Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New York Comprehensive Program Integrity Review

Final Report

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Introduction and Executive Summary

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through these reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve their efforts. The reviews identify two types of risks: 1) non-compliance with federal statute or regulation; and 2) program weaknesses or failure to incorporate program safeguards which, though not legally mandated, would generally be considered prudent and reasonable. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of risks and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report.*

The purpose of this review was to determine whether New York's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act, as well as to determine areas where the state is at risk. During the review, CMS also followed up on risks identified during prior state comprehensive program integrity reviews to determine if the state appropriately implemented corrective actions. This review examined:

- Program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and False Claims Act education and monitoring;
- How the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating anti-fraud and abuse efforts;
- Medicaid provider enrollment, disclosures, and reporting;
- Medicaid managed care oversight at the state level; and
- Program integrity activities conducted by managed care entities (MCEs).

The review of New York's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the CMS review found the state's Medicaid program has risks in both its fee-for-service (FFS) and managed care program integrity activities. These risks are related to state oversight of program integrity and provider enrollment operations in managed care, and provider enrollment practices and reporting.

Prior to this review, CMS conducted a comprehensive program integrity review of New York in FY 2010. The FY 2010 review identified 12 risks: 5 involving regulatory non-compliance and 7 involving weaknesses in the state's program integrity operations. The state submitted a corrective action plan that addressed all of the risks identified in the report and took specific steps to correct a majority of the identified risks. During the 2013 review, the CMS review team identified the following areas where the state did not fully implement their proposed corrective actions: 1) the Office of Health Insurance Programs (OHIP) did not capture all required ownership, control, and relationship information from its fiscal agent; 2) the OHIP did not collect all required health care-related criminal conviction information from FFS providers and MCEs; and 3) MCEs were not conducting key provider enrollment activities. Each of these repeat risks is described in detail in this report. CMS will work closely with New York to ensure that all

risks, particularly those that remain from the 2010 review, are satisfactorily resolved as soon as possible.

Overview of New York's Medicaid Program

The Department of Health administers the New York Medicaid program. In January 2012, the program served 5,020,497 beneficiaries. Of that total, 3,062,369 beneficiaries were enrolled in managed care plans, and the remaining 1,958,128 beneficiaries were served on a FFS basis. The state had approximately 125,000 providers enrolled in the FFS program and it paid these providers $31.4 billion during calendar year 2012. The state's managed care program had 89,830 MCE providers enrolled in 51 managed care plans, to which it paid $19.1 billion during calendar year 2012. During calendar year 2012, New York State's total computable Medicaid expenditures totaled approximately $53 billion, the most of any state. The Federal Medical Assistance Percentage for New York in 2012 was 50 percent.

Medicaid Program Integrity Unit

In New York, the Office of the Medicaid Inspector General (OMIG) is the organizational component dedicated to anti-fraud and abuse activities. The OMIG is an independent entity within the New York State Department of Health. At the time of the review, the OMIG had 521 full-time equivalent (FTE) staff working on Medicaid program integrity functions. These positions include auditors, investigators, nurses, data analysts, pharmacists, other clinical / medical professionals, program administrators/managers, and persons providing legal, technological, and clerical support. Between FY 2009 and the time of this review, OMIG staffing declined by a total of 66 FTEs or 11 percent, with the most significant decline in the audit area. There was a significantly greater decline in OMIG's authorized FTEs, which decreased over the same time period by roughly 30 percent, from 729 to 506. The state attributed the reduction in staffing over the past four years to a decrease in funding and authorized FTEs from the state legislature.

Methodology of the Review

In advance of the onsite visit, the CMS review team requested that New York complete a comprehensive review guide and supply documentation in support of its answers, including the state's managed care contracts. The review guide included such areas as program integrity, provider enrollment and disclosures, managed care, and relationship with the MFCU. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted in-depth telephone interviews with representatives from the MFCU and four MCEs.

