without enforcing recipient restrictions.
  - Another MCO did not implement any claims processing controls to enforce the Restriction Program. During the audit period, this MCO paid 37,336 claims totaling $4.6 million without enforcing recipient restrictions.

Key Recommendations

- Review the identified $117 million in payments on behalf of restricted recipients and determine whether any recoveries should be made or any penalties assessed.
- Take steps to ensure MCOs consistently and appropriately enforce Restriction Program policies and regulations, including monitoring claims and determining whether any recoveries should be made or any penalties assessed.

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

November 26, 2024

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
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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 for Services Not Coordinated Through Recipient Restriction Program Providers*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

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

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
Designated provider	A health care provider that oversees the health care needs of a restricted recipient	*Key Term*
eMedNY	DOH's Medicaid claims processing and payment system, which also contains information on recipient restrictions	*System*
Encounter claim	Record of a health care service provided to a recipient	*Key Term*
Encounter system	DOH's system for collecting encounter claims data	*System*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
Provider ID	Identification number given to enrolled Medicaid providers	*Key Term*
Restriction Program	Recipient Restriction Program	*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, 2024, New York's Medicaid program had approximately 9.1 million recipients and Medicaid claim costs totaled about $87.5 billion (comprising $41.7 billion in fee-for-service health care payments and $45.8 billion in managed care premium payments). The federal government funded about 56.8% of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.2%.

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 and managed care. Under the fee-for-service 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 health care services and reimburse providers for those services. MCOs then submit claims (referred to as encounter claims) to DOH's encounter system to inform DOH of each service provided to their enrollees.

Under federal authorization (Title 42, Code of Federal Regulations, Section 431.54(e)), the Recipient Restriction Program (Restriction Program) was created to reduce the cost of inappropriate utilization by identifying Medicaid recipients who demonstrated a pattern of misusing and abusing the Medicaid program. Through increased coordination of medical services by a limited group of providers, recipients in the Restriction Program are ensured access to medically necessary quality health care, and unnecessary costs to the Medicaid program are prevented.

In New York State, the Office of the Medicaid Inspector General (OMIG), an independent entity within DOH, administers the Restriction Program and has implemented criteria for utilization reviews of recipients' Medicaid services to identify candidates for restriction. A restriction is implemented if a recipient is found to have received duplicative, excessive, contraindicated, or conflicting health care services, drugs, or supplies or if a recipient commits fraudulent acts with their benefit card (e.g., card loaning, doctor shopping). When a restriction is in place, designated health care providers oversee the health care needs of restricted recipients. As such, restricted recipients are required to receive care either directly from the designated health care providers (e.g., physicians, clinics, or hospitals) or through referral by one of the designated health care providers.

Fee-for-service claims processed by eMedNY are subject to several automated Restriction Program controls that determine whether the claims are eligible for reimbursement. These controls are intended to prevent payments for restricted services from providers other than the designated providers without proper referral.

Medicaid recipients enrolled in managed care are also subject to the Restriction Program. MCOs are contractually required to continue OMIG's Restriction Program

efforts by administering the restrictions when processing and paying Medicaid claims and by identifying recipients who should be placed in the program. MCOs may designate providers responsible for providing all non-emergency services or for arranging referrals to specialty care for their restricted recipients during the restriction period. When recipients are placed in the Restriction Program, whether through recommendation of an MCO or OMIG, the recipient restriction information (i.e., the restriction service types, designated provider IDs, and the restriction time periods) are listed in eMedNY. Similar to eMedNY where system controls are in place to prevent payments for restricted services from providers other than the designated providers without proper referral, MCOs can also use claims processing system controls to flag for review or to deny payment for certain services when recipients have restrictions.

DOH and OMIG have the authority to require that MCOs recover overpayments if MCOs determine improper payments were made for restricted services. Penalties can also be imposed on health care providers, where appropriate.

Audit Findings and Recommendations

We found that DOH and OMIG did not have adequate oversight of the Restriction Program to ensure managed care recipients received services from the appropriate providers. As a result, Medicaid MCOs routinely made payments for services that were not properly coordinated through Restriction Program providers, including approximately $117 million identified during our audit.

