Medicaid Managed Care Program Integrity Reviews
Matrix of Contract Obligations and Performance Standards

In accordance with New York State Social Services Law ("SSL") 364-j(36)(b), the New York State Office of the Medicaid Inspector General ("OMIG"), in consultation with the Department of Health, is required to publish on its website a list of those contractual obligations, including benchmarks, by which a Medicaid managed care plan's program integrity performance shall be evaluated. This Matrix pertains to the March 1, 2019, as amended March 1, 2020 and April 1, 2021, Medicaid Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (the "Contract") and is for Medicaid Managed Care Program Integrity Reviews ("MCPIR") conducted with a Review Period from January 1, 2023 through December 31, 2023.

Pursuant to SSL 364-j(36)(c), where OMIG determines that a Managed Care Organization ("MCO") is not meeting its program integrity obligations under the Contract, OMIG may recover up to 2% of the administrative component of the Medicaid premium paid to the MCO for the period under review. OMIG shall evaluate MCO performance under each line of this Matrix and assess a score for that line (between 0% and 100%), and then take the average score for all Matrix Lines ("ML").

The recovery percentage shall be calculated based on the following ranges of the average score:

Average Score	Recovery Percentage
≤70%	2%
>70% and <80%	1.5%
≥80% and <90%	1.0%
≥90% and <100%	.5%
100%	0%

This Matrix does not constitute rulemaking by OMIG and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in this Matrix alters any statutory, regulatory, or contractual requirement and the absence of any contractual requirement from this Matrix does not preclude the State from evaluating or enforcing the requirement. In the event of a conflict between statements in this Matrix and either statutory, regulatory or contractual requirements, the requirements of the statutes, regulations and contracts shall govern. Furthermore, this Matrix does not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend this Matrix as necessary to address identified issues of non-compliance. Additional reasons for amending this Matrix include, but are not limited to, responding to a hearing decision, litigation decision, or statutory, regulatory or contractual change. Any amendment to this Matrix will be published on OMIG's website.

All terms and acronyms contained within this Matrix, unless otherwise noted, shall have the same meaning as defined in Section 1 and Appendix Q of the Contract.

ML	Obligation	Performance Standard	Measurement Assessment	Benchmark
Fraud, Waste and Abuse Prevention				
1	**State and Federal Databases and Excluded Providers** Section 18.9(b) & (c), 21.5(a)	The MCO checked its employees, Participating Providers and Non-Participating Providers against the Federal and State databases, at the frequency specified in the Contract. The MCO took the required action upon identification of an excluded individual or entity, as specified in the Contract.	OMIG will review to determine if the MCO performed the checks of the Federal and State databases identified in the Contract, at the frequency required. To determine if the MCO met its obligation, OMIG will complete a review of the databases and compare its results to the list of terminated provider agreements provided by the MCO.	The MCO performed all the required checks on all employees, Participating Providers and Non-Participating Providers, and took the required action if found to be excluded.
2	**Provider Managing Employees – Federal Database Checks** Section 18.9(d)	The MCO confirmed that its providers had procedures to identify and determine the exclusion status of managing employees through checks of Federal databases, at the frequency required in the Contract.	The MCO shall provide and OMIG will review documentation demonstrating that the MCO confirmed that providers had the procedures in place to identify and determine the exclusion status of managing employees.	The MCO confirmed that its providers had procedures in place to identify and determine the exclusion status of managing employees.
3	**Reporting Payments to Excluded Providers** Section 21.5(d)	The MCO reported and explained within sixty (60) days of identification of payments made to excluded providers and identified the date on which the encounter data was adjusted to reflect the recovery.	OMIG will review the corresponding encounter data to determine if the encounter data was adjusted.	All inappropriate payments were reported within sixty (60) days of identification and the encounter data was adjusted.
4	**Compliance Program** Section 23.2(a)	The MCO had a mandatory compliance program, that included all seven (7) elements identified under Section 23.2(a) of the Contract.	The MCO shall provide and OMIG will review evidence to determine that it had a compliance program that met the requirements of the Contract.	OMIG determines that the MCO had a compliance program that had the seven (7) elements identified in 23.2(a) of the Contract.
5	**Fraud, Waste and Abuse Prevention Program and Special Investigation Units (SIU)** Section 35.1 (18 NYCRR 521-2.4)	The MCO had a Fraud, Waste and Abuse Prevention Program, that includes a Special Investigation Unit (SIU), that met contractual, statutory, and regulatory requirements.	The MCO shall provide its Fraud, Waste and Abuse Prevention Program and OMIG will review to determine that it met contractual, statutory, and regulatory requirements.	OMIG determines that the Fraud, Waste and Abuse Prevention Program, that includes a Special Investigation Unit (SIU), met contractual, statutory, and regulatory requirements.

