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Center for Program Integrity

New York Focused Program Integrity Review

Final Report

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Table of Contents

Objective of the Review 1
Background: State Medicaid Program Overview 1
Methodology of the Review 1
Results of the Review 2
Section 1: Affordable Care Act Provider Screening and Enrollment 2
Section 2: Managed Care Program Integrity 13
Recommendations for Improvement in Managed Care: 24
Technical Assistance Resources 25
Conclusion 27
Review of Corrective Action Plan as of September 23, 2014 28
Official Response from New York A1

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine whether New York's program integrity procedures satisfy the requirements of federal regulations that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. Another purpose of the review was to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care entities (MCEs) under contract with the state. The review also included a follow up on the state's progress in implementing the corrective action plan (CAP) that resulted from CMS's comprehensive program integrity review performed in 2013.

The report below discusses the results of the focused review on provider enrollment and screening as well as managed care program integrity activities. The assessment of the Medicaid agency's CAP is included in this report.

Background: State Medicaid Program Overview

The New York Medicaid program is administered by the Department of Health (DOH). In federal fiscal year (FFY) 2013, it ranked second among states in total computable Medicaid expenditures. Of the approximately $55.7 billion[1] spent in FFY 2013, a little over $22.2 billion (or 40 percent) was spent on beneficiaries in the state's managed care programs. However, of the 5.4 million Medicaid beneficiaries in New York, approximately 4.4 million (or 81 percent) were enrolled in one of the state's 19 mainstream or 30 long term care managed care plans. The mainstream managed care plans cover regular Medicaid beneficiaries, persons in the state's Family Health Plus program (FHP, a Medicaid expansion program) and plans serving certain special needs populations. Persons in need of long term care services are served by plans under a partially capitated managed care long term care contract.

New York is an expansion state under the Affordable Care Act. Between the fall of 2013 and June 2014, the state's total Medicaid and Children's Health Insurance Program enrollment grew by 440,619 people, with expansion enrollees being integrated into the state's various managed care programs. An additional 428,000 enrollees were phased into the state's other managed care programs from the FHP program, which had existed since the year 2001.

Methodology of the Review

In advance of the onsite visit, CMS requested that New York and the MCEs selected for the focused review complete a review guide that provided the CMS review team detailed information on the operational activities of the areas that were subject to the focused review. A six-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

[1] This figure represents total computable Medicaid expenditures. The Federal Medical Assistance Percentage for New York is 50 percent.

During the weeks of September 22 and 29, 2014, the CMS review team visited several DOH offices including the Office of Health Insurance Programs (OHIP) and the Office of the Medicaid Inspector General (OMIG). It conducted interviews with numerous state staff involved in program integrity, provider enrollment, and managed care. The CMS review team also undertook onsite interviews with four MCEs[2] and their Special Investigation Units (SIUs). In addition, the CMS review team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate New York's and the selected MCEs' program integrity practices.

Results of the Review

The review of New York's program integrity activities found the state to be in compliance with many of the current program integrity requirements. However, the CMS review team identified some areas of concern and instances of regulatory non-compliance in its program integrity activities, which represent a risk to the Medicaid program.

CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

In New York State's fee-for-service (FFS) Medicaid program, the provider enrollment and screening process is handled by the Medicaid fiscal agent[3] under the oversight of the State Medicaid agency, which is called OHIP. At the time of our review, there were 152,615 providers enrolled in the FFS program. During the provider enrollment process, the fiscal agent conducts an initial screening to determine the completeness of a provider application. Applications are then sent to OHIP for additional screening and final approval.

The OMIG plays a role in the provider enrollment and screening process for certain categories of providers who are deemed of higher risk to the Medicaid program. The OMIG is an independent entity within the New York State DOH whose Medicaid Inspector General reports directly to the Governor. The OMIG is responsible for preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds. The Enrollment and Reinstatement Unit (EAR) within OMIG's Division of Medicaid Investigations conducts more intensive screening of pharmacies, ambulettes, durable medical equipment (DME) providers, portable X-ray providers, and physical therapy providers. Besides performing ownership searches on such providers, the EAR coordinates pre-enrollment inspections on physical therapy providers, portable x-ray providers, and all non-chain pharmacies and DME applicants. The OMIG can deny the enrollment of a provider subject to its

[2] Capital District Physician's Health Plan (CDPHP), MetroPlus, Fidelis, and Healthfirst
[3] At the time of the review, the Medicaid fiscal agent was the Computer Sciences Corporation, but the transition to a new fiscal agent was in progress.

scrutiny, if there are questions about that provider's suitability for Medicaid enrollment. However, the final approval of provider applications normally rests with OHIP.

The OHIP also provides general guidelines for provider enrollment and screening in New York's extensive Medicaid managed care program through the provisions of its model managed care contracts. However, managed care network providers are enrolled by the individual MCEs and are not required to be FFS Medicaid providers.

42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the state plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is not fully in compliance with this regulation.
The OHIP has made provision for screening all providers seeking to enroll in Medicaid. The State agency has also simplified the provider enrollment process by reducing the number of different provider enrollment forms in use from 30 to six. One of the six forms now in use has been specifically designed for physicians and other healthcare professionals ordering or referring services under the state plan or under a waiver of the state plan. Since April 2013, the state has opened its system to the enrollment of ordering, referring and prescribing (ORP) providers, and effective January 1, 2014, the state's Medicaid Management Information System (MMIS) began rejecting claims for services ordered, referred or prescribed by providers who were not enrolled in the Medicaid program. Despite having a process for enrolling ORP providers in place, at the time of the review, the state had made only limited progress towards fully enrolling this pool of providers. Based on state responses to the CMS review guide and onsite interviews, since April 2013, over 16,000 ORP physicians and other providers had enrolled in the program. However, around 64,000 remained to be brought in at the time of the review, although safeguards were in place to deny claims listing unenrolled ORP providers. While the state does require all Medicaid provider applicants to undergo a prescribed screening process, not all aspects of this process are performed in full compliance with federal regulations. These compliance issues are discussed at greater length below. They must be addressed for the state to be in full technical compliance with the regulation at 42 CFR 455.410.
Recommendations: • Develop policies and procedures to implement the required screening of all providers seeking to enroll in the Medicaid program as described in 42 CFR 455 subpart E. This includes ordering or referring physicians or other professionals providing services under the state plan or under a waiver. Ensure that all ORP providers are enrolled as participating providers.

42 CFR 455.412: Verification of provider licenses

The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

The state is not fully in compliance with this regulation.

Providers with a New York license must submit a copy of their license or current registration with their enrollment form. Medicaid receives daily license updates from the New York State Education Department (SED). The updates are automatically applied to the provider file in New York's MMIS, which is also known as eMedNY.

If a provider is enrolled and subsequently loses his/her license, the SED and Office of Professional Medical Conduct (OPMC) communicate the loss of license via eMedNY, which automatically changes the provider enrollment status to "36 - Suspension License Expired, Revoked". Furthermore, the OMIG reviews OPMC's website on a weekly basis for new disciplinary actions against physicians and physician assistants. The OMIG also reviews a web-based SED monthly report on published disciplinary actions against all other licensed professionals.

Providers with out-of-state licenses must submit a copy of their current license with their enrollment form. The status of that license is verified on the home state's website. There are license limitation indicators that are a part of the daily license updates from SED. In addition, OHIP and OMIG work jointly to review all DOH licensure actions taken against enrolling or enrolled providers and to determine whether there are any limitations for Medicaid enrollment purposes. SED and DOH both maintain lists of providers' licenses that have limitations.

However, if a provider loses its out-of-state license, the state would not know unless the provider also had an in-state license. The State Medicaid agency does check with other states at the time of enrollment, but during the interview state staff indicated that some state websites do not provide all the information the State Medicaid agency needs. When asked which state websites did not provide all the information the State Medicaid agency needed, after some checking, the OHIP indicated that most contiguous states had enhanced their websites to include information on licensure limitations. However, there is no perfect way for states to check licensure limitations on out-of-state providers nationwide using internet searches at present.