During the week of February 4, 2013, the CMS review team visited the OMIG and OHIP offices and conducted interviews with numerous OMIG and OHIP officials. The team met separately with the Division of Health Plan Contracting and Oversight staff within OHIP to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate New York's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the OMIG but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and managed care contract management, both responsibilities of the OHIP. The risks cited throughout this report at the network provider level are based on interviews conducted and documentation provided by four of New York's MCEs.

New York operates its Children's Health Insurance Program (CHIP) as both a Title XIX Medicaid expansion program and a stand-alone Title XXI program. The expansion program operates under the same billing and provider enrollment policies as New York's Title XIX program. The same effective practices and risks discussed in relation to the Medicaid program also apply to the expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, the OMIG provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the OMIG provided.

Results of the Review

The CMS review team found a number of risks related to program integrity in New York's Medicaid program. These issues fall into two major categories of risk as outlined and discussed below. To address them, New York should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's oversight of program integrity and provider enrollment operations in managed care.

Managed Care Contract Oversight

Over the past few years, New York has shifted a large portion of its beneficiaries from Medicaid FFS into managed care plans. The OHIP has primary responsibility for oversight of the MCEs, while the OMIG coordinates fraud, waste, and abuse control activities for all state agencies responsible for services funded by Medicaid. At the time of this review, the state did not have written policies and procedures to address specific program integrity contract requirements in managed care because it was still in the process of finalizing its Medicaid managed care contracts with the MCEs. The OHIP's model contract, *Medicaid Managed Care and Family Health Plus* with the MCEs outlined some program integrity requirements; however, in several instances, OHIP did not check to see if those contractual obligations were actually being followed. For example, the OHIP's MCE model contract at section 23.3 requires MCEs to implement a service verification process with beneficiaries pursuant to 42 CFR 455.20. One of the four MCEs interviewed was not verifying billed services with beneficiaries in accordance with the contract. This MCE had over 250,000 beneficiaries enrolled at the time of the review.

Additionally, OHIP had not developed and implemented adequate Medicaid agency policies and procedures for monitoring MCE provider enrollment activities to ensure the baseline standards

were being met and safeguards were in place. In New York, managed care network providers are enrolled and credentialed by the MCEs. The OHIP's contract with the MCEs outlines many key provider enrollment requirements. However, there were varying levels of compliance by the four MCEs interviewed related to collection of ownership, control, and criminal conviction disclosures, requiring business transaction disclosures upon request, and reporting of adverse actions. Similar risks were also cited in the 2010 review. The OHIP did not provide a documented process to ensure MCE compliance with these provisions of the contract. Risk Area 2 contains more information about the specific risks related to provider enrollment.

Inadequate Safeguards in Place to Ensure Payments Are Not Made to Excluded or Debarred Individuals or Entities

The OHIP had inadequate safeguards in place in the managed care program to ensure payments were not made to excluded or debarred individuals or entities. The federal regulations at 42 CFR 1001.1901 prohibit Medicaid and other federally funded health care programs from paying for any item or service furnished, ordered, or prescribed by an excluded provider. This prohibition applies to payments to the excluded provider and anyone who contracts with the excluded provider. The payment prohibition also applies to all administrative and management services furnished by an excluded provider, regardless of which entity submits the claim for reimbursement.

Further, the federal managed care regulations at 42 CFR 438.610 prohibit MCEs from knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, or excluded, or from having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the state where the individual or entity is debarred, suspended, or excluded. CMS issued guidance to states through a series of State Medicaid Director Letters and a best practices document on this topic that provided states direction on screening for excluded individuals and entities. [1] The guidance also communicated the important point that while states may delegate many provider enrollment or credentialing functions to MCEs for managed care network providers, the state remains responsible for ensuring that excluded or debarred parties do not receive Medicaid funds.

