Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK STATE MADE UNALLOWABLE MEDICAID FEE-FOR-SERVICE PAYMENTS FOR BENEFICIARIES ALSO ENROLLED IN MEDICAID MANAGED CARE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Deputy Inspector General

January 2014
A-02-12-01007

Office of Inspector General

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EXECUTIVE SUMMARY

New York State claimed at least $23.4 million over approximately 5 years in unallowable Federal Medicaid reimbursement for fee-for-service payments for beneficiaries also enrolled in managed care.

WHY WE DID THIS REVIEW

During a prior review, we identified a vulnerability in New York State's Medicaid program. Specifically, we found that New York assigned some Medicaid beneficiaries more than one Medicaid identification number, resulting in separate Medicaid managed care payments being made for the same beneficiary. The review raised concern that Medicaid fee-for-service payments could also be vulnerable.

The objective of this review was to determine whether the New York State Department of Health (State agency) prevented separate Medicaid fee-for-service payments for inpatient hospital services from being made on behalf of beneficiaries who were also enrolled in a Medicaid managed care organization (MCO).

BACKGROUND

Federal regulations authorize payments to States for eligible Medicaid beneficiaries enrolled in an MCO. States may enter into comprehensive risk contracts with MCOs for the provision of medical services to enrollees. A comprehensive risk contract provides for the coverage of comprehensive medical services, including inpatient hospital services. States must ensure that no payments are made to providers other than MCOs for services available under the contract between the States and the MCOs.

In New York, the State agency electronically maintains eligibility information in its Welfare Management System, which operates as two separate systems: one for beneficiaries residing in New York City and one for beneficiaries residing elsewhere in the State.

HOW WE CONDUCTED THIS REVIEW

Our review covered Medicaid-reimbursed services related to 3,984 inpatient hospital admissions, totaling approximately $51.4 million ($25.7 million Federal share), paid for the same month that a managed care payment was made for the same beneficiary under a different Medicaid identification number during the period October 1, 2006, through November 30, 2011. We reviewed all fee-for-service payments related to our random sample of 107 inpatient hospital admissions.

WHAT WE FOUND

The State agency did not prevent separate Medicaid fee-for-service payments from being made for beneficiaries also enrolled in a Medicaid MCO. Specifically, for all 107 inpatient admissions included in our sample, the State agency improperly claimed Federal Medicaid fee-for-service

reimbursement for inpatient hospital services on behalf of beneficiaries for whom separate Medicaid managed care payments were made under a different Medicaid identification number. These improper payments occurred because the State agency operated two eligibility systems that did not identify beneficiaries with multiple Medicaid identification numbers. In addition, local departments of social services did not use all available resources within the systems to ensure that beneficiaries were not issued multiple Medicaid identification numbers.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $23,406,895 in Federal Medicaid fee-for-service reimbursement for inpatient hospital services made on behalf of beneficiaries for whom separate Medicaid managed care payments were also made.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $23,406,895 to the Federal Government and

- use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially agreed with our first recommendation (financial disallowance) and generally agreed with our second recommendation. Specifically, the State agency indicated that the amount it should recover and refund to the Federal Government is significantly less than what we recommended because some of the beneficiaries associated with the unallowable claims were ineligible for enrollment in the Medicaid MCO during our audit period. Therefore, according to the State agency, the beneficiaries' associated fee-for-service claims were billed correctly. The State agency stated that rather than recover the fee-for-service payments for these beneficiaries, it should recover the monthly capitation payment made to the Medicaid MCO. Finally, the State agency described steps that it has taken or planned to take to ensure that no beneficiary is issued multiple Medicaid identification numbers.