Recommendations:

- Develop and implement policies and procedures for confirming whether all border and out-of-state provider licenses have restrictions as part of the state's provider enrollment and screening process. Review and assess any providers with restrictions on their licenses prior to deciding to enroll them.
- Maintain a complete list of border and out-of-state providers which records both expiration dates as well as license restrictions and limitations.

42 CFR 455.414: Revalidation of enrollment

The regulation at 42 CFR 455.414 requires that the State Medicaid agency revalidate the enrollment of all providers regardless of provider type at least every 5 years.

The deadline has been revised according to *Sub Regulatory Guidance for state Medicaid Agencies: Revalidation (2016-001).* The purpose of this guidance is to align Medicare and Medicaid revalidation activities to the greatest extent possible. The new requirement is now a two-step deadline under which states must notify all affected providers of the revalidation requirement by the original March 24, 2016 deadline, and must have completed the revalidation process by a new deadline of September 25, 2016.

The state is potentially at risk of non-compliance with this regulation for both the March 25, 2016 and September 25, 2016 deadlines.

The OHIP began revalidating laboratories, laboratory directors, and hospice providers in February 2013. The State Medicaid agency staff indicated that they intentionally started with smaller provider groups to work out the processes for revalidating the larger provider groups. However, as of July 2014, OHIP had revalidated only 823 providers out of a total provider pool of over 152,000.

Since April 2014 in an effort to step up the revalidation process, the state has shifted resources internally. It created a revalidation team to generate correspondence to targeted providers. The revalidation team is using existing communication resources to encourage providers to initiate the revalidation process themselves. It is also identifying opportunities for the current or future fiscal agent to take on certain maintenance activities to free up bureau resources for revalidation.

In the past year, the State Medicaid agency rebid its fiscal agent contract, with bid requirements that include a web-based provider enrollment system and additional resources for review and processing. At the time of the review, the state had selected a bid winner for fiscal agent services, but the selection was under protest. The protest threatened to delay implementation of an improved and more efficient provider enrollment/revalidation system. This could potentially further complicate implementation of a fast track revalidation process.

An additional problem in the state's revalidation efforts has to do with enhanced risk levels for individual providers. New York's MMIS identifies provider risk levels based on the group to which individual providers belong. Since revalidation is being conducted by provider groups, an individual provider that has been elevated to a moderate or high risk for reasons prescribed in federal regulations, such as the presence of an outstanding overpayment, may not receive an enhanced screening in the revalidation process. The state should address this potential compliance issue as it moves forward with its revalidation efforts.

Recommendations:

- Revisit the formal revalidation plan and make revisions to ensure that all eligible providers are properly revalidated by September 25, 2016. This plan must include the proper risk-based revalidation screening for individual providers that have had their risk level elevated beyond the level currently associated with their provider class. Ensure that adequate staff resources are allocated to meet this requirement.

42 CFR 455.416: Termination or denial of enrollment

The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program or another state Medicaid or Children's Health Insurance Program has terminated a provider for cause on or after January 1, 2011. The regulation also describes several other conditions under which a State Medicaid agency must terminate or deny enrollment to any provider unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

The state is in compliance with this regulation.

In the review guide responses, state staff indicated that they terminated 1,030 providers for cause since July 1, 2012. The CMS review team identified 713 providers on the CMS database which contains for-cause terminations. This database is housed in CMS's TIBCO MFT server and will be referred to as the TIBCO server. CMS identified two providers on the TIBCO server with revoked Medicare billing privileges that OMIG did not refer for termination until October 2014. However, the state was able to establish that it had identified these cases at the time of Medicare revocation and sought CMS documentation on these cases to support its termination action. Other than these examples, the state promptly terminated providers who appeared on the TIBCO server.

The CMS review team also randomly selected 25 providers that the state indicated they terminated for cause that were not on the TIBCO server and asked the State Medicaid agency to explain why those 25 providers were absent from the database. The state provided the following responses:

- Nineteen of the terminated providers were not added to the TIBCO server because they were not directly enrolled in the NYS Medicaid program but rendered services through agencies or other enrolled providers.
- Two providers were not added to TIBCO server because the exclusions were the result of an indictment and were not a final action/determination.
- Two providers were not added to TIBCO server because their terminations occurred less than 6 months from the date of notice. *(The state waits 6 months from the date of notice to the provider before adding them to the TIBCO server in case the provider files an appeal.)*
- One provider was not added to TIBCO server because the provider was already on the nationwide exclusion list called the List of Excluded Individuals/Entities (LEIE) maintained by the U.S. Department of Health & Human Services-Office of Inspector General (HHS-OIG).
- One provider was not added to TIBCO server because her exclusion was reversed on appeal.

The CMS review team concluded that the state's for-cause termination postings were appropriate.

According to the regulation at 42 CFR 455.416, the State Medicaid agency, on a case-by-case

basis, may enroll or reinstate a Medicaid provider who has been terminated or denied enrollment for cause if the State agency determines that this course of action is in the best interests of the Medicaid program. In New York, the review team found that the State Medicaid agency had reversed termination decisions and enrolled two providers using this justification. The countermanding of the terminations was based on a vote from a mixed OHIP/OMIG Appeals Committee.

Recommendations:

- None

42 CFR 455.420: Reactivation of provider enrollment

The regulation at 42 CFR 455.420 requires that the State Medicaid agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.

The state is in compliance with this regulation.

Providers who are deactivated for any reason must go through the same enrollment and screening process as any provider who is enrolling for the first time. The State Medicaid agency provided a list of over 2,400 providers that were reactivated between 2012 and 2014. Most of these providers had been denied enrollment or removed from the program for not having a National Provider Identifier (NPI) or because of license loss or expiration. The CMS review team's sampling of 10 provider reactivation files confirmed that such providers had to undergo rescreening before they could get back in the program. Although some aspects of the enrollment and screening process were not fully in compliance with current federal regulations, the same process was used to review reactivated provider applications as was used for initial enrollments.

Recommendations:

- None

42 CFR 455.422: Appeal rights

The regulation at 42 CFR 455.422 requires that the State Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under state law or regulations.

The state is in compliance with this regulation.

The State Medicaid agency affords appeal rights to a provider when the state has taken adverse action against the provider's participation in the Medicaid program. The OHIP identified the sections in the New York Administrative Codes (18 NYCRR, 504.5 and 515.8), which required the state to offer providers appeal rights consistent with the regulation. The state also provided a copy of a provider denial letter which contains information on appeal rights.

Recommendations:

- None

42 CFR 455.432: Site visits

The regulation at 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program.

The state is not fully in compliance with this regulation.

In the interview discussion on site visits, the State Medicaid agency referred the CMS review team to the state regulation at 18 NYCRR 504.4. This regulation is not specific to site visits, but rather speaks to conducting an investigation to verify the information in the application. All nuances of language aside, the review team confirmed that the state conducts some site visits as part of the provider enrollment and screening process. New York's institutional provider enrollment application references site visits in the attached provider agreement. As noted already, after an initial screening, OHIP routinely refers to the OMIG three provider types classified as moderate or high-risk (DME, portable X-ray, and physical therapy) as well as individual providers that are deemed a special risk to the program. The OMIG's EAR unit then provides additional scrutiny including an on-site visit. The on-site visits are unannounced. They are undertaken by trained investigators who photocopy records, take pictures of both the interior and exterior of the provider location, and complete a form summarizing the on-site interviews conducted. Nevertheless, although state policy provides for some pre-enrollment site visits consistent with the federal regulation, the State Medicaid agency acknowledged that it did not perform site visits for the full range of moderate and high-risk providers.

Besides conducting pre-enrollment site visits only on a limited subset of in-state providers, New York indicated that it does not conduct site visits on moderate or high risk out-of-state providers as part of the application process due to resource limitations.

Recommendations:

- Develop and implement policies and procedures for conducting site visits for moderate and high-risk providers who are located in and out of state. In lieu of New York performing out of state visits, arrange for necessary site visits by other states and/or confirm that Medicare's site visit contractor has performed such visits.