Since federal regulations prohibit payment for items or services furnished by excluded individuals and entities, it is imperative that this first line of defense in combating fraud and abuse be conducted accurately, thoroughly, and routinely. The OHIP and its MCEs could not demonstrate that they had a process in place that was thorough or frequent enough to verify that they do not have a relationship with an individual or entity that has been debarred, suspended, or otherwise excluded from participating in a contract paid with federal funds at the MCE or

[1] CMS, State Medicaid Director Letter, SMDL #08-003 (June 12, 2008), available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd061208.pdf.
CMS, State Medicaid Director Letter, SMDL #09-001 (January 16, 2009), available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf.
CMS, *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment,* available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/bppedisclosure.pdf.

network provider level. Without conducting routine searches of federal exclusion and debarment databases for providers, as well as those with an ownership or control interest, or who are agents or managing employees of the provider at both the MCE level and of the network providers they enroll, the OHIP cannot ensure that excluded or debarred parties did not receive federal health care funds through Medicaid managed care contracts.

Managed Care Investigations

The CMS review team noted that relatively few managed care provider investigations were being performed for a managed care program with almost 90,000 MCE providers that were paid over $19 billion in 2012: 191 investigations of suspected provider fraud and abuse were initiated and 134 investigations were completed over the last four state fiscal years for all MCEs. CMS also reviewed the cases referred to the MFCU between March 25, 2011 and the end of 2012. During this timeframe, OMIG referred 120 cases to the MFCU. Only one was based on a managed care provider investigation. In interviews with the MFCU, they indicated that the transition to managed care has resulted in a decline in the quantity of referrals coming from the state.

Finally, the review also found that the memorandum of understanding between the state and the MFCU had not been updated since 2005, which was prior to the formation of the OMIG, and it did not address managed care.

Recommendations:

- Develop and implement written policies and procedures to facilitate stronger OHIP oversight of MCE program integrity and provider enrollment activities.
- Monitor and enforce MCE compliance with the contract requirement to verify with enrollees whether services billed by providers were received.
- Develop and implement a process to ensure that neither the state nor its MCEs are affiliated with any individual or entity prohibited from receiving federal funds. At a minimum, either the state or the MCEs should search providers and any person with an ownership or control interest or who is an agent or managing employee of the provider against the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG's) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the National Plan and the Provider Enumeration System (NPPES), and the Social Security Administration Death Master File during the enrollment process and against the LEIE and EPLS monthly thereafter. The OHIP should also conduct these same searches of all of the parties disclosed by the MCE itself.
- Monitor the MCEs' compliance with contract provisions requiring the same disclosure, reporting, and provider screening and enrollment requirements that apply to Medicaid providers in the FFS program.
- Ensure that the state and its MCEs are allocating sufficient resources to the detection, investigation, and referral of managed care fraud at both the plan level and network provider and subcontractor level. This is especially important given the size of New York's Medicaid managed care program both in terms of expenditures, providers, and beneficiaries.

- Update the memorandum of understanding between the state and the MFCU to address managed care. Work with the MFCU to ensure the state is developing an adequate quantity of managed care cases.

Risk Area 2: Risks were identified in the state and MCEs' provider enrollment practices and reporting.

Ownership and Control Disclosures

The regulation at 42 CFR 455.104 requires states to collect ownership and control disclosures from disclosing entities, fiscal agents, and MCEs regarding persons with an ownership and control interest, or who are managing employees of the disclosing entity, fiscal agent, or MCE. These disclosures include the name, address, date of birth, and Social Security Number (in the case of an individual), or other tax identification number (in the case of a corporation) of each person or entity with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE, or in any subcontractor in which the entity has a direct or indirect ownership interest of 5 percent or more. It also requires information on familial relationships and the name, address, date of birth, and Social Security number of the managing employees. The information disclosed is important and necessary if the state is to have complete information about parties who must be screened for exclusions. It can also shed light on personal and organizational relationships across health care entities.

This review found that OHIP did not ensure collection of the full range of disclosures at three levels – 1) from its fiscal agent; 2) from its MCEs; and 3) from network providers as part of the MCE enrollment and credentialing process. Each of these issues is described below:

Fiscal Agent:
The state requires the fiscal agent to complete a *Vendor Responsibility* questionnaire through the New York Office of the State Comptroller every six months. The Department of Health reviews the questionnaire at the time of initial contracting or when amending the contract. This form asks the contractor to disclose any person with a 10 percent or more voting stock in a publicly traded corporation, or 25 percent or more in a private corporation. This is inconsistent with the regulation at 42 CFR 455.104, which requires disclosure of anyone with a 5 percent or more ownership interest. New York's questionnaire also does not include those with a controlling interest or managing employees. The team also reviewed the fiscal agent's completed contract and was unable to locate all of the required disclosures. This risk was also cited in the 2010 CMS review.