While MCOs are contractually required to have effective monitoring of restricted Medicaid services and identify when restricted recipients attempt to access restricted services from providers other than their designated providers, OMIG was not aware of what specific controls MCOs had in place to ensure compliance with the Restriction Program. According to OMIG officials, MCOs are responsible for developing their own policies and procedures to enforce program requirements. While OMIG regularly conducts utilization reviews of fee-for-service claims, it did not review MCO encounter claims for compliance with the Restriction Program and instead relied on MCOs to follow program guidelines when determining whether to pay claims.

MCO Payments for Services Not Coordinated Through Restriction Program Providers

For the audit period July 2018 through May 2023, we found MCOs paid 525,182 encounter claims totaling approximately $117 million on behalf of Medicaid recipients who had designated Restriction Program providers on file in eMedNY, yet the restricted services were not furnished or referred by the designated providers, as required. The table below shows these payments in more detail.

Payments for Services Not Furnished or Referred by Designated Providers

Claim Type	Paid Amount	Number of Claims
Clinic	$50,480,357	234,576
Inpatient	40,549,162	4,991
Practitioner	17,072,928	147,700
Laboratory	6,690,512	127,817
Durable medical equipment	2,190,473	10,098
Totals	**$116,983,432**	**525,182**

We reviewed information from eight MCOs (that accounted for over 80% of the payments in our audit population) to determine if restricted services were properly coordinated by designated providers and paid by the MCOs consistent with Restriction Program requirements. Because Restriction Program rules state that access to emergency services must not be restricted, we removed emergency services from the audit population.

From our audit population, we judgmentally sampled 186 claims totaling $4.7 million from seven of the eight MCOs we contacted across clinic, inpatient, practitioner, laboratory, and durable medical equipment claims. The claims represent a variety of services, providers, rates, and diagnoses. We found that 93% of the sampled claims (173 of the 186) were not processed and paid in accordance with Restriction

Program requirements. Although the sample was judgmentally selected and cannot be projected, the information obtained during our review indicated significant issues within the audit population.

MCOs authorized and paid 64 (of the 186) claims totaling about $2 million based on medical necessity alone and did not consider the restricted status of the recipient. For example, some MCOs flagged inpatient claims for manual review and then authorized payment based on medical necessity, ignoring the recipient's Restriction Program status.

Another 48 (of the 186) claims totaling $429,155 were paid because MCOs' claims processing system controls for the Restriction Program were either not configured adequately or were turned off. Three MCOs stated their Restriction Program claims processing controls were configured only for specific claim types. Therefore, these MCOs' system controls did not apply to all restricted claim types, resulting in payments that were not properly coordinated through Restriction Program providers. For example, one MCO applied Restriction Program controls only to practitioner claims, allowing all other claim types to be paid without considering restrictions. However, DOH's policy states all claim types listed on recipients' restriction files in eMedNY should be subject to Restriction Program controls. Another MCO stated its claims processing controls did not consistently recognize restricted recipients, causing claims to be processed as if there were no restrictions on file. Within the sample, this MCO paid 22 (of the 48) claims totaling $293,307 without enforcing Restriction Program requirements.

Processing errors resulted in MCOs paying 43 (of the 186) claims, totaling nearly $2 million. For example, one MCO paid $38,851 when a restricted recipient received services from other than their designated clinic provider. The MCO stated it was notified of the restriction, but failed to make the required system update timely before the claim in question was processed and paid. Another MCO paid $6,722 for a claim that did not apply Restriction Program requirements because it incorrectly categorized the claim as emergency instead of urgent. One MCO stated it planned to correct four (of the 43) claims totaling $11,028 that were paid due to processing errors.