42 CFR 455.436: Federal database checks

The regulation at 42 CFR 455.436 requires that the State Medicaid agency must 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 HHS-OIG's LEIE, the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration Death Master File (SSA-DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The state is not fully in compliance with this regulation.

OHIP staff performs the required federal database checks manually for providers who are initially enrolling, reenrolling, reactivating or revalidating, or when there is a requested change of ownership. The state relies on the U.S. Treasury Department's Do Not Pay (DNP) service to conduct ongoing monthly LEIE and SSA-DMF checks. While New York had subscribed to the DNP for monthly EPLS checks as well, its access to the EPLS was revoked due to a Memorandum of Understanding (MOU) issue between the General Services Administration and the U.S. Department of the Treasury. Consequently, monthly searches of the EPLS were not being undertaken at the time of the review; and there was some uncertainty about whether the DNP initiative would be able to continue the monthly LEIE Checks for states. During

interviews, state staff indicated that they were working with the current fiscal agent to see if the EPLS could be downloaded on a monthly basis and matched against the MMIS provider file. The provider enrollment managers also remarked that plans were being developed to use a commercial vendor in the future for all database checks.

During the interview, the State Medicaid agency staff noted that they performed some additional checks besides those mandated in the regulation. For example, they manually checked for Medicaid terminations and Medicare revocations on the TIBCO server every 60 days.

Lastly, the team identified some potential database matching issues during a provider enrollment walkthrough which the State Medicaid agency staff conducted as part of the interview. The walkthrough involved the virtual enrollment of two provider types: a group practice and an institutional provider. It was noted during this demonstration that both providers were in the process of enrolling with outdated provider enrollment forms. Both submitted a May 2013 version of the provider enrollment form even though there is a September 2014 version of the form. In addition, the team noted that the institutional provider application listed only one managing employee and that this was not challenged during the enrollment process. The state must provide for a quality control review of the disclosures submitted on provider applications in order to be sure that all persons with direct or indirect ownership and control interests of five percent or more and all agents and managing employees are subject to the required database searches. Appropriate quality controls in the provider enrollment process would also include ensuring that all databases have been checked at the time of enrollment in the provider enrollment files through the use of a checkbox or some other indicator.

Recommendations:

- Besides ensuring that all required federal database checks are conducted at the time of provider enrollment, reenrollment, or revalidation, ensure that the full range of required LEIE and EPLS database checks are performed on a monthly basis. Ensure that the most current provider enrollment forms are used and that provider enrollment staff scrutinizes application forms critically to identify providers and entities that may be underreporting persons with ownership and control interests in the provider as well as agents and managing employees of the provider. Ensure that required database checks are documented in the provider enrollment file.

42 CFR 455.440: National Provider Identifier

The regulation at 42 CFR 455.440 requires that the State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the NPI of the physician or other professional who ordered or referred such items or services.

The state is in compliance with this regulation.

The state uses a Medical Assistance Health Insurance Claim Form from 2008. This form does not specifically ask for a provider's NPI as does the CMS-1500. It only asks for an identification number of a referring physician or other source. However, billing guidelines for the form require the name and NPI to be supplied for an ordered procedure or referred service. The state documented that it has an error code which will reject claims in the MMIS, if an ORP provider's

NPI is not present on the claim form.
Recommendations: • None

42 CFR 455.450: Screening levels for Medicaid providers
The regulation at 42 CFR 455.450 requires that the State Medicaid agency screen all initial applications, including applications for a new practice location, and any applications received in response to a reenrollment or revalidation of enrollment request based on a categorical risk level of ''limited,'' ''moderate,'' or ''high.'' Under certain circumstances, such as where the provider has an existing overpayment or where there is a credible allegation of fraud against the provider or an HHS-OIG exclusion in the past 10 years, the state must adjust the categorical risk level from "limited" or "moderate" to "high.
The state is not fully in compliance with this regulation.
The State Medicaid agency has assigned provider risk levels based on provider type and will screen limited, moderate, and high risk providers differently. However, at the time of the review, the State Medicaid agency had no procedures in place for adjusting the risk level of an individual provider based on certain additional criteria set forth in the regulation, such as having an outstanding overpayment. The State Medicaid agency staff indicated that they had not yet had occasion to adjust such risk levels. Several weeks after completion of the onsite review, the state provided the review team with an undated document that discussed circumstances in which the state would adjust a categorical risk level of a provider from limited or moderate to high. Nevertheless, while the CMS team was onsite, the State Medicaid agency staff noted that the current MMIS could not record instances in which the state adjusts a limited categorical risk level provider type to either a moderate or high level risk level. Since the State Medicaid agency screens providers based on the provider group to which they belong, staff would not be able to locate a provider in the MMIS that had its categorical risk level adjusted upwards.
Recommendations: • Develop and implement a policy and procedure for adjusting the categorical risk levels of providers who have an existing Medicaid overpayment or meet the other conditions for an increase in risk classification specified at 42 CFR 455.450 and identify those providers individually in the MMIS regardless of their provider group.

42 CFR 455.460: Application fee
The regulation at 42 CFR 455.460 requires the State Medicaid agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or reenrolling Medicaid-only providers as stipulated in the regulation.
The state is in compliance with this regulation.
The state indicated it had begun collecting Medicaid application fees effective May 1, 2013 and that 1,479 providers had paid the fees at the time of the review. Also, the State Medicaid agency has a method for determining whether a provider maybe granted an exception from the application fee. The State Medicaid agency reviews the provider's justification and consults with CMS on the appropriateness of the request. If an exception is requested due to fiscal hardship, extraordinary circumstances or impact to Medicaid enrollees, the State Medicaid Agency will support the request.

Prior to the review, the CMS review team requested a list of all providers enrolled, revalidated and reactivated in the Medicaid program as of July 1, 2012. The team selected 20 newly enrolled, 10 revalidated, and 10 reactivated provider files to review. Based on this limited sample, there was no evidence that the state failed to comply with the application fees requirement.
Recommendations: • None

42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in compliance with this regulation.
The State Medicaid agency does not have any statute or regulations, policies or procedures that provide it with the authority to impose a temporary moratorium. The State Medicaid agency has never had to issue a moratorium and to date has not deemed temporary moratoria necessary. However, state officials indicated during the interview that they would be able to comply with a federal moratorium if requested.
Recommendations: • None

Provider Enrollment and Screening in Managed Care

In New York's Medicaid managed care program, network providers do not have to be enrolled by the state. For the most part, the MCEs are responsible for performing the enrollment and screening of their network providers. During the interview with state managed care staff, the CMS review team asked whether there are provisions in the New York Medicaid managed care contract that direct the MCEs to conduct enhanced provider enrollment and screening activities similar to the activities the state is required to conduct by the regulations at 42 CFR 455 subpart E. The CMS review team was particularly interested in whether managed care contracts require the reporting of for-cause terminations and the checking of federal databases for excluded parties. Likewise, CMS asked if different provider types are assigned different risk levels and subject to greater screening and site visits during the credentialing process when categorized at a higher risk.

At the time of the review, the state had drafted a version of the model contract that included the provider enrollment and screening requirements of 42 CFR 455 subpart E. The contract had been submitted to CMS for approval in July 2014, but CMS approval was not yet given. Thus, while the version of the model contract still in effect did address the managed care provider

credentialing process, it did not yet require the MCEs to follow the Affordable Care Act-related provisions at 42 CFR 455 subpart E.

The team conducted onsite interviews with four of the state contracted mainstream MCEs. The interviews contained some questions about enrollment and screening procedures to determine if actual MCE provider enrollment and screening practices were aligned with the current regulations that apply to the FFS Medicaid program. Capital District Physician's Health Plan Inc. (CDPHP) serving the Albany area was the smallest MCE interviewed. The three other MCEs, Healthfirst, Fidelis Care, and MetroPlus Health Plan, are located in New York City and provide services mainly to downstate beneficiaries. Below are the team's observations:

- ***Federal Database Checks:*** Section 18.9 of the model contract requires the MCEs to certify initially and after changed circumstances that they do not knowingly have debarred providers, owners and managing employees. The contract also requires MCEs to monitor all new, reenrolling, and existing providers against the LEIE for exclusions on a monthly basis. MCE network providers are required to monitor staff and employees on the LEIE as well and report any exclusions to the contractor on a monthly basis.