MCE:
The OHIP is not collecting the full range of required ownership and control disclosures from its MCEs. While the OHIP obtained a one-time collection of ownership and control information from its MCEs under contract at the time in 2010, the model contract at sections 18.6 and 18.10 is limited and does not address all of the disclosures required by the regulation. Further, the OHIP has its MCEs complete character and competency forms at the time of certification, when new officers and directors are hired or appointed, or when an MCE goes through a corporate transaction such as an acquisition or merger. The forms collect information on owners, those with a controlling interest, officers, and

the board of directors. However, the forms do not contain all of the elements required by the regulation at 42 CFR 455.104.

The OHIP provided the CMS review team with a copy of a completed MCE contract. The contract demonstrates that OHIP does not collect full disclosures prior to entering into a contract with the MCEs as required by the regulation. A review of other model contracts provided by New York - *Medicaid Advantage Plus Model Contract Miscellaneous Consultant Services (MAP), Medicaid Advantage Model Contract, Managed Long-Term Care Contract (MLTC), and Primary Care Partial Capitation Provider Medicaid Managed Care Model Contract (PCPCP)* found that OHIP does not require its MCEs to provide complete disclosures.

Network Provider:
The OHIP's managed care contracts require MCEs to collect disclosure information from network providers pursuant to 42 CFR 455.104. All MCEs interviewed used the Council for Affordable Quality Healthcare (CAQH) credentialing application. A detailed comparison of the regulation at 42 CFR 455.104, the MCEs' contractual requirements, and the CAQH form are located in the appendix of this report. Two MCEs used a supplemental form to capture disclosure information but only one of the MCE's forms covers the full range of disclosures. The other MCE's supplemental form does not collect relationship information for all owners or those with controlling interest; it was limited to those with 5 percent or more ownership.

Exclusion Searches

A critical element of Medicaid program integrity is the assurance that individuals or entities do not receive payments when they are excluded or debarred from receiving such payments. For this reason, the regulation at 42 CFR 455.436 requires that, for any provider enrolled as a participating provider by the state, the State Medicaid Agency check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the LEIE, EPLS, the Social Security Administration Death Master File, and the NPPES upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

Although the OHIP was in the process of determining a solution to automate exclusion checks, the state was not searching the Social Security Administration Death Master File upon enrollment for FFS providers and was also not searching the EPLS on a monthly basis for providers, persons with ownership or control interest, agents and managing employees of the provider as required by the regulation at 42 CFR 455.436.

Criminal Offense Disclosures

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs since the inception of those programs for each person with ownership or control interests in the provider, or who is an agent or managing employee of the provider. Such information must be furnished

at the time providers apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made within 20 working days from the date it receives the information. Requiring disclosure of health care-related criminal conviction history allows the state to be fully informed before deciding which providers to allow into its program. The 2013 review of New York found incomplete criminal conviction disclosure at three levels – 1) OHIP's enrollment of FFS providers 2) OHIP's requirements at the MCE-level; and 3) MCE requirements for network providers. Each of these issues is described below:

FFS:
The OHIP's FFS enrollment form, *NY Medicaid Provider Enrollment Form for Institutions & Rate-Based Providers* does not ask if any person with a controlling interest in the provider or who is an agent or managing employee of the provider has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of the program in accordance with 42 CFR 455.106. This risk area was also cited in the 2010 review with regard to the FFS practitioner enrollment forms.

MCE:
The OHIP sent letters to all MCEs following CMS's 2010 review with a request for the submission of all required health care related criminal conviction disclosures. This form met the requirements of the regulation at 42 CFR 455.106. However, the model contract at section 18.12 which asks for disclosure of criminal convictions of managing employees, does not ask for disclosures of any person who has an ownership or control interest, or who is an agent of the MCE. All model contracts provided by New York during the review were insufficient in identifying all required parties in accordance with 42 CFR 455.106. Further, the character and competency forms completed by the MCEs collect criminal history information. However, these forms are not required to be completed by all parties identified at 42 CFR 455.106. This risk was also cited in the 2010 review.

