Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Program Integrity
New York Focused Program Integrity Review
Medicaid Managed Care Oversight
August 2025
Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services (CMS) conducted a focused program integrity review to assess New York's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified **one** finding that created a risk to the New York Medicaid program related to managed care program integrity oversight. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. This recommendation includes the following:

Interagency and MCO Program Integrity Coordination

> **Recommendation #1**: In accordance with § 455.21(c)(3)(v), New York should update the current Memorandum of Understanding (MOU) in place with the Office of Attorney General Medicaid Fraud Control Unit (MFCU) at least every five years to ensure the agreement reflects current laws and practices. Additionally, to come into compliance with 455.21(c)(3)(iv), New York should revise the MOU to ensure there is a written agreement in place to establish procedures by which the Office of Attorney General MFCU will receive referrals of potential fraud from MCOs, either directly or through the agency. A current MOU serves to establish certain parameters for the relationship between the Office of Attorney General MFCU and the SMA and guide the coordination of efforts between the two agencies.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **five** observations related to New York's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages New York to ensure MCOs establish a Special Investigation Unit (SIU) with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. CMS encourages New York to include a staffing ratio requirement in all MCO contracts.

MCO Contract Compliance

Observation #2: CMS encourages New York to strengthen its MCO Model Contract language regarding beneficiary verification activities, consistent with § 438.608(a)(5). In addition, CMS encourages the state to ensure MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place to monitor this process.

MCO Investigations of Fraud, Waste, and Abuse

Observation #3: CMS encourages New York to work with the MCOs to develop more case referrals and routinely provide specific program integrity training aimed at enhancing the identification and quality of case referrals from the MCOs. CMS encourages the state to consider establishing metrics to uniformly assess the quality and quantity of case referrals. In addition, the state should provide additional guidance to MCOs clarifying the procedures for reporting referrals of fraud, waste, and abuse.

Observation #4: CMS encourages New York to consider implementing an effective mechanism to monitor, track, and verify/validate the accurate reporting of referrals, number of investigations, and overpayments identified and recovered by the MCOs.

Observation #5: CMS encourages New York to consider the inclusion of MCO Model Contract language addressing investigative provider site visits to ensure all MCOs are utilizing this practice.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services (PCS). These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between SMAs and (MCOs that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage the utilization of health services.

Overview of the New York Managed Care Program and the Focused Program Integrity Review

The New York State Department of Health (DOH) is responsible for the administration of the New York Medicaid program, New York State Medicaid. The Office of the Medicaid Inspector General (OMIG) is an independent agency within DOH tasked with oversight of program integrity-related functions for the managed care program. During the review period, New York contracted with fifteen MCOs to provide health services to the Medicaid population. As part of this review, three of these MCOs were interviewed: Fidelis Care[2], Healthfirst, and MVP Health Care. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In July 2023, CMS conducted a virtual focused program integrity review of New York's managed care program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[2] New York Quality Healthcare Corporation doing business as Fidelis Care

program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff, including the MCOs SIUs, as well as reviewed other primary data. CMS also evaluated the status of New York's previous corrective action plan that was developed in response to a previous focused program integrity review of New York's PCS program conducted by CMS in 2017, the results of which can be found in Appendix A.

During this review, CMS identified a total of **one** recommendation and **five** observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

In New York, these oversight and monitoring requirements are the responsibility of the Office of the Medicaid Inspector General (OMIG). The OMIG is an independent agency within DOH that is charged with program integrity functions. The OMIG performs audits, investigations, and reviews of Medicaid services and providers. Oversight of the many elements of the state monitoring plan is accomplished through required MCO reporting as outlined in Section 18 of the MCO Model Contract. The MCOs report daily, weekly, monthly, quarterly, annually, and ad hoc as needed, regarding administration and management, appeal and grievance systems, claims and encounters, finances, utilization management, program integrity, network management, availability and accessibility of services, and quality improvement.

The OMIG Division of System Utilization and Review (DSUR) utilizes data analytics to systemically prevent and detect improper billing practices. The DSUR staff conducts various analytical tasks that support management decisions, audits, investigations, and hearings. The data analysis encompasses a wide range of provider types and program areas. In addition, OMIG contracts with Health Management Systems, Inc. (HMS). HMS as its recovery audit contractor (RAC) and third-party liability contractor. The RAC helps supplement the agency's Medicaid program integrity efforts by detecting and collecting overpayments and reporting suspected fraudulent and/or criminal activities. The OMIG is heavily reliant upon and utilizes various Medicaid information technology systems to perform oversight of the Medicaid program, confirm the appropriateness of provider payments, and provide timely, accurate, and defensible data and analysis to support Medicaid program integrity initiatives throughout the agency.