  All of the MCEs reviewed by the team recredentialed their providers every three years. All checked the NPPES and the LEIE as part of the credentialing and enrollment process. Beyond that, database checking practices of plans differed from one another and several were different from the practices required in the FFS Medicaid program:

  - One of the four plans (MetroPlus) required all providers--with the exception of some hard-to-find subspecialists--to be enrolled in the FFS Medicaid program. With these rare exceptions, its providers and affiliated parties were screened to the same extent that the state screens all FFS providers.

  - A second plan (Healthfirst) checked its providers and affiliated parties against the LEIE, MED and EPLS upon enrollment and reenrollment. However, while it collected information on affiliated parties at the time of enrollment, it only searched provider names for exclusions or debarments on an ongoing basis.

  - The third plan (Fidelis) checked the LEIE for excluded providers on a monthly basis. However, it had not yet begun monthly checks of the EPLS and did yet have access to the SSA-DMF. Also, its representatives could not give a clear picture of whether the plan's monthly exclusion searches in the LEIE covered the full range of affiliated parties, including all persons with direct or indirect ownership and control interests of 5 percent or more in the provider as well as agents and managing employees of the provider.

  - The fourth plan (CDPHP) also searched for sanctioned providers on an ongoing basis by checking the EPLS and LEIE. However, its searches too covered only providers and not the full range of affiliated parties that must be checked in the

FFS program. This plan also had not yet begun to search the SSA-DMF (such checks were planned for the spring of 2015).

- All of the plans selected for review reported that they checked various supplementary sources to identify problem providers that were not referenced in the federal regulation at 42 CFR 455.436. These included the OMIG's list of terminated providers, the New York State Office of Professional Medical Conduct's records of licensure actions taken against providers, the National Practitioner Data Bank, and the registration list maintained at the state licensing agency.

- Several of the plans interviewed used large contractors to enroll, screen, and monitor the billing practices of certain provider types, such as pharmacies and dentists. For the most part, the large pharmacy and dental benefit managers were in the process of aligning their database checking requirements with federal FFS standards.

- Lastly, the sampling of selected provider enrollment files from each plan showed that the three plans which did not require providers to be enrolled in the FFS program did not always capture the full range of disclosure information required by federal regulations.[4] Unlike other enrollment and screening requirements which were not yet part of the contract, the federal regulations on ownership and control and criminal conviction disclosures were incorporated in sections 10.6 and 18.12 of the managed care contract. If the ownership and control information solicited by plans is incomplete, the MCEs by definition cannot perform complete federal database checks. Similarly, incomplete disclosures of criminal conviction information may allow providers or affiliated parties to enter MCE networks whose credentialing is otherwise acceptable.

- ***Provider Risk Levels and Site Visits:*** None of the plans assigned limited, moderate, or high risk designations to all providers, as federal regulations have required in the FFS Medicaid program. This notwithstanding, Metro Plus indicated that it does require site visits for any provider type classified as high risk by CMS. Fidelis Care indicated that it occasionally performs site visits, while Healthfirst and CDPHP do not require site visits.

- ***Provider Terminations:*** Section 18.8(c) of the model contract requires MCEs to report to DOH and OMIG any adverse action taken against providers as set forth in the federal regulation at 42 CFR 1002.3. This includes terminations and providers denied credentialing for program integrity reasons. The four plans interviewed were able to document timely reporting to the state of providers who were terminated from their network or denied credentialing for program integrity reasons. All plans likewise submitted annual reports summarizing their actions.

Section 2: Managed Care Program Integrity

[4] At 42 CFR 455.104 and 42 CFR 455.106, respectively.

Overview of the State's Managed Care Program

As noted earlier, roughly 4.4 million beneficiaries, or 81 percent of New York's Medicaid population, were enrolled in 19 mainstream MCEs and 30 long term care MCEs during FFY 2013. The mainstream managed care contract applied to plans covering regular Medicaid beneficiaries, persons in the FHP program and plans serving certain special needs populations, such as persons living with HIV. Persons in need of long term care services are served by plans under a partially capitated managed long term care (MLTC) contract. New York State spent approximately $22.2 billion on both the mainstream and MLTC contracts in FY 2013.

As a result of a comprehensive state program integrity review in 2013, the state modified its mainstream managed care contract to incorporate numerous provider enrollment and screening provisions as well as program integrity and reporting requirements recommended by CMS. However, as noted, the contract changes were sent to CMS for approval in July 2014 but had not been formally approved at the time of this review. During the review, OHIP managed care officials indicated that they were waiting on changes to the MLTC contract pending CMS' final approval of the mainstream model contract. The MLTC plans and contract were not the subjects of this review.

Summary Information on the Plans Reviewed

The CMS review team interviewed four MCEs. They ranged in size from 87,000 to over 900,000 enrollees. Their contracted Medicaid provider networks varied in size from 12,000 to over 63,000 in size and were reimbursed by a combination of sub-capitation and FFS payments. The smallest plan reviewed, Capital District Physician's Health Plan or CDHP, was based in the Albany area and served beneficiaries in upstate New York. Medicaid enrollees were approximately 38.5 percent of its total enrollment. While all the other plans had some other business lines, Medicaid enrollees comprised at least 80 percent or more of their enrollment. The other three plans, MetroPlus, Fidelis, and Healthfirst, were all based in New York City and served predominantly downstate enrollees, although Fidelis did some upstate business. All of the plans had SIUs of varying sizes and compositions. The activities of the SIUs will be discussed at greater length below.

The following chart summarizes the baseline information on the MCEs reviewed:

MCE	Medicaid Enrollees[5]	Medicaid Contracted Providers[5]	Percentage Medicaid Enrollees	Size and Composition of SIU
CDPHP	87,614	12,099	38.5%	7 FTEs (4 investigative analysts, 1 investigator, 1 data analyst, 1 manager)
MetroPlus	375,613	20,029	80.25%	4 FTEs (1 compliance officer, 1 SIU and 1 health care investigator, 1 SIU auditor)
Fidelis	902,278	63,605	87%	5 FTEs (1 director, 4 full-time investigators)
Healthfirst	747,397	26,577	96%	10 FTEs (1 director, 1 supervisor, 3 senior investigators, 3 investigators, 2 fraud examiners)

State Oversight of Managed Care Program Integrity

In New York, the OHIP has primary responsibility for oversight of the contracted Medicaid MCEs, while the OMIG coordinates fraud, waste, and abuse (FWA) control activities for all state agencies involved in Medicaid-funded services. The state does not utilize an external quality review organization or other contractor to validate MCE compliance with program integrity-related contract provisions.

As part of the focused review, the CMS review team reviewed the state's boilerplate contract with its MCEs for specific program integrity requirements. Besides the selected provider enrollment and screening requirements discussed above, the team considered the contractual requirements for program integrity compliance programs and staffing for such activities. The team found that in Section 23 of the contract, the state requires its MCEs to have a compliance program that meets the federal regulations at 42 CFR 438.608. Related to this requirement, each MCE with more than 10,000 enrollees must have an SIU and file a Fraud and Abuse Prevention Plan. However, the contract does not delineate how many staff must be assigned to perform program integrity activities based on the number of providers in the plan's network or the number of members served.

CMS recommends that New York mandate the minimum size of plan SIUs based on standard measures and a level of effort for staff that will ensure adequate program integrity oversight of network providers.