Network Provider:
Three of the four MCEs interviewed do not collect the full range of criminal conviction disclosures that are required by their contract and identified by CMS as a best practice. One MCE utilized a supplemental form that asks about any person who has ownership or control interest in the provider, but did not collect criminal conviction information for agents and managing employees. Two additional MCEs utilized the CAQH form which does not solicit criminal conviction information on any person who has ownership or control interest in the provider, or who is an agent or managing employee. A detailed comparison of the regulation at 42 CFR 455.106, the MCEs' contractual requirements and the CAQH form are located in the appendix of this report.

Business Transaction Disclosures

The regulation at 42 CFR 455.105(b) requires that, within 35 days of the date of a request, providers furnish to the state or HHS full and complete information about (1) the ownership of

any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period of the date of request, and (2) any significant business transaction between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period of the date of request. The OHIP's FFS provider enrollment form, *NY Medicaid Provider Enrollment Form for Institutions & Rate-Based Providers* was in compliance with the regulation and required providers to agree to provide business transaction disclosures upon request.

The contract between OHIP and the MCEs obligated the MCEs to require network providers to disclose the same information. However, two of the four MCEs selected for review did not have language in the credentialing forms and/or the provider agreements for network providers to disclose certain business transactions with wholly owned suppliers or any subcontractors upon request as required by their contract and identified by CMS as a best practice. Further, the state provided CMS with a copy of the *New York State Department of Health Standard Clauses for Managed Care Provider / IPA Contracts,* which should be in each provider agreement. However, these standard clauses contain partial language reflecting the business transaction disclosures described at 42 CFR 455.105(b)(1). They are missing the language at 42 CFR 455.105(b)(2) that requires disclosure of complete information about any significant business transaction between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period of the date of request.

Notifications to HHS-OIG

The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a state takes on provider participation in the Medicaid program.

FFS:
The state was not reporting all fraud and abuse-related adverse actions taken against FFS providers to the HHS-OIG according to 42 CFR 1002.3. The OMIG did not report to HHS-OIG when it denied enrollment to a provider for a program integrity reason.

MCE:
In the managed care program, two of the four MCEs interviewed were not reporting all actions taken to limit a provider's participation in the Medicaid program as required by their contract. These plans provide for services for over 250,000 beneficiaries and over 30,000 beneficiaries respectively. They had almost 30,000 providers and almost 2,000 providers enrolled in their networks respectively at the time of the review. The model contract at section 18.8(c) requires reporting of any adverse action taken for program integrity reasons against providers to the state pursuant to 1002.3(b). However, one MCE's response to the review guide indicates the MCE did not report to the state when it denied credentialing, denied a contract, or denied enrollment. Another MCE's response indicated that it only reported to the state when a provider is decredentialed. While MCEs are not required by federal regulations to report directly to HHS-OIG, keeping the state informed of these actions is critical if the state is going to be able to provide HHS-OIG with an accurate overview of adverse actions cutting across both FFS and alternate delivery systems.

Recommendations:

- Revise the fiscal agent and managed care contracts to require disclosure of complete ownership and control information in accordance with the requirements at 42 CFR 455.104.
- Revise the state's FFS enrollment form and managed care contracts to require disclosure of criminal history from all parties required by the regulation at 42 CFR 455.106.
- Monitor MCE disclosure of required 455.104 and 106-related information and ensure that MCEs collect the same information from the providers they enroll as required by their contract.
- Ensure that MCE credentialing forms and/or provider agreements mandate the disclosure of the business transaction information specified in 42 CFR 455.105 from network providers upon state or HHS request as required by the contract.
- Ensure that any person with an ownership or control interest or who is an agent or managing employee of the provider is checked against the LEIE, EPLS, NPPES and Social Security Administration Death Master File during the enrollment process and against the LEIE and EPLS monthly thereafter. Ensure that adverse action reporting requirements are met in accordance with the regulations at 42 CFR 1002.3, making certain that MCEs are reporting to the state all adverse actions taken for program integrity reasons against network providers as required by their contract.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice. The OMIG reported that its business line teams, conflict and exception reporting, and beneficiary lock-in program were all effective.