The New York MCO Model Contract, Section 23.5 requires MCOs to have a SIU if the MCO has over 10,000 enrollees in the aggregate in any given year. Responsibilities of the SIU include having a process in place for the detection, investigation, and prevention of fraudulent activities to the extent required by New York Public Health Law § 4414 and DOH regulations. However, CMS noted the state has not included a provision in the MCO Model Contract that specifies SIU staffing ratios for its MCOs. While not a federal requirement, specifying SIU staffing ratios would allow MCOs to build SIUs with sufficient resources and staffing commensurate with the size of the managed care program and conduct the full range of program integrity functions, including the review, investigation, referral, and auditing of provider types where Medicaid dollars are most at risk. Based on the quantity and quality of cases investigated during the review period, CMS believes the state could benefit from including a staffing ratio requirement in the MCO Model Contract.

Observation #1: CMS encourages New York to ensure MCOs establish an SIU with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. CMS encourages New York to include a staffing ratio requirement in all MCO contracts.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO Model Contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO Model Contract for New York is developed by the DOH Office of Health Insurance Programs, Division of Health Plan Contracting and Oversight (DHPCO). DHPCO/Bureau of Managed Care, Certification, and Surveillance Unit monitors contract compliance with the fraud, waste, and abuse requirements.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable fand state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
5. Effective lines of communication between the Compliance Officer and employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law

enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Section 23.2 of New York's MCO Model Contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCO's compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii). The OMIG conducted compliance program reviews in accordance with federal requirements as well as New York's Social Services (SOS) § 363-d and 18 New York Code, Rules and Regulations Part 521 until FY 2020. According to OMIG, procedures were recently implemented to conduct reviews with the goal of reviewing all providers over a five-year period. In addition, the OMIG Division of Medicaid Audit identifies compliance-related contract provisions and evaluates the MCO's adherence to the outlined requirements. Lastly, the DOH includes a regular review of the MCOs and the program integrity requirements in the Comprehensive Operational Survey, which is completed at a minimum of once every 3 years.

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In New York, this requirement is met through the MCO Model Contract Section 23.6, which requires all MCOs to implement a service verification process that accurately evaluates the delivery of billed services to the recipient population by using statistically valid sample sizes and timeframes that determine whether enrollees received services billed by providers.

While New York's MCO Model Contract meets CMS' regulatory requirements, in practice, the MCOS were inconsistent with the number of beneficiary verifications conducted during the review period. CMS noted that the contract does not provide detailed guidance for this program integrity activity, including a lack of clarification on the recommended or required volume of verifications to be conducted.

Observation #2: CMS encourages New York to strengthen its MCO Model Contract language regarding beneficiary verification activities, consistent with § 438.608(a)(5). In addition, CMS encourages the state to ensure MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place to monitor this process.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or

agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The state is compliant with this requirement. A review of the state's policy found that MCOs are required by MCO Model Contract Section 23.10 to have written policies for New York State Medicaid employees, contractors, subcontractors, and agents that provide detailed information about the Federal False Claims Act, and other federal and state laws described in Section 1902(a)(68) of the Social Security Act, and the New York State Finance Law § 187 including information about the rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

New York Medicaid MCOs are contractually required to suspend payments to providers, but only at the state's request. Section 23.7 of the MCO contract requires MCOs to withhold payments to providers, in whole or in part, when DOH or OMIG has determined that a provider is the subject of a pending investigation of a credible allegation of fraud in accordance with 42 CFR 455.23 and Title 18 New York Codes, Rules, and Regulations § 518.7. The MCO is required to withhold payments to the provider no later than five business days from the date of notification from the DOH or OMIG. The MCOs are required to report payment suspensions in the monthly Provider Investigative Report. Managed care program integrity reviews are conducted to ensure the MCOs implemented the payment suspensions in a timely manner.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in §

438.4.