After reviewing the State agency's comments on our draft report, we maintain that our findings are valid. The State agency did not prevent separate fee-for-service payments from being made for beneficiaries already enrolled in Medicaid MCOs. If beneficiaries were ineligible for enrollment in an MCO, the State agency should have disenrolled them from the MCO when they became ineligible (i.e., prior to claiming reimbursement for services on a fee-for-service basis). In order for the State agency to determine the appropriate amount it should recover using the approach it described in its comments, it would have to develop a sampling frame of monthly capitation payments made for these beneficiaries during the audit period. The State agency would then have to estimate the total unallowable monthly capitation payments made on behalf of beneficiaries ineligible for enrollment in MCOs.

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INTRODUCTION

WHY WE DID THIS REVIEW

During a prior review, we identified a vulnerability in New York State's Medicaid program. Specifically, we found that New York assigned some Medicaid beneficiaries more than one Medicaid identification number, resulting in separate Medicaid managed care payments being made for the same beneficiary.[1] The review raised concern that Medicaid fee-for-service payments could also be vulnerable.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) prevented separate Medicaid fee-for-service payments for inpatient hospital services from being made on behalf of beneficiaries who were enrolled in a Medicaid managed care organization (MCO).

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

New York State's Medicaid Program

In New York State, the State agency administers the Medicaid program. Local departments of social services (local districts) are responsible for determining whether individuals applying for Medicaid meet eligibility requirements and ensuring that eligible individuals have only one active Medicaid identification number. Each county is considered its own local district, except the five counties that make up New York City, which are considered a single district.

The State agency pays Medicaid providers by one of two methods: the fee-for-service method, in which a provider is paid for every Medicaid-eligible service rendered to a beneficiary, and the capitation method, in which an MCO is paid a monthly fee to ensure that an enrolled beneficiary has access to a comprehensive range of medical services.

[1] *New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers* (A-02-11-01006, issued April 15, 2013).

Beneficiary Enrollment

The State agency electronically maintains eligibility information, including beneficiaries' Medicaid identification numbers, in its Welfare Management System (WMS).[2] The WMS operates as two systems: one for beneficiaries residing in New York City (downstate WMS) and one for beneficiaries residing elsewhere in New York State (upstate WMS). Local districts also use the WMS to assign Medicaid identification numbers. State agency guidance states that the local district is to check its WMS to determine whether an applicant is receiving medical or public assistance benefits and has been issued a Medicaid identification number.[3]

Federal Requirements

Federal regulations authorize payments to States for eligible Medicaid beneficiaries enrolled in an MCO.[4] States may enter into comprehensive risk contracts with MCOs for the provision of medical services to their enrollees.[5] A comprehensive risk contract provides for the coverage of comprehensive medical services, including inpatient hospital services.[6] States must ensure that no payments are made to providers other than MCOs for services available under the contract between the States and the MCOs.[7]

HOW WE CONDUCTED THIS REVIEW

Our review covered Medicaid fee-for-service payments that the State agency made for inpatient hospital services on behalf of beneficiaries also enrolled in a Medicaid MCO during the period October 1, 2006, through November 30, 2011.[8] We excluded 3,822 inpatient hospital admissions,[9] totaling $130,046,096 ($65,023,067 Federal share), that were not covered by MCO capitation payments. Our revised sampling frame consisted of 3,984 inpatient hospital

[2] The WMS maintains and processes information relating to individuals who have been determined eligible for benefits under all assistance programs, including Medicaid.

[3] The databases for both the downstate and upstate WMS compare the name, date of birth, Social Security number (SSN), and sex of an applicant to all other beneficiaries within the same database and produce a report of individuals with similar SSNs and/or names as the applicant. Local district employees are expected to review these reports to determine whether an individual applying for Medicaid is the same as another individual on the report with an existing Medicaid identification number.

[4] The Social Security Act, section 1903(m).

[5] 42 CFR § 438.6(b).

[6] 42 CFR § 438.2.

[7] 42 CFR § 438.60.

[8] These inpatient hospital services were all covered services by MCO capitation payments.