Business Line Teams

In 2012, the OMIG introduced and initiated a new organizational structure known as the Business Line Team (BLT) approach to better support its mission of preventing and detecting fraud, waste, and abuse. The idea of BLTs is to create expertise within a given category of service and to coordinate the work throughout each division. Each BLT consists of a multidisciplinary group of executives, managers, supervisors, and employees from various divisions of OMIG—audit, investigations, legal, clinical, and technical— who evaluate program integrity within specific categories of service. OMIG has nine BLTs that focus on specific areas of Medicaid health care service delivery, including: Managed Care; Medical Services in an Educational Setting; Home and Community Care Services; Hospital and Outpatient Clinic Services; Mental Health, Chemical Dependence, Developmental Disabilities Services; Pharmacy and Durable Medical Equipment; Physicians, Dentists and Laboratories; Residential Health Care Facilities; and Transportation.

According to OMIG, this approach allows it to operate with improved efficiency, conduct more thorough reviews and investigations, and reduce the time needed to complete investigations. It

reported that the team structure more effectively makes use of its members' shared knowledge and experience with particular business lines.

Conflict and Exception Reporting

In 2012, home health providers billing over $15 million per year were required by New York State law to have automated conflict and exception reports. The law requires providers to verify whether a service was provided to an eligible Medicaid beneficiary by electronically capturing the identity of the caregiver, the identity of the Medicaid beneficiary, and the date, time, duration, location, and type of service provided.

The OMIG has blended the home health project with its traditional prepayment review activities by pending the claims for targeted home health providers for a full day and then requesting all supporting documentation for claims that were billed after resolving an exception. This approach has allowed OMIG to monitor provider behaviors, educate the providers on proper billing practices and advise them on how to improve their compliance programs. The OMIG has also denied numerous claims and has realized significant cost avoidance for the Medicaid program as a result of these controls and activities.

Beneficiary Lock-In Program

New York has implemented a rigorous lock-in program for beneficiaries with a demonstrated pattern of abusive utilization of Medicaid services and has achieved program cost savings of approximately $170,728,336 in state fiscal year 2011-2012. Care is coordinated because beneficiaries are locked in to specific primary providers. These primary providers may include a primary medical provider, pharmacy, hospital, durable medical equipment provider, dentist, and podiatrist. In addition, restricted beneficiaries who are eligible for managed care will be transitioned into managed care, which will be completed by state fiscal year 2016. The MCEs also have their own restriction programs, which will be monitored by OMIG.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for New York to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in RISS for information provided by other states including best practices and managed care contracts.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Consider attending a

- seminar covering topics related to program integrity in managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Work with the assigned CMS MIG State Liaison to discuss program integrity issues and request technical assistance as needed.
- Access the Medicaid Integrity Program website at www.cms.gov/medicaidintegrityprogram. The website is frequently updated and contains resources for states including annual program integrity review summary reports, best practices reports, and educational toolkits developed by CMS for training purposes.

Summary

The CMS review found the state's Medicaid program has risks in both its FFS and managed care program integrity activities. These risks are related to state oversight of program integrity and provider enrollment operations in managed care, and provider enrollment practices and reporting. Because of the size and complexity of New York's Medicaid program, it is at significant risk for fraud, waste and abuse and requires an unparalleled level of oversight. It is critical that the state is prepared to meet the challenges of the rapidly changing Medicaid environment including New York's Medicaid expansion population and the transition to managed care. For this reason, the risks identified in this report are of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat risks that remain from the 2010 comprehensive program integrity review.

We will require the state to provide a corrective action plan (CAP) for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the State Medicaid Agency is responsible for correcting the risk. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct risks, the plan should identify those corrections as well.

