NEW YORK STATE | Office of the Medicaid Inspector General

Division of Medicaid Audit
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Audit Project Fact Sheet

Managed Care Program Integrity Reviews

Audit Profile

Year Under Review
2018

Audits Initiated
15

Final Audit Reports
11

Positive Audit Reports
3

Overpayments Identified
$5 Million

Project Summary

Managed Care Program Integrity Reviews (MCPIR) are reviews of Medicaid managed care organizations (MMCO) to assess their compliance with the program integrity requirements specified in their contract with the department of Health (DOH). NYS Social Services Law 364-j(36)(b) provides that "The Medicaid inspector general shall conduct periodic reviews of the contractual performance of each [MMCO] as it relates to the [MMCO's] program integrity obligations under its contract with the department." Where OMIG determines that an MMCO is not meeting its program integrity obligations, OMIG may recover up to 2% of the administrative component of the Medicaid premium paid to the MMCO for the period under review.

OMIG initiated 15 reviews in 2019, that covered a review period of January 1, 2018, through December 31, 2018. In these reviews OMIG assessed MMCO compliance with the program integrity provisions in the Medicaid Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract. Each review consisted of an assessment of 15 different program integrity obligations including the MMCO's compliance program, restricted recipient program, fraud and abuse reporting, exclusions checks, etc.

Matrix

Prior to conducting these audits, OMIG published a Matrix on its website summarizing the requirements it would be assessing in its reviews and how performance would be measured. For the 2018 reviews, there were 15 Matrix Lines.

Scoring

In conducting these reviews, OMIG assessed MMCO performance across the 15 Matrix Lines. The average score of those lines was then the MMCO's final score. If an MMCO scored 90% or above, then no overpayment was identified for recovery. Scores between 60% and 89% resulted in a recovery between 0.067% and 1.93%, depending on the score. Scores below 60% would result in a 2% recovery.

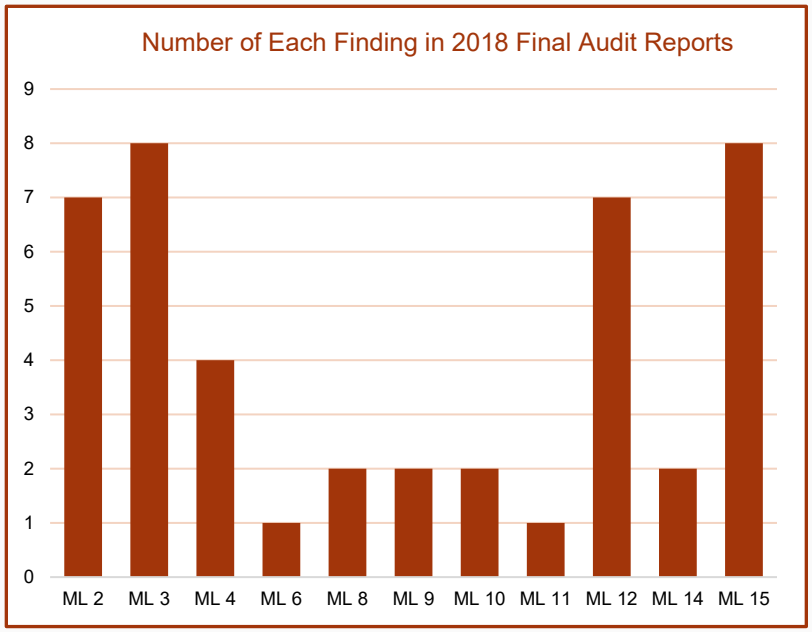
MMCO Program Integrity

MMCOs are required, through their contract with DOH, to implement and maintain administrative arrangements or procedures that are designed to detect and prevent fraud, waste and abuse. These arrangements include, but are not limited to, having a compliance program, reporting of identified or recovered overpayments, service verification, referral of any confirmed or suspected fraud and abuse to the State, suspension of payments where there is a credible allegation of fraud, procedures for providers to self-disclose overpayments, and checking the exclusion status of network providers, subcontractors and managing employees.

Audit Findings

Line #	Requirement
ML-1*	SDOH Certification
ML-2	State and Federal Databases and Excluded Providers
ML-3	Participating Provider- Federal Database Checks
ML-4	Report, Explain and Adjust
ML-5*	Administrative and Management Arrangements to Prevent Fraud and Abuse
ML-6	Fraud and Abuse Prevention Plan and Special Investigation Units (SIU)
ML-7*	Service Verification
ML-8	Withholds for Credible Allegations of Fraud
ML-9	Restricted Recipient Program Review Team Composition
ML-10	Restricted Recipient Program Processes and Monitoring
ML-11	Restricted Recipient Program Document Retention
ML-12	Reporting Cases of Fraud and Abuse
ML-13*	Reporting Recipient Restrictions
ML-14	Deficit Reduction Act
ML-15	Provider Investigative Report

*No findings in this review period.



Common Findings

Overpayment Reporting

MMCOs are required to submit reports on amounts of overpayments identified and recovered, including copies of any settlement agreements with providers. Accurate reporting of overpayments identified or recovered by MMCOs to the State is necessary to measure MMCO performance in the detection and prevention of fraud, waste and abuse. OMIG found several instances where MMCO's did not fully comply with these requirements.

Exclusion Lists

MMCOs are required to check certain state and federal databases, such as the OMIG list of excluded individuals, and to confirm that its network providers are checking such databases for their managing employees. Such checks are essential for ensuring that payments are not being made to individuals and entities excluded from participation in the Medicaid program. OMIG found several instances where MMCO's did not fully comply with these requirements.

Fraud and Abuse Reporting

MMCOs were required to submit ongoing referrals of confirmed or suspected fraud and abuse to OMIG, and following making the referral, MMCOs were prohibited from taking certain actions without OMIG's written approval. These requirements support OMIG's role in conducting investigations of provider fraud and abuse, taking administrative action or referring to law enforcement where appropriate. OMIG found several instances where MMCO's did not fully comply with these requirements.

Finalized Audits

Audit #	MMCO Name	Score	Recovery %*	Final Audit Amount
19-5107	Affinity Health Plan, Inc.	90%	0.00%	$0
19-4742	Capital District Physician Health Plan	93%	0.00%	$0
19-5111	Excellus Health Plan Inc	93%	0.00%	$0
19-4743	Fidelis Care	81%	0.60%	$2,233,563.12
19-5128	HealthNow NY Inc	87%	0.20%	$25,252.21
19-4741	HealthPlus HP LLC	84%	0.40%	$431,362.43
19-4740	Health Insurance Plan of Greater NY	73%	1.13%	$576,731.80
19-6251	Independent Health Association	89%	0.06%	$11,178.01
19-6252	MetroPlus Health Plan Inc	91%	0.00%	$0
19-6255	Molina Healthcare of New York	86%	0.26%	$22,406.57
19-6256	MVP Health Plan	96%	0.00%	$0
19-6257	United Healthcare of NY	75%	1.00%	$1,364,435.94
19-6258	WellCare of New York Inc	77%	0.86%	$271,742.61
19-6259	YourCare Health Plan, Inc	80%	0.66%	$90,337.37

*Recovery % is the percentage of the administrative component of the rate paid to the plan for the year under review that corresponds to the identified overpayment in the final audit report.
^Audit reports are available on the OMIG website for 5 years.