Audit Activity

The OHIP monitors mainstream MCEs onsite using an operational survey every 2 years. This survey tool has been used for years, but a section with questions about plan program integrity activities was recently added to address vulnerabilities in managed care oversight that CMS identified during its 2013 comprehensive program integrity review. In March 2014, all 19 mainstream plans were surveyed utilizing the updated survey tool, which included the enhanced

[5] Figures based on data reported by the plans for March 1 or June 1, 2014.

program integrity portion. OHIP's Division of Health Plan Contracting and Oversight (DHPCO) jointly conducted the review with OMIG. The state indicated that follow-up activities will be performed once the plans have implemented required corrective action.

The OMIG also regularly monitors MCE capitation payments to ensure that they are consistent with the provisions of the model contract. OMIG's Division of Medicaid Audit initiates audits when inappropriate payments have occurred. Over the past 4 FFYs, the OMIG conducted 46 investigations, and 322 audits of MCEs. The audits led to recoveries of capitated payments issued on behalf of deceased recipients and incarcerated individuals. They also identified overpayments due to other factors that caused beneficiaries to be ineligible for managed care, such as admission to residential treatment facilities or nursing homes and placement in foster care.

In addition, mainstream plans are required to submit an annual report that includes overpayment collections for financial purposes. Eleven of the nineteen plans provide this report to the OHIP's Bureau of Managed Care Fiscal Oversight. However, this report only provides statistical reporting of recoveries (net of settlements) and does not identify provider names. The information is self-reported by the plans and evaluated for reasonableness when premiums are set. The other eight mainstream plans, which are the largest, file their annual reports with the Department of Financial Services. These reports were not shared with OHIP, and it was not clear that OMIG receives a copy either.

OHIP's Division of Long Term Care conducts focused audits and desk reviews of the plan's MLTC programs. However, there are no independent on-site reviews. Moreover, these reviews do not utilize the mainstream managed care plan review tool that includes program integrity related questions. OMIG audit staff has weekly communications with both mainstream and long term care managed care staff to discuss ongoing audit and investigative activities and issues.

CMS recommends New York continue to conduct program integrity reviews of mainstream MCEs and expand into the MLTC arena. The state should also conduct program integrity reviews of network providers in both mainstream and MLTC plans in addition to monitoring program integrity and education activities reported by MCEs.

Compliance Plans

The MCEs are required by contract to have a compliance plan that meets the requirements of 42 CFR 438.608. OMIG's Bureau of Compliance conducts compliance program reviews of all MCEs as well as other large providers that are required to have a mandatory compliance program. The DHPCO, in conjunction with OMIG, conducted a program integrity focused survey for all MCEs during March 2014. This review was focused on the plan's compliance with all federal program integrity requirements.

Training

The compliance plans that MCEs must have in place includes the requirement that there be effective training and education for the compliance officer and employees. OMIG's Bureau of Compliance assists MCEs in this regard by routinely holding webinars to address various

compliance related issues. All webinars are open to MCEs and SIU personnel though they are advertised to everyone who receives OMIG listserv notifications. The DHPCO conducted a program integrity training session during an operational issues meeting held for MCEs in 2014. Two webinars were conducted on February 25, 2014 and February 28, 2014 for both upstate and downstate MCEs by Department staff outlining the specific CMS program integrity requirements. Emphasis was put on the 2013 CMS audit findings and areas of deficiency and corresponding recommendations. All of the contracted plans participated in the sessions, and all plans were given notice about the upcoming program integrity surveys which the state had scheduled in March 2014.

The OMIG meets on a bi-monthly basis with the New York City MCEs and the Medicaid Fraud Control Unit (MFCU) to discuss ongoing and pending provider fraud and abuse investigations. Recently, OMIG created an additional workgroup that meets on a monthly basis with several of the large MCEs to discuss provider issues in an attempt to increase the number of referrals. The OMIG also meets with the upstate plans at Health Care Task Force meetings coordinated by the U.S. Department of Justice. However, these meetings focus more on general program integrity trends and less on specific provider fraud cases. During interviews with the MCEs, several mentioned that the meetings that currently take place would be more useful if the state communicated more specific information about suspect providers enrolled in more than one plan.

CMS recommends New York continue to hold and expand program integrity training sessions for state staff and all managed care plans. In addition, meetings with MCEs should furnish provider-specific agendas in advance, allowing MCEs to bring relevant information to the meeting that will assist the program integrity efforts of all plans and the state.

Encounter data

Section 18.5(a)(iv) of the contract requires the MCEs to submit encounter data in a prescribed format. However, the State indicated that it cannot rely on encounter data to detect aberrant provider billing patterns because the quality of the data is not yet sufficient for this. State representatives also noted that all the required fields are not always populated and when provided, they are often submitted in different formats. At the time of the review, it was still a time-consuming process to work with MCE encounter data.

CMS recommends New York require plans to submit complete encounter data in a single format with penalties for non-compliance. The state should also supplement FFS investigations with managed care data mining activities for specific providers who work across both delivery systems.

Reporting Investigations and Overpayments

Section 18.5 of the model managed care contract requires the MCEs to report confirmed cases of fraud and abuse to the state. The review team was told by state management that there have been 80 to 90 reports of fraud and abuse reported by the plans over the past 4 years. The state provided 5 examples to the review team, which showed detailed case development, but all of these were developed by a national pharmacy benefit manager which contracts with many of New York's Medicaid MCEs.

The state also indicated that the MCEs reported conducting 236 provider investigations over the past 4 years. The list of reported cases was unequally distributed across plans. Fewer than half the plans reported more than 75 percent of the cases. Moreover, the reports in many instances did not clearly specify the reason for the investigation or its outcome. In addition, the state's list of reported MCE case investigations was difficult to reconcile with the plans' own list of reported cases. For example, the state reported that CDPHP referred 9 cases, while CDPHP reported that it referred 34 cases to a state government agency. Likewise, state officials reported receiving 10 cases from Healthfirst, while the plan said it reported no cases. The equivalent figures for MetroPlus were 15 and none, respectively. Similarly, OHIP reported receiving 9 referrals from Fidelis; however, Fidelis said that it reported 8 cases to the OMIG and/or MFCU, with an additional 4 referrals being made straight to the MFCU.

Some of these reporting discrepancies may be due to differences in how either the state or the plans counted case referrals. A plan, such as CDPHP, which appeared to overestimate the number of cases, may have included provider investigations reported to the state licensing agency, for example, and not just those that went to OHIP. On the other hand, the state may have counted some cases that were presented orally at quarterly meetings with the plans. The discrepancies are mainly of concern because many problem providers are enrolled in multiple plans and programs. The more confusion exists in case reporting, the more opportunities exist for such providers to escape attention across the broad spectrum of contractors. The state should endeavor to develop standardized criteria across plans for reporting provider investigations.

During interviews, state officials indicated that they were aware of the need for a broader overview of potential fraud taking place at the plan level. They noted that the OMIG has collaborated with the MFCU to update the model contract's requirements on fraud and abuse reporting. Section 18.5 of the draft model contract, for example, was amended to require plans not just to report confirmed cases of fraud but to report all cases of suspected fraud and abuse on an ongoing basis to the OMIG. Plans are also required to list suspected and confirmed cases in an annual financial report. However, again, the annual financial reports that go to OHIP do not include a level of detail that could help the state identify problem providers that it would want to review further or share with other MCEs.

This is also true of annual reports which the eight largest plans are required submit to the state's Department of Financial Services that oversees banking and insurance functions in the state including fraud and abuse activities. The reporting includes the number and dollar value of suspicious claims identified by the plan's SIU, number of claims reviewed by the SIU, the number of referrals by the SIU, and number of cases opened and closed by the SIU. The reports also tally the number of investigated claims not paid or partially paid along with the dollar value of savings and the dollar value of recoveries and restitutions. However, no specific provider information is included in these, and they are not sent to OHIP for review.

CMS recommends New York require plans to report all provider investigative and educational activities on a monthly basis utilizing standard data elements which include provider name, reason for the action, overpayments identified and collected, and a summary of the results.