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d) in the following sections of the MCO Model Contract:

- Section 18.5(a)(viii)(F) requires the MCO to submit a monthly Provider Investigative Report to the DOH and OMIG in a form and format to be determined by OMIG. This report must include but is not limited to, all provider investigative and educational activities and all overpayments identified or recovered from providers, specifying the overpayments due to potential fraud.
- Section 18.5(a)(viii)(G) and Section 23.3 requires the MCO to submit a Contractor Overpayment Report to DOH and OMIG within 60 days after it identifies, or has received notice of, any capitation payments or other payments in excess of amounts specified in the agreement. In addition, the MCO is required to return the overpayments to DOH in accordance with Section 23.3. The report must be in a form and format determined by DOH and OMIG.
- Section 22.7(a)(iv and v) states when the MCO recovers overpayments from a provider, the MCO may retain the recoveries, except where such recoveries are made on behalf of the DOH or OMIG as provided in Section 22.7(b), a combined audit as provided in Section 22.7(c), or recoveries made in violation of the MCO's obligation to comply with the fraud, waste, and abuse reporting requirements of Section 18.5(a)(vii).
- Section 22.7(e) requires the MCO to have procedures in place for providers, subcontractors, or all other third parties to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment. The MCO should report any amount recovered in its quarterly Medicaid Managed Care Operating Report and its monthly Provider Investigative Report in accordance with Section 18.5(a)(viii)(F) of the contract.

The MCOs are provided guidance and a template for the required reports and the information from these reports is used by the contracted actuary for the development of capitation rates.

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship

between the MFCU and the SMA. New York does not have a MOU in place with the New York State Office of Attorney General MFCU that meets the regulatory criteria. Specifically, the current MOU between the DOH/OMIG, and the Office of Attorney General MFCU has not been revised since 2016, which is in direct violation of § 455.21(c)(3)(v) which requires the MOU to be reviewed and as necessary, updated at least every five years to ensure that the agreement reflects current laws and practices. In addition, the current MOU does not contain procedures by which the Office of Attorney General MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). CMS noted the state does meet with the Office of Attorney General MFCU on a regular basis to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with their MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, abuse, and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions.

> **Recommendation #1**: In accordance with § 455.21(c)(3)(v), New York should update the current MOU in place with the Office of Attorney General MFCU at least every five years to ensure the agreement reflects current laws and practices. Additionally, to come into compliance with 455.21(c)(3)(iv), New York should revise the MOU to ensure there is a written agreement in place to establish procedures by which the Office of Attorney General MFCU will receive referrals of potential fraud from MCOs, either directly or through the agency. A current MOU serves to establish certain parameters for the relationship between the Office of Attorney General MFCU and the SMA and guide the coordination of efforts between the two agencies.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

New York has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). According to Section 23.11 of the MCO Model Contract, the MCO is required to refer all cases of potential fraud, waste, and abuse to OMIG with the option to refer cases of potential fraud to the Office of Attorney General MFCU within 10 business days of identification. The MCO is to include referrals in reports submitted in accordance with the fraud, waste, and abuse reporting requirements of Section 18.5(a)(vii) of the contract.

Section 18.5(a)(vii)(A)(I - III) outlines the required information necessary for a referral and the procedures for reporting. Section 18.5(a)(vii)(B) outlines the specific policies for the MCO to

have the option to refer fraud to the Office of Attorney General MFCU. If OMIG determines the investigation involves suspected fraud or criminality, OMIG will make the referral to the Office of Attorney General MFCU as required under Title 3 Article 1 § 32 of New York State Public Health Law. The DOH has provided the definition of fraud, waste, and abuse in the MCO Model Contract.

CMS observed a lack of case referrals from the MCO SIUs to not only the OMIG but also to the Office of Attorney General MFCU. CMS finds this concerning, especially based on the size of the New York Medicaid program. During the interview, Office of Attorney General MFCU noted a lack of quality and quantity of fraud referrals for the review period from the MCOs.

> **Observation #3**: CMS encourages New York to work with the MCOs to develop more case referrals and routinely provide specific program integrity training aimed at enhancing the identification and quality of case referrals from the MCOs. CMS encourages the state to consider establishing metrics to uniformly assess the quality and quantity of case referrals. In addition, the state should provide additional guidance to MCOs clarifying the procedures for reporting referrals of fraud, waste, and abuse.

MCO Oversight of Network Providers

CMS verified whether each New York MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

All three MCOs reported the use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources, including but not limited to claims, emails, hotline calls, state and federal notifications, referrals from subcontractors, and data analytics. If the MCO identifies initial findings during a preliminary investigation that necessitate a full investigation, the MCO is required to notify OMIG of its intention to initiate an audit prior to making contact with the provider, as outlined in Section 19.9 of the MCO Model Contract. The OMIG is to acknowledge receipt of the notification, acknowledge that there is no conflict with the MCO conducting the audit, or alert the MCO to stop the audit or any further activity if a conflict exists. If the MCO does not receive a response from OMIG in 10 business days, the MCO may proceed with the audit. Cases that are determined to be credible are documented and reported within 10 business days of identification to OMIG and the MCO has the option to refer to OMIG and Office of Attorney General MFCU simultaneously.