CMS looks forward to working with New York to build an effective and strengthened program integrity function.

Appendix

Ownership and Control Disclosure:

42 CFR 455.104	New York MCE contract requirement for MCE to disclose	New York MCE contract requirement to collect from network providers	CAQH Credentialing Application
The Medicaid agency must require that disclosing entities (a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent), fiscal agents, and managed care entities disclose the following: (1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. (ii) Date of birth and Social Security Number (in the case of an individual). (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest. (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling. (3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).	18.6 a): The Contractor shall report ownership and related information to SDOH, and upon request to the Secretary of Health and Human Services and the Inspector General of Health and Human Services, in accordance with 42 U.S.C. §§ 1320a-3 and 1396b(m)(4) (Sections 1124 and 1903(m)(4) of the SSA). 18.10 a) Conflict of Interest Disclosure: Contractor shall report to SDOH, in a format specified by SDOH, documentation, including but not limited to, the identity of and financial statements of person(s) or corporation(s) with an ownership or contract interest in the Contractor, or with any subcontract(s) in which the Contractor has a five percent (5%) or more ownership interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR §§ 455.100 through 455.104.	18.6 b) Pursuant to 42 CFR 455.104, the Contractor will obtain a disclosure of complete ownership, control, and relationship information from all MCO Providers.	The CAQH is missing: • Ownership or control interest and enhanced address information for corporations (b)(1)(i); • The date of birth and Social Security Number for owners or those with a controlling interest (b)(1)(ii); • Other tax identification number with an ownership or control interest in the disclosing entity or any subcontractor which the disclosing entity has 5% or more interest (b)(1)(iii); • Relationship information (b)(2); • The name of any other disclosing entity in which an owner or the disclosing entity has an ownership or control interest (b)(3); and • Name, address, date of birth, and Social Security Number of any managing employees.

Criminal Conviction Disclosure:

42 CFR 455.106	New York MCE contract requirement for MCE to disclose	New York MCE contract requirement to collect from network providers	CAQH Credentialing Application
(a) *Information that must be disclosed.* Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who: (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.	Section 18.12 a) Pursuant to 42 CFR 455.106, the Contractor will disclose to SDOH any criminal convictions by managing employees related to Medicare, Medicaid, or Title XX programs at the time the Contractor applies or renews an application for participation in the Medicaid managed care program or Family Health Plus program or at any time on request. SDOH is required to notify the HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.	18.12 b) Pursuant to 42 CFR 455.106, the Contractor will require Providers to disclose health care related criminal conviction information from all parties affiliated with the Provider. Upon entering into an initial agreement or renewal of any agreement between the Contractor and its Providers, the Contractor must disclose to SDOH any conviction of a criminal offense related to that Provider or Provider's managing employee involvement in any program under Medicare, Medicaid, or Title XX services program.	Asks about the provider's criminal conviction history only; missing information on anyone with an ownership or control interest in the provider, or who is an agent or managing employee of the provider. Specific language includes: *Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

August 6, 2014

Mr. Peter Leonis
Director of the Division of Field Operations
Peter.Leonis@cms.hhs.gov

Dear Mr. Leonis:

New York State hereby submits its Formal Response and Corrective Action Plan to the New York Comprehensive Program Integrity Review Final Report issued by the Centers for Medicare and Medicaid Services (CMS). We appreciate the opportunity to respond to this report and highlight New York State's accomplishments in protecting the integrity of the Medicaid program.

New York State is a national leader in its oversight of the Medicaid program. Through the efforts of the Department of Health and the Office of the Medicaid Inspector General, over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team ("MRT") was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

As outlined in our response, New York State remains committed to improving upon New York's already record breaking efforts to protect the integrity of the Medicaid program. The two main risk areas noted in the Comprehensive Program Integrity Review Final report, as well as the noted recommendations, will be addressed in this response. The response to the Supplemental Program Integrity Review Final report will be in a separate document.

Sincerely,

Jason A. Helgerson
Medicaid Director
NYS Department of Health

James C. Cox
Medicaid Inspector General
Office of the Medicaid Inspector General

Enclosure