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6	**Service Verification** Section 23.6	The MCO implemented a service verification process that evaluated the delivery of billed services to the recipient population by using statistically valid sample sizes and timeframes.	The MCO shall provide a list of all verifications conducted during the Review Period.	OMIG determines that the MCO established a process to determine whether enrollees received services billed by Providers by evaluating a sample size of the recipient population.
7	**Report, Return and Explain Overpayments** Section 22.7(e), 35.1 (18 NYCRR 521-2.4(f), (h)(2))	The MCO had procedures for their Participating Providers, Non-Participating Providers, Subcontractors and all other third parties to report when it has received an overpayment within sixty (60) calendar days after the date on which the overpayment was identified. The MCO included information on its website on how and where to report, return and explain overpayments.	The MCO shall provide and OMIG will review its procedures and website to determine that they contained the required information and instruction.	The MCOs procedures provided instruction to the necessary parties on the need to report overpayments within sixty (60) calendar days after the overpayment was identified.
				The MCOs website contained information on how and where to report, return and explain overpayments to the MCO.
8	**Restricted Recipient Program Review Team Composition** Appendix Q, section (1)(f)	The MCO was required to maintain a Restricted Recipient Program Review Team (RRPRT) comprised of at minimum: one (1) physician, one (1) registered professional nurse, and one (1) pharmacist.	The MCO must provide a list of the RRPRT members. The professional members of the RRPRT should be listed and their titles must be included. OMIG will review the list provided by the MCO to ensure that the composition of the RRPRT met the minimum contractual obligations.	The RRPRT must contain the minimum number of professional members, in each required professional category.
9	**Restricted Recipient Program Processes and Monitoring** Appendix Q, section (3)	The MCO was required to have: • effective mechanisms to ensure that an Enrollee was restricted to an RRP Provider within 45 days of confirming that an enrollee met conditions outlined in the Contract; • effective mechanisms to monitor the activity of all Restricted Enrollees to ensure that enrollees are only accessing the restricted service through the Restricted Recipient Program Provider(s) (RRP); and • criteria for determining whether an Enrollee has engaged in Abusive Practices or demonstrated a pattern of misuse of Benefit Package services.	The MCO must provide dates of implementation for OMIG directed restrictions and OMIG will review to determine if timely.	OMIG determines that the MCO had mechanisms that ensured that restrictions were implemented within 45 days of confirming that an enrollee met certain conditions outlined in Section 2(a) of Appendix Q.
			OMIG will review encounter and claims data to determine if payments were made to providers that were not an enrollee's RRP Provider.	OMIG determines that the encounter and claims data demonstrate that the MCO had effective mechanisms to ensure that all services were provided by a designated RRP Provider.
			The MCO must provide documentation that it established criteria in accordance with Appendix Q, Section (3)(e).	OMIG determines that the MCO has established criteria for determining whether an Enrollee has engaged in Abusive Practices or demonstrated a pattern of misuse of Benefit Package services that was in accordance with 18 NYCRR 360-6.4 and consistent with criteria established by OMIG, pursuant to Appendix Q, section (3)(e).

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10	**Restricted Recipient Program Document Retention** Appendix Q, section (7)	The MCO maintained a file for each review conducted by the RRPRT and for each Restricted Recipient. Each file shall include the required components identified under Appendix Q, section (7) and be readily available for review by SDOH and OMIG, on-site or off-site, upon request.	The MCO shall provide their Restricted Recipient Program (RRP) policies and procedures, and the file for those Restricted Recipient files requested. OMIG will review the files to determine compliance with the requirements of Appendix Q, section (7).	The MCO policies and procedures demonstrate that they maintained a file for each review conducted by the RRPRT and for each Restricted Recipient.
				OMIG determines that the MCO Restricted Recipient files requested from the MCO are readily available for review and contain the required components pursuant to Appendix Q, section (7) of the Contract.
Reporting Requirements				
11	**Reporting Cases of Fraud, Waste and Abuse** Section 18.5(a)(vii)(A)(II), (III)	The MCO submitted timely reports of potential fraud, waste or abuse which contained all required components identified in the Contract. The MCO received written authorization from the OMIG before taking any of the actions identified under section 18.5(a)(vii)(A)(III)(3) regarding potential fraud, waste or abuse.	Each report submitted will be reviewed by OMIG to determine timeliness and completeness. OMIG will review to ensure that the MCO received written authorization before taking any of the actions identified under section 18.5(a)(vii)(A)(III)(3) regarding potential fraud, waste or abuse.	All reports submitted are determined by OMIG to be timely and complete. The MCO received written authorization from OMIG prior to taking any of the actions identified under section 18.5(a)(vii)(A)(III)(3) regarding potential fraud, waste or abuse.
12	**Reporting Recipient Restrictions** Section 18.5(a)(viii)(A)(I)-(II) Appendix Q, section 4(h)(i)	The MCO had the obligation to report Enrollee Restriction(s) at the time they became effective as well as when there is any continued restriction period. The MCO must also have reported any changes to an existing restriction on a monthly basis. Each report submitted must have conformed to the form and format requirements specified by the SDOH and OMIG.	OMIG will compare the restriction dates to the date the MCO reported the new and continued Enrollee Restriction(s), and whether the MCO reported, at least monthly, changes to existing restrictions	New restrictions were reported at the time the restriction became effective.
				Continued restrictions were reported at the time the restriction was continued.
				Changes to existing restrictions were reported monthly.
13	**Provider Investigative Report** Section 18.5(a)(viii)(F)	The MCO timely submitted twelve (12) monthly Provider Investigative Reports (PIR) during the calendar year of the Review Period. Each report submitted must have conformed to the form and format requirements as specified by OMIG. The report includes copies of any agreements where applicable, a summary of the investigative results, and the Chief Financial Officer (CFO) attesting to the accuracy of the data for each report submitted.	OMIG will review the PIRs submitted by the MCO to ensure each submission included a valid CFO certification, that the reports conformed to form and format requirements, that the reports were submitted timely, that settlement agreements were submitted where applicable, and will review the content of the report for completeness and accuracy.	The MCO timely submitted twelve (12) PIRs during each calendar year of the Review Period.
				Each submission contained a valid certification.
				Each report was accurate based on OMIG's review of a subset of report fields.