Two of the three MCOs utilized corrective action plans during the review period. CMS found that only one MCO performed investigative provider site visits. One MCO stated that due to the SIU's remote staffing model, announced or unannounced site visits are not practical. Investigative provider site visits can be an effective tool in the detection of fraud, waste, or abuse within the Medicaid program. CMS further noted that the MCO Model Contract does not address investigative provider site visits.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements.

Figure 1 below describes the number of investigations referred to New York by each MCO. As illustrated, overall, the number of Medicaid MCO provider referrals is low.

Figure 1. Number of Investigations Referred to New York by each MCO

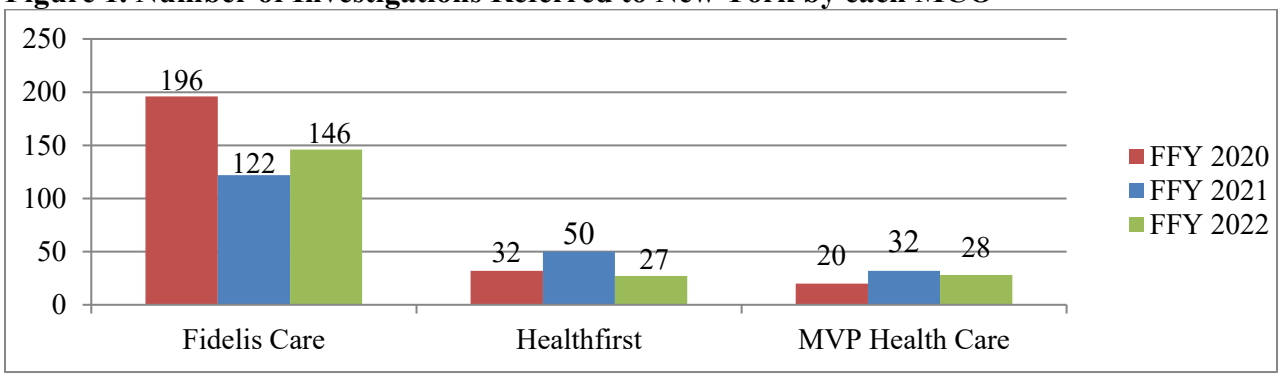

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Fidelis Care's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	468	221	$6,085,557	$3,974,617
2021	585	321	$8,702,968	$3,749,485
2022	624	251	$23,780,315	$6,076,240

Healthfirst's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	588	516	$6,359,951	$29,020
2021	335	267	$12,746,907	$0
2022	359	129	$5,397,769	$314,915

MVP Health Care's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	0	55	$1,788,868	$312,738
2021	7	53	$349,671	$335,265
2022	4	46	$626,269	$626,269

As illustrated above, the overpayments identified and recovered varies widely across MCOs. CMS identified significant discrepancies between the totals reported by the MCOs compared to the totals reported by the state.

Observation #4: CMS encourages New York to consider implementing an effective mechanism to monitor, track, and verify/validate the accurate reporting of referrals, number of investigations, and overpayments identified and recovered by the MCOs.

Observation #5: CMS encourages New York to consider the inclusion of MCO Model Contract language addressing investigative provider site visits to ensure all MCOs are utilizing this practice.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including the allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the New York MCO Model Contract and interviews with each of the MCOs, CMS determined that New York was in compliance with § 438.242. Specifically, the contract language in MCO Model Contract Section 18.5 (iv)(A) through (H) requires the MCO to submit encounter data twice a month to DOH through its designated Fiscal Agent and comply with the format prescribed by the DOH. The MCO is required to submit pharmacy data on a daily basis, in a required format to the DOH. The MCO is required to submit an annual notarized attestation that the encounter data submitted through the DOH is accurate and complete. If the MCO fails to submit encounter data within the required timeframe, the DOH may impose monetary sanctions upon the MCO of $2,000 each calendar day that the encounter data is not submitted. Lastly, if the MCO fails to correct a deficiency in submitted encounter data upon notification and within the timeframes specified in a corrective action plan, the DOH may impose monetary sanctions upon the MCO of $2,000 for each calendar day that exceeds the timeframes specified in the corrective action plan. The DOH may waive these sanctions if it is determined that the MCO was not at fault. Additional sections within the MCO Model Contract outline the DOH disenrollment, utilization, and grievance and appeal requirements.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. New York was in compliance with § 438.602(e) for the review period.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. New York has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the DOH must receive an encounter claim for all post-adjudicated claims from MCOs. The OMIG analyzes claims data utilizing various algorithms and software platforms to allow auditors, investigators, and other OMIG staff to mine encounter data. The OMIG Bureau of Business Intelligence utilizes multiple algorithms to perform data matches using Medicaid claim data to identify outliers, beneficiaries with two or more client identification numbers, and claims paid to excluded providers.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports New York's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and five observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

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

V. Appendices

Appendix A: Status of Prior Review

New York's last CMS program integrity review focused on PCS was in August 2017, and the report for that review was issued in April 2018. The report contained nine recommendations for improvement. During the virtual review in July 2023, the CMS review team conducted a thorough review of the corrective actions taken by New York to address all recommendations reported in the calendar year 2018. The findings from the 2018 New York focused program integrity review report have not all been corrected by the state as noted below.