Additionally, 18 (of the 186) claims, totaling $261,433, were paid because the MCOs' internal policies excluded certain services from Restriction Program requirements. These internal policy exceptions did not align with the State's Restriction Program policies and regulations. The MCOs developed policies that allowed payment for certain services regardless of the recipient restrictions. These policies varied greatly among the MCOs we contacted. For example, one MCO considered any ophthalmology-related claim as always payable, while another MCO identified exceptions for specific providers, rate codes, or locations of service.

We determined that 13 (of the 186) claims, totaling $75,900, were adjudicated appropriately. We found the claims to be appropriate for various reasons, including:

- MCO internal records identified that the referring provider was the designated provider.

- The restriction ended prior to the service date on the claim; however, this restriction information was not updated in eMedNY.
- The claim was for emergency services based on DOH's definition.
- MCOs stated they were informed of the restrictions after they had adjudicated the claim.

Inadequate Oversight of MCO Restriction Program Implementation

While OMIG is responsible for ensuring compliance with the Restriction Program, OMIG did not monitor encounter claims data to ensure MCO compliance. Consequently, MCOs did not consistently implement Restriction Program requirements and did not have effective mechanisms to ensure restricted recipients received restricted services from the designated providers or that those designated providers made proper referrals. OMIG had released two Medicaid policy newsletters (in June 2011 and April 2023) regarding Restriction Program requirements, and during our audit in April 2024, OMIG emailed MCOs reiterating that, under the Restriction Program, recipients must receive non-emergency care from designated providers (e.g., physicians, clinics, or hospitals) or through referrals from the designated providers.

One MCO improperly turned off all Restriction Program claims processing system controls since March 2020 in response to the COVID-19 public health emergency. OMIG had directed all MCOs to not enforce Restriction Program controls for practitioner and clinic claims to ensure medical care continuity during the early months of the COVID-19 public health emergency. However, this MCO turned off its Restriction Program claims processing controls for all claim types. Moreover, OMIG instructed all MCOs to reinstate Restriction Program controls effective November 2020, but the MCO failed to do so. After we contacted the MCO during this audit, the MCO stated it would turn the controls back on. The MCO paid 96,397 claims totaling $23.4 million (of the $117 million) between March 2020 and May 2023 when recipient restrictions were not enforced.

Another MCO applied the Restriction Program claims processing controls only to practitioner claims, allowing all other claim types to be paid regardless of the restriction status. As a result, the MCO paid 18,452 claims totaling about $6.1 million during the audit period without ensuring the restricted services were properly coordinated by designated providers.

We also found that one MCO did not implement any claims processing system controls to enforce Restriction Program requirements. During the audit period, this MCO paid 37,336 claims (for clinic, inpatient, practitioner, laboratory, and durable medical equipment services) totaling $4.6 million (of the $117 million) on behalf of restricted recipients where restricted services were not provided by the designated providers and where a required referral was not made on the claim.

Three MCOs did not configure Restriction Program claims processing controls for laboratory claims. These three MCOs paid 75,742 lab claims totaling $4.3 million during the audit period (22,918 claims totaling $1.1 million are also included in the $23.4 million amount above). In response to our audit, one MCO addressed this in January 2024 by publishing guidance to providers to help ensure restricted recipients' laboratory services are furnished or referred by the designated providers.

Recommendations

1. Review the identified $117 million in encounter claim payments on behalf of restricted recipients and determine whether any recoveries should be made or any penalties assessed.
2. Take steps to ensure MCOs consistently and appropriately enforce the State's Restriction Program policies and regulations, including but not limited to monitoring encounter claims and determining whether any recoveries should be made or any penalties assessed. Prioritize engagement with the MCOs identified in the audit that did not fully apply Restriction Program controls and ensure corrective actions are taken.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether DOH provided adequate oversight to ensure managed care recipients in the Restriction Program received services from the appropriate providers. The audit covered the period from July 2018 through May 2023.