[9] An inpatient hospital admission consisted of all fee-for-service payments related to a beneficiary's inpatient hospital admission.

admissions, totaling $51,441,844 ($25,740,732 Federal share), of which we reviewed a random sample of 107 inpatient hospital admissions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDING

MEDICAID FEE-FOR-SERVICE PAYMENTS MADE ON BEHALF OF BENEFICIARIES ENROLLED IN MANAGED CARE

Sections 2(d)(2)(A) and (B) of the Improper Payments Information Act of 2002[10] define improper payments as any payments that should not have been made, including duplicate payments. Federal regulations (42 CFR § 438.60) require States to ensure that no payments are made to providers other than MCOs for services available under contracts between the States and the MCOs.

The State agency did not prevent separate Medicaid fee-for-service payments from being made for beneficiaries also enrolled in a Medicaid MCO. Specifically, for all 107 inpatient admissions included in our sample, the State agency improperly claimed Federal Medicaid fee-for-service reimbursement for inpatient hospital services on behalf of beneficiaries for whom separate Medicaid managed care payments were made under a different Medicaid identification number.

We identified several circumstances that caused the assignment of multiple Medicaid identification numbers and led to the same beneficiary being enrolled in both a Medicaid MCO and in the fee-for-service program during the same month. Specifically:

- **Beneficiaries were issued multiple Medicaid identification numbers through the different eligibility systems.** For 67 inpatient admissions, case records indicated that local districts assigned beneficiaries one Medicaid identification number through the upstate WMS and another through the downstate WMS.

- **Beneficiaries were issued multiple Medicaid identification numbers by the same local district offices.** For 22 inpatient admissions, case records indicated that beneficiaries applied multiple times for medical and/or public assistance benefits and were assigned more than one Medicaid identification number by the same local district office.

[10] The Improper Payments Information Act is codified at 31 U.S.C. § 3321.

- **Newborns and Supplemental Security Income beneficiaries were issued multiple Medicaid identification numbers.** For 18 inpatient admissions, case records indicated that a second Medicaid identification number was issued to a newborn or Supplemental Security Income (SSI) beneficiary even though the child or beneficiary already had an active Medicaid identification number.[11]

The improper payments made on behalf of these beneficiaries occurred because the State agency operated two eligibility systems that did not identify beneficiaries with multiple Medicaid identification numbers. In addition, local districts did not use all available resources within both the downstate WMS and upstate WMS to ensure that beneficiaries were not issued multiple Medicaid identification numbers. State agency guidance states that local district employees should review a WMS-generated report on potential beneficiary matches to determine whether an applicant is receiving medical or public assistance benefits and has been issued a Medicaid identification number. These reports, however, do not identify matches between the downstate WMS and upstate WMS. Local district employees have the ability to manually search both systems to determine whether an applicant in their district is currently enrolled in any medical or public assistance program or whether a newborn or SSI beneficiary already has a Medicaid identification number. However, local district employees did not effectively use these tools.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $23,406,895 in Federal Medicaid fee-for-service reimbursement for inpatient hospital services made on behalf of beneficiaries for whom separate Medicaid managed care payments were also made.

RECOMMENDATIONS

We recommend that the State agency:

- refund $23,406,895 to the Federal Government and

- use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially agreed with our first recommendation (financial disallowance) and generally agreed with our second recommendation. Specifically, the State agency indicated that the amount it should recover and refund to the Federal Government is significantly less than what we recommended because some of the beneficiaries associated with the unallowable claims were ineligible for enrollment in the Medicaid MCO during our audit period. Therefore, according to the State agency, the

[11] Both the State agency and local districts may assign a Medicaid identification number to a newborn or SSI beneficiary.

beneficiaries' associated fee-for-service claims were billed correctly. The State agency stated that rather than recover the fee-for-service payments for these beneficiaries, it should recover the monthly capitation payment made to the Medicaid MCO. Finally, the State agency described steps that it has taken or planned to take to ensure that no beneficiary is issued multiple Medicaid identification numbers.

The State agency's comments are included in their entirety as Appendix D.

OUR RESPONSE

After reviewing the State agency's comments on our draft report, we maintain that our findings are valid. The State agency did not prevent separate fee-for-service payments from being made for beneficiaries already enrolled in Medicaid MCOs.