Findings

1. ***Take actions, or conduct audits, to ensure that FIs have proper safeguards from employing individual personal care assistants (PCAs) who may have been terminated by Medicare, Medicaid, or other state Medicaid programs, as well as those that may have been convicted of a healthcare related criminal offense.***
   Status at time of the review: Partially Corrected

   The DOH indicates that legislation was proposed to require all workers to obtain a National Provider Identifier (NPI) which was not passed. In the state fiscal years 2020-2021 New York State Budget, section 3613(1-a) of the New York State Public Health Law was amended to require home care services workers to obtain a unique identifier from the state. In that same year, section 365-f of the New York State Social Services Law was amended to require personal assistants working in the Consumer Directed Personal Assistance Program to also obtain a unique identifier from the state. It appears this finding has not been corrected for agencies billing PCA services but rather for self-directed care only.

2. ***Consider providing routine training to PCS providers on updated rules and regulations to ensure appropriate billing, reducing improper payments.***
   Status at time of the review: Partially Corrected

   The DOH indicates that the department continually provides the local Department of Social Services and managed care plans with updated guidance on PCS and consumer-direct personal assistant services (CDPAS) as well as updating templates to use for contracts/agreements with providers detailing what the provider responsibilities are under the PCS/CDPAS programs. The department has not provided specific training to providers.

3. ***Encourage PCS agencies to conduct unannounced visits to ensure that accurate billing by PCAs and services are rendered according to DOH guidelines.***
   Status at time of the review: Not Corrected

   The DOH indicates that no actions have been taken on the provider level to date.

4. ***Consider creating a reconciliation report to validate the number of hours billed against the hours authorized.***
   Status at time of the review: Partially Corrected

   The DOH indicates that legislation was passed in early 2023 to allow the DOH to promulgate regulations to develop a more comprehensive electronic visit verification (EVV) compliance program in which fee-for-service claims and encounter data that do not have matching EVV data may have their payments pended or recouped. Prior to this implementation, the DOH was actively reaching out to providers that had not adequately submitted EVV attestations to ensure this process was completed, as well as reaching out to providers with missing or mismatched EVV data submissions to better understand the reasons for the errors and encourage submission.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- 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 the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- 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 training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for New York MCOs

New York MCO Data	Fidelis Care	Healthfirst	MVP Health Care
Beneficiary enrollment total	1,868,596	1,198,904	202,794
Provider enrollment total	81,179	66,644	54,169
Year originally contracted	2011	2019	2003
Size and composition of SIU	9*	18	9
National/local plan	Local	Local	Local

* Fidelis Care's SIU is also supported by Centene's SIU, their parent company. Centene's SIU consists of 212 full-time employees.

Table C-2. Medicaid Expenditure Data for New York MCOs

MCOs	FY 2020	FY 2021	FY 2022
Fidelis Care	$7,093,740,390	$8,918,592,373	$10,173,575,329
Healthfirst	$5,699,391,111	$6,830,034,602	$7,719,721,563
MVP Health Care	$915,857,576	$1,075,584,875	$1,225,803,177
Total MCO Expenditures	$13,708,989,077	$16,824,211,850	$19,119,100,069

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	In accordance with § 455.21(c)(3)(v), New York should update the current MOU in place with the Office of Attorney General MFCU at least every five years to ensure the agreement reflects current laws and practices. Additionally, to come into compliance with 455.21(c)(3)(iv), New York should revise the MOU to ensure there is a written agreement in place to establish procedures by which the Office of Attorney General MFCU will receive referrals of potential fraud from MCOs, either directly or through the agency. A current MOU serves to establish certain parameters for the relationship between the Office of Attorney General MFCU and the SMA and guide the coordination of efforts between the two agencies.	**X**	

Acknowledged by: Please do not send PDF file-Typed signature is acceptable.

Frank Walsh, Acting Medicaid Inspector General

_____
[Name], [Title]

10/31/2025

_____
Date (MM/DD/YYYY)