MCE Program Integrity Activities

The review team interviewed four MCEs as part of the focused review process. New York State managed care regulations require all managed care plans with more than 10,000 enrollees to have an organizationally distinct SIU and to provide a rationale for the size of the unit and the resources devoted to it.[6] All four of the MCEs interviewed had a distinct SIU located onsite with staffing levels that varied from 4 to 10 FTEs. While there are no contract requirements for SIU staff size, both MetroPlus and Fidelis followed state regulations in basing their SIU staffing on a report from the New York State Department of Insurance which suggested that health insurers licensed to do business in New York and other states should have at least one investigator for every 142,750 to 213,000 members. CDPHP likewise based its SIU's 7 FTEs on provisions in the New York State Insurance Laws and administrative code, rules and regulations. In contrast, Healthfirst did not provide a rationale but had the largest SIU with 10 FTEs and an additional 7.5 FTEs from contractor staff.

The MCEs interviewed had other lines of business besides Medicaid,[7] but with one exception, the large majority of their enrollees were Medicaid beneficiaries. Healthfirst reported that 96 percent of its business line was Medicaid, while Fidelis reported doing 87 percent Medicaid business and MetroPlus 80 percent. Only CDPHP, at 38.5 percent, had less than half its enrollees in Medicaid. Program integrity personnel at each plan worked across all business lines with no staff allocated solely to Medicaid.

The MCEs also used a variety of tools to identify fraud and abuse, with many, but not all, using a combination of in-house and contracted activities. During interviews all plans reported that in-house systems were in place to identify and investigate FWA. However, Healthfirst and Fidelis also contracted with or used General Dynamics Information Technologies products for FWA analytics while MetroPlus contacted with IBM for similar services. CDPHP handled its data mining in house. Additionally Fidelis contracted with Health Management Systems (HMS) for third party liability and IHealth Technologies for claims review and, post pay activities.[8]

In addition, all of the plans contracted with vendors for pharmacy and dental services. CDPHP and MetroPlus contracted with CVS Caremark for pharmacy benefits and HealthPlex for dental benefits. Healthfirst and Fidelis contracted with CVS Caremark for pharmacy and DentaQuest for dental benefits. In addition to administering the pharmacy and dental benefits, these contractors processed claims and undertook their own data mining and post payment review activities in an effort to prevent and detect fraud, abuse and improper payments.

Preliminary Investigations, Case Tracking, and Sharing of Information: - All of the plans conducted preliminary investigations of suspected provider fraud; and all had some form of case tracking mechanism. However, given the contract requirements in place at the time of the review, the reporting of potential fraud cases to either the OMIG or the MFCU was limited. The review team looked at 10 investigative case files from each plan in the course of the focused

[6] See Title 10, New York Codes, Rules and Regulations, Part 98-1.21(a) and (b)(1) and (b)(3).
[7] See response to MCE review guide question MCE 10.
[8] See response to MCE review guide question MCE 22.

review. Within this sample, CDPHP referred one fraud case to the OMIG during the four quarters preceding the review. This was the only submission by a plan. All of the plans interviewed also reported that they do not share information on investigations of suspected provider fraud directly with other plans because of liability issues. There is some sharing of information on current cases at the monthly meetings of New York City-based MCEs hosted by the OMIG and at the quarterly meetings of upstate plans hosted by an Assistant United States Attorney. However, as noted, the discussions at these meetings tended to be more general in nature. According to the plans, relatively little actionable information was communicated about problem providers who might be operating in multiple MCEs.

Lastly, each plan had a method to verify with members if billed services were rendered. A CPDHP contractor conducted phone interviews with beneficiaries. Fidelis and MetroPlus sent beneficiary verification surveys, and Healthfirst performed member outreach through telephone calls, mail surveys, and on-site interviews to verify that services and supplies were delivered as billed[9]. These verification activities are useful as spot checks. However, in the MCE interviews, only one plan indicated that it had derived actionable leads from them.

To promote investigative activity in the managed care sector, CMS recommends that the state strengthen its efforts to systematically transmit information to plans about providers who are suspected of being involved in fraud and abuse across plans and across the FFS and managed care delivery systems.

Compliance Plans and Training

All of the MCEs interviewed were required to have a compliance plan in accordance with 42 CFR 438.608. All of the plans submitted these to the State for review.

Among many other things, the compliance plans required all MCE staff to receive training on FWA upon hire and annually thereafter. All of the plans reviewed by the CMS team provided extensive documentation of such in-house training, although the CDPHP and Healthfirst training guides and manuals submitted for review dealt more with Medicare FWA issues than Medicaid.

All of the MCEs likewise documented the provision of program integrity training to providers or identified methods by which program integrity information was conveyed to the provider community (websites, provider bulletins, etc.). The materials submitted to the review team from Fidelis and Healthfirst also included training on the Federal False Claims Act pursuant to section 1902(a)(68) of the Social Security Act, which requires that entities that receive $5 million dollars or more annually educate employees and members on how to report Medicaid fraud waste and abuse and whistleblower protections.

[9] See responses to MCE review guide question 27.

Reporting of Investigations and Overpayments

Although the State agency pays each MCE a capitated rate for each Medicaid enrollee, the mainstream managed care contract does not require MCEs to return overpayments recovered from providers to the State agency. When the MCE enters into a contract with a provider, the MCE assumes any risks associated with the terms of the contract to provide services to enrollees. If the MCE recovers monies from overpayments due to fraud and abuse, the money is not returned to the State agency, but must be reported on financial statements to the state. However, this information is self-reported and while the state reviews it for reasonableness, it is not verified. The OMIG retains the right to recover overpayments from providers or MCEs identified during audits that it conducts directly. In addition, the mainstream managed care contract requires the MCEs to suspend payments if directed by DOH or the OMIG based on the raising of a credible allegation of fraud against the provider.

As part of the focused review, the CMS team asked all of the MCEs interviewed to report overpayment dollars collected over the past three FFYs as a result of SIU program integrity activities. The amounts reported by the plans showed wide variations which were not necessarily correlated with the size of their SIUs. MetroPlus, with only 2 FTEs, reported total recoveries over 3 years of $20.6 million, with $17.7 million coming from Medicaid cases). Fidelis reported a 3 year total of $9.7 million ($8.8 million Medicaid), while CDPHP reported roughly $6.6 million, but with less than $700,000 of this coming from Medicaid cases. Of the 4 plans reviewed, Healthfirst had the lowest amount of Medicaid recoveries at $456,000, although its SIU had the largest staff, with 10 members and 7.5 contractors.

A review of the CDPHP data shows that only about 10 percent of CDPHP's collections were Medicaid-related, although 38 percent of the plan's enrollees were on Medicaid. The Medicaid overpayments reported by the other plans were more in proportion with their Medicaid enrollment. On the other hand, only a fraction of the MetroPlus recovery figures, which are more than twice as high as those of the next MCE, represent actual collections. Ninety-nine percent of MetroPlus's three year recovery totals come from 2011 and 2012, when the plan included both costs avoided through claims edits and real collections in its recovery figures. In 2013, when MetroPlus began to count only money collected in its recovery figures, its identified overpayments totaled only $158,520, with actual collections of $9,509. The state should consider requiring standard definitions for plan reporting of actual recoupments versus different types of cost avoidance.

The last MetroPlus example highlights another issue as well: that the discrepancy between identified and actual collections in the managed care program is often significant. During interviews, Healthfirst acknowledged that the appeals process and litigation frequently whittle down the amount of large identified overpayments that can be recovered in practice. In the same vein, MetroPlus cited a 2012 case where over $1 million in improper payments was identified but only $220,000 recouped. The plan indicated that it looked at the cost of litigation and carefully weighs its chances of winning in deciding on settlements with providers. These factors are also considered in the FFS Medicaid program, but the dollars recouped and recovery rate

were significantly higher. The state should consider what types of assistance it can provide to facilitate MCE collection activities.