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, rules, and regulations. We used DOH's Medicaid Data Warehouse (MDW) to extract clinic, inpatient, practitioner, laboratory, and durable medical equipment encounter claims for restricted recipients for services between July 1, 2018 and May 31, 2023. We analyzed encounter claims data from the MDW and DOH's encounter system to identify non-emergency encounter claims paid on behalf of Medicaid recipients who had designated Restriction Program providers on file in eMedNY, yet the restricted services were not furnished or referred by the designated Restriction Program providers. We removed emergency claims and claims for services related to methadone treatment from our population. Additionally, clinic and practitioner claim types were not included from March 2020 through October 2020 due to OMIG guidance for the COVID-19 public health emergency.

We selected judgmental samples to reach conclusions on the audit objective. Because we used a non-statistical sampling approach, the results cannot be projected. Our samples comprised seven of the eight MCOs we contacted that accounted for over 80% of the payments in our audit population.

- We selected a judgmental sample of 186 claims totaling $4.7 million from these MCOs across clinic, inpatient, practitioner, laboratory, and durable medical equipment claims with service dates during the audit scope.
- We selected claims based on various attributes including rate codes, diagnosis-related group codes, diagnosis codes, and procedure codes.

We obtained data from the MDW, the encounter system, and eMedNY and assessed the reliability of that data. We determined that the data from these systems was sufficiently reliable for the purposes of this report. We shared our methodology and findings with DOH and OMIG officials during the audit for their review. We took their comments into consideration and adjusted our analyses 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 and administration of Medicaid managed care payments for recipients in the Recipient Restriction Program.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered their comments in preparing this report and have included them in their entirety at the end of the report. In their response, DOH officials concurred with the audit recommendations and indicated certain actions will be taken to address them.

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

Agency Comments

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

November 1, 2024

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

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2023-S-18 entitled, "Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2023-S-18 entitled, "Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2023-S-18 entitled, "Medicaid Program: Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers." Included in the Department's response is 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.

Recommendation #1

Review the identified $117 million in encounter claim payments on behalf of restricted recipients and determine whether any recoveries should be made or any penalties assessed.

Response #1

OMIG is performing analysis on the OSC-identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. Should inappropriate Medicaid overpayments be validated, OMIG will take appropriate actions to recover these payments, assess penalties, and enforce program requirements. The impacted Managed Care Organizations will maintain their due process protections to challenge such recoveries or enforcement actions. MCOs compliance with RRP requirements can also be assessed through OMIG's Managed Care Program Integrity Reviews (MCPIR). MCPIR findings can lead up to a 2% recovery of the administrative component of the capitation payments. OMIG's analysis determined that as of now more than $2.9 million in encounters have been voided or adjusted to zero or are no longer recoverable due to the 6-year lookback provision in regulation.

Recommendation #2

Take steps to ensure Managed Care Organizations consistently and appropriately enforce the State's Restriction Program policies and regulations, including but not limited to monitoring encounter claims and determining whether any recoveries should be made, or any penalties assessed. Prioritize engagement with the Managed Care Organizations identified in the audit that did not fully apply Restriction Program controls and ensure corrective actions are taken.

Response #2

Managed Care Organizations are responsible for developing policies and procedures to enforce Restricted Recipient Program requirements. Managed Care Organizations are contractually required to have effective mechanisms for monitoring and identifying when restricted recipients attempt to access restricted services from providers other than their designated providers. Such mechanisms are subject to audit and review by OMIG, and where Managed Care Organizations are found to be not in compliance with their contractual obligations, recoveries will be made where appropriate.

OMIG has established guidelines, educated Managed Care Organizations on these guidelines and their contractual requirements and identified and informed the Managed Care Organization where corrective action is necessary. OMIG has also performed reviews of Managed Care

Organizations, which included encounter claims, and will continue to review Managed Care Organization compliance with Medicaid rules, regulations, and contractual obligations. OMIG continues to work to improve processes to monitor Managed Care Organization encounter claims for compliance with the Recipient Restriction Program and for whether recovery of overpayments would be appropriate.

OMIG will verify Managed Care Organization Restricted Recipient Program contacts, to ensure that the monthly roster is being sent and reviewed by the appropriate personnel. OMIG will continue to look for ways to improve communication processes between Managed Care Organizations and OMIG and seek this greater engagement.

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