Relating to the audit function, during interviews each plan reported that there is no other unit besides the SIU which conducted audits and collects overpayments in cases related to FWA. However, contractors do perform audit functions in specialized service areas. For example, representatives of CVS Caremark reported that the pharmacy benefit manager conducts audits of pharmacies and will report overpayments to the plan(s) though it is not contractually required to return recouped funds. If CVS auditors find potential fraud they will notify the State. It was also noted that CVS will exclude problem pharmacies from their networks but not individual pharmacists. This is a potential concern because such individuals are not reported to the plan, state, or CMS and can gain employment at another pharmacy that participates in federally funded programs. CVS reported that if an investigation results in an administrative action, it would notify the plan and/or the OMIG and MFCU.

Both HealthPlex and DentaQuest reported conducting network dental provider investigations and audits and indicated that if any FWA was found as a result of audits or investigations, it would be reported to the appropriate plan. However, it was not clear if any overpayments recovered by contractors are reported to the plans unless the SIU initiated the case. This is a potential concern because it could have an impact on the state's rate setting process.

The MCEs were also asked how cost avoidance and return on investment (ROI) are calculated and the dollar amounts associated with these activities for the past three years. CDPHP reported a cost avoidance numbers of $254,075 and an ROI of $888,780. It explained that the ROI number is calculated by adding overpayment recoveries and cost avoidance numbers. Its overpayment recovery figures in turn are derived from the sum of actual recoveries, projected recoveries based on system edits, and identified overpayments that are not recoverable but resolved through provider education and settlements. Fidelis reported cost avoidance numbers of $3.7 million and ROI in the more typical form of a ratio. It collected roughly five dollars for every one dollar spent on SIU activities in FFY 2013. Fidelis indicated that it calculated ROI by adding recoveries and cost avoidance together divided by the total SIU budget.[10] Healthfirst and MetroPlus did not provide cost avoidance or ROI numbers.

As mentioned previously, plans are required to issue an annual report of overpayment collections for financial purposes. Eleven of the nineteen mainstream MCEs report to the OHIP Bureau of Managed Care Fiscal Oversight of fraud and abuse activities. However, this report only provides statistical reporting of recoveries (net of settlements) and does not identify provider names. The information is self-reported by the plans and evaluated for reasonableness when premiums are set. The other eight larger plans file their annual reports to the Department of Financial Services. These reports are not shared with OHIP and it is not clear if OMIG receives a copy either. The OHIP paid the MCEs interviewed a total of $8 billion in the FFY ending October 30, 2013, while the plans reported recovering a total of $33.2 million dollars, including $27.2 million in Medicaid funds, over a three year period. Healthfirst received approximately $3 billion of the total capitation paid yet only recovered less than half a million dollars in a three year period and as mentioned had no data on cost avoidance or ROI.

[10] See response to MCE question 9.

CMS recommends that New York verify that identified and collected overpayments are fully reported by the MCEs and that they are incorporated into the rate-setting process along with the overpayments determined by state-initiated reviews. Reported overpayments should include those identified by MCE subcontractors such as pharmacy and dental benefit managers. The state should also ensure that individual pharmacists found to have engaged in fraudulent activities during audits and investigations are removed from all MCE provider networks. Terminations should not only apply to the pharmacies where the fraud occurred. Lastly, the state should work with the plans to develop standard definitions of cost avoidance and return on investment to facilitate uniform reporting.

Terminated Providers and Adverse Action Reporting

Article 44 of New York State Public Health Law allows MCEs to terminate providers and provides a process for undertaking those terminations. No hearing is required when the plan is terminating someone for issues related to fraud and abuse. However, as noted in the managed care oversight section, New York's mainstream model contract requires MCEs to report to the state when terminating or taking adverse actions against a provider for program integrity reasons. Besides the reporting of fraud-related terminations, pursuant to 42 CFR 1002.3(b), MCEs must report any program integrity related adverse action taken against a provider both to OHIP and OMIG. The plans reported the following summary information on overall provider enrollments, disenrollments, and for-cause terminations over the past three federal fiscal years:

MCE	Number of providers at the time of review	Number of providers enrolled in last 3 completed FFYs	Number of providers disenrolled or terminated in last 3 completed FFYs	Number of providers terminated for cause in last 3 completed FFYs
CDPHP	12,099	2013: 16,068 2012: 14,132 2011: 12,996	2013: 594 2012: 585 2011: 601	2013: 1 2012: 0 2011: 0
Fidelis	63,605	2013: 59,373 2012: 53,540 2011: 49,568	2013: 2,843 2012: 2,452 2011: 2,461	2013: 22 2012: 23 2011: 28
Healthfirst	28,230	2013: 28,370 2012: 26,311 2011: 25,497	2013: 332 2012: 732 2011: 1,011	2013: 13 2012: 9 2011: 14
MetroPlus	20,029	2013: 2,889 2012: 2,349 2011: 3,519	2013: 1,781 2012: 1,388 2011: 3,105	2013: 574 2012: 414 2011: 367

The chart above shows that relatively few providers are terminated for cause when compared to the number of non-program integrity-related disenrollments. MetroPlus terminated more

providers for cause than any of the others. However, this may be because the SIU employs a broader definition of "for cause" than the other plans. MetroPlus defines for cause as a contract termination based on non-compliance with specific terms of the provider agreement. This does not include potential fraud, and the plan indicated that none of its terminations were for that specific reason.

CMS recommends New York develop a "for cause termination" definition similar to what CMS has presented to states and require plans to use it as a standard for reporting purposes.

Payment Suspensions

All Medicaid MCEs are contractually required to suspend/withhold payments to providers at the state's request. However, there is no provision in the contract for plans to report payment suspensions undertaken at their own initiative to the OHIP or the OMIG[11]. Some plans did so regardless, but not always in a consistent fashion. For example, the CMS review team sampled eight files which indicated that Fidelis proactively suspended payments to providers based on lack of medical necessity and billing for services not rendered[12]. It was evident in six of the case files that Fidelis reported the payment suspension to the state, but not clear what was done in the other two. On the other hand, CDPHP reported that it would not suspend payments unless first directed to do so by the appropriate government oversight agency and said it had never received such a request. Healthfirst and MetroPlus likewise reported that they do not make use of payment suspensions.

CMS recommends that New York contractually require MCEs to suspend payment to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.

Recommendations for Improvement in Managed Care:

- CMS recommends that New York mandate the minimum size of plan SIUs based on standard measures and a level of effort for staff that will ensure adequate program integrity oversight of network providers.
- CMS recommends New York continue to conduct program integrity reviews of mainstream MCEs and expand into the MLTC arena. The state should also conduct program integrity reviews of network providers in both mainstream and MLTC plans in addition to monitoring program integrity and education activities reported by MCEs.
- CMS recommends New York continue to hold and expand program integrity training sessions for state staff and all managed care plans. In addition, meetings with MCEs

[11] See MC contract section 23.4 on shared drive.
[12] See Fidelis MCE 39 sampling worksheet on shared drive.

should furnish provider-specific agendas in advance, allowing MCEs to bring relevant information to the meeting to assist program integrity efforts of all plans and the state.

- CMS recommends New York require plans to submit complete encounter data in a single format with penalties for non-compliance. The state should also supplement FFS investigations with managed care data mining activities for specific providers who work across both delivery systems.
- CMS recommends New York require plans to report all provider investigative and educational activities on a monthly basis utilizing standard data elements which include provider name, reason for the action, overpayments identified and collected, and a summary of the results.
- To promote investigative activity in the managed care sector, CMS recommends that the state strengthen its efforts to systematically transmit regular information to plans about providers who are suspected of being involved in fraud and abuse across plans and across the FFS and managed care delivery systems.
- CMS recommends that New York verify that identified and collected overpayments are fully reported by the MCEs and that they are incorporated into the rate-setting process along with the overpayments determined by state-initiated reviews. Reported overpayments should include those identified by MCE subcontractors such as pharmacy and dental benefit managers. The state should also ensure that individual pharmacists implicated in fraudulent activities during audits and investigations are removed from all MCE provider networks. Terminations should not only apply to the pharmacies where the fraud occurred. Lastly, the state should work with the plans to develop standard definitions of cost avoidance and return on investment to facilitate uniform reporting.
- CMS recommends New York develop a "for cause termination" definition similar to what CMS has presented to states and require plans to use it as a standard for reporting purposes.
- CMS recommends that New York contractually require MCEs to suspend payment to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.

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 as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing System for information provided by other states including best practices and managed care contracts.
- Consult with other states on methods of conducting out-of-state site visits to provider applicants. Consider using other available state, county, and local government resources

to assist in the provider screening process in order that the state can comply with the requirements of 42 CFR 455.432 listed in Section 1.

- Consult the managed care plan compliance toolkit developed for CMS by a private contractor. This is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/managedcare-toolkit.html.
- 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.
- Regarding the development of viable encounter data systems, consult the Encounter Data Toolkit developed for CMS by a private contractor in November 2013. This is available on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Medicaid-Encounter-Data-toolkit.pdf.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process for MCEs that is consistent with federal regulations and guidance. CMS can also refer New York to states that are further along in this process to address risks identified is Section 2.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to New York based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that New York review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate. The state should also review effective practices related to the handling of terminated providers to address the issues identified in the Affordable Care Act section of this report.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately. However, CMS supports New York's efforts and encourages it to look for additional opportunities to improve overall program integrity.

We require the state to provide a CAP for each of the recommendations 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 issue. The State Medicaid agency should also provide any supporting documentation associated with the CAP, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. 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 Medicaid agency has already taken action to correct compliance deficiencies or vulnerabilities, then those corrections should be identified as well.

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

Review of Corrective Action Plan as of September 23, 2014

As part of the focused review the CMS review team reviewed the state's CAP from the last Medicaid Comprehensive Program Integrity Review conducted in February 2013. The final program integrity report was issued in July 2014 and the state's CAP was submitted to CMS on August 6, 2014. During the 2014 focused review, the CMS review team asked about the status of planned corrective actions which were not yet completed or fully addressed in the CAP:

1. In the 2014 Comprehensive Program Integrity Review Final Report CMS cited the state for not adequately overseeing the state's program integrity and provider enrollment operation in managed care. This oversight includes developing adequate contract language to ensure fraud waste and abuse requirements are communicated to the plans, and the development of policies and procedures to evaluate the execution of those contract requirements. In response to the CAP, the state responded that the mainstream model contract had been modified to collect all required MCE and network provider disclosures, and contains safeguards to ensure payments are not made to excluded or debarred entities. The contract and was sent to CMS for approval on July 11, 2014. The state also mentioned that policies and procedures have been developed and implemented to facilitate stronger oversight of managed care plans and conducted focused reviews of all managed care plans.

- The CMS review team followed up on results of the contract modifications. The modifications incorporated into the model contracts only apply to the mainstream MCE contracts and not the MLTC contracts. The state is waiting on the approval by CMS of the mainstream contract before incorporating the changes into the MLTC contracts.

- The CMS review team followed up on the development and implementation of policy and procedures to monitor the program integrity contract requirements. The policies and procedures to monitor only the mainstream contracts were in final clearance and not supplied to the review team. The state conducted reviews of the comprehensive plans in March of 2014 using an enhanced Fraud and Abuse Compliance Tool that includes the new contract requirements mentioned in the CAP as well as a verification of services review. These steps will also be included in the state's bi-annual Operational Surveys of the plans.

2. In the 2014 Comprehensive Program Integrity Review Final Report CMS cited the state for not conducting many program integrity reviews of managed care network providers, and for a relatively small number of managed care case referrals to the MFCU. In addition, the MOU with the MFCU had not been updated since the formation of the OMIG. In response to the CAP, the state mentioned that the mainstream model contract awaiting CMS approval had been modified to allow the OMIG to audit network providers and also suspend payments to those providers suspected of fraud and abuse. The state also noted that the MOU with the MFCU has been updated to address managed care issues.

- The CMS review team followed up on whether or not the state is conducting billing audits of network providers. The state indicated it is not conducting network provider audits but has conducted reviews of provider participation, appointment availability surveys, network exclusion reviews, eligibility audits of MLTC and Social Adult Day Care providers, and reviews of plan program integrity activities.

- The CMS review team followed up on whether or not the state is referring network provider cases to the MFCU. While no numbers were provided, the state said there has been an uptick in referrals with the PBM referring cases to the state that can be then referred to the MFCU. The eligibility reviews have resulted in the referral of 12 investigations to the MFCU. The bi-monthly meetings with the MCEs that have been going on for years have become more productive lately and there is a new monthly workgroup consisting of larger managed care plans where information about problem providers is shared.

3. In the 2014 Comprehensive Program Integrity Review Final Report, CMS cited the state for risks associated with the state's and MCE's provider enrollment and reporting practices. The provider enrollment risks include ownership and control disclosures, exclusion searches for FFS providers, criminal offense and business transaction disclosures, and notifications to the HHS-OIG. In response to the CAP, the state responded that it collects all required ownership and control information from its fiscal agent, and that the model contract awaiting CMS approval was modified to collect all the ownership and control and criminal conviction disclosures from the mainstream MCEs and network providers. The state also reported it is collecting all healthcare related criminal conviction disclosures with its updated provider enrollment form. In addition, the state reported that it modified the standard clauses appended to all managed care provider contracts to include the appropriate business transaction disclosure information.

    - The CMS review team followed up on ownership and control disclosures from the fiscal agent, and network providers. The Review Team received a Proxy Statement showing the previous fiscal agent's ownership and corporate officers and directors. However, there were no personal addresses, dates of birth, or Social Security Numbers. In addition, there was no expanded information for corporate ownership, subcontractor ownership, or relationship information. It is not known if the incoming fiscal agent submitted any disclosures. The proposed model contract modifications require network provider ownership and control disclosures. However, the contract language uses the definition of disclosing entity that leaves out individual practitioners and groups of practitioners from the requirement to disclose. As a result, those persons and entities may not be available for searches against the Federal databases.

    - The CMS review team followed up on exclusion searches to determine if they are being performed by the state and the MCEs. The state's comments echoed those referenced in Section 1 of this report in the discussion of the federal database checks required at 42 CFR 455.436. As a result of restrictions placed on the use

of the U.S. Department of the Treasury Do Not Pay program, New York is seeking out alternate ways to perform automated monthly searches of the EPLS for debarments. It is not yet in compliance with the monthly search requirement.

- The CMS review team followed up on the state's reporting of adverse action notification to the HHS-OIG. The CAP did not address the state's reporting of enrollment denials to the HHS-OIG. The changes to the model contract for mainstream MCEs only requires the reporting of any adverse actions based on program integrity reviews and only addresses the reporting of enrollment denials for criminal conviction reasons. Since not all MCEs were reporting actions taken against a provider's enrollment to the state, the state mentioned it would monitor the reporting of adverse actions taken by the MCEs during its bi-annual Operational Survey. However, this would not allow for timely reporting if any plans were found out of compliance.

Summary:

The state addressed all questions asked during the CAP review. Some potential compliance issues such as federal database searches and adverse action reporting are not fully resolved at this time. Going forward, the state's managed care oversight should take into account the recommendations in this report. CMS will periodically monitor the state's activities in this regard as well as the outstanding CAP issues.

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

April 1, 2016

Ms. Laurie Battaglia
Acting Director of the Division of State Program Integrity
Centers for Medicare and Medicaid Services – Center for Program Integrity
Investigations and Audits Group
Laurie.Battaglia@cms.hhs.gov

Dear Ms. Battaglia:

New York State (NYS) hereby submits its Formal Response and Corrective Action Plan to the Focused Program Integrity Review conducted of NYS by the Centers for Medicare and Medicaid Services (CMS) for FFY2014. We appreciate the opportunity to respond and believe the input CMS provides in this report is valuable in strengthening the Medicaid program in NYS.

NYS remains a national leader in its oversight of the Medicaid program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department of Health (Department), NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Enclosed please find NYS's comments on the Final Report, as well as the State's Corrective Action Plan outlining measures that have been or will be implemented to address the Recommendations made by CMS.

Sincerely,

Dennis Rosen
Medicaid Inspector General
Office of the Medicaid Inspector General

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health

Enclosures