States must ensure that no payments are made to providers other than MCOs for services available under the contract between the States and the MCOs. All of the inpatient services in our population were available under the MCO plans. If beneficiaries were ineligible for enrollment in an MCO, the State agency should have disenrolled them from the MCO when they became ineligible (i.e., prior to claiming reimbursement for services on a fee-for-service basis).

Because our objective was to determine whether the State agency prevented separate Medicaid fee-for-service payments for inpatient hospital services from being made on behalf of beneficiaries who were enrolled in a Medicaid MCO, we did not determine whether the sample beneficiaries were eligible for enrollment in a Medicaid MCO. In order for the State agency to determine the appropriate amount it should recover using the approach it described in its comments, it would have to develop a sampling frame of monthly capitation payments made for these beneficiaries during the audit period. The State agency would then have to estimate the total unallowable monthly capitation payments made on behalf of beneficiaries ineligible for enrollment in MCOs.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 3,984 inpatient hospital admissions, totaling $51,441,844 ($25,740,732 Federal share), paid for the same month that a managed care payment was made for the same beneficiary under a different Medicaid identification number during the period October 1, 2006, through November 30, 2011. An inpatient hospital admission consisted of all fee-for-service payments related to a beneficiary's inpatient hospital admission.

We limited our review of the State agency's internal controls to those applicable to our objective. Specifically, we obtained an understanding of the controls the State agency had in place to prevent inpatient claims from being made on behalf of beneficiaries enrolled in a Medicaid MCO. Additionally, we gained an understanding of the State agency's procedures for assigning Medicaid identification numbers to eligible beneficiaries.

We conducted fieldwork at 13 local districts throughout New York State, including New York City, from May through October 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and State guidance;
- met with State agency officials to obtain an understanding of the controls it had in place for preventing fee-for-service and managed care payments from being made for the same beneficiary;
- met with State agency and local district officials to gain an understanding of the procedures for assigning Medicaid identification numbers and preventing the assignment of multiple Medicaid identification numbers;
- identified beneficiaries who have the same SSN, matching beneficiary information (i.e., name, date of birth, and sex), and more than one Medicaid identification number;
- ran computer programming applications at the Medicaid Management Information System fiscal agent that identified a sampling frame of 7,806 inpatient hospital admissions, totaling $181,487,940 ($90,763,799 Federal share), paid during the same month that a managed care capitation payment was made for the same beneficiary under a different Medicaid identification number during the period October 1, 2006, through November 30, 2011;
- excluded 3,822 inpatient hospital admissions, totaling $130,046,096 ($65,023,067 Federal share), that were not covered by the managed care capitation payment;

- determined that our revised sampling frame consisted of 3,984 inpatient hospital admissions, totaling $51,441,844 ($25,740,732 Federal share);

- selected a stratified random sample of 107 inpatient admissions from the sampling frame;

- obtained and reviewed case record documentation from the local district(s) for each sample item to determine whether a beneficiary was issued multiple Medicaid identification numbers;

- estimated the unallowable Federal Medicaid fee-for-service reimbursement paid in the total population of 3,984 inpatient hospital admissions; and

- discussed the results of our review with State officials.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of inpatient hospital admissions made during the same month that a managed care payment was made for the same beneficiary under different Medicaid identification numbers during the period October 1, 2006, through November 30, 2011. An inpatient admission consisted of all fee-for-service payments related to a beneficiary's inpatient hospital admission.

SAMPLING FRAME

The sampling frame consisted of an Access file containing 3,984 inpatient hospital admissions, totaling $51,441,844 ($25,740,732 Federal share), made during the same month that a managed care payment was made for the same beneficiary during the period October 1, 2006, through November 30, 2011. The inpatient and managed care payments were extracted from the New York State Medicaid Management Information System.

SAMPLE UNIT

The sample unit was an inpatient hospital admission.

SAMPLE DESIGN

We used a stratified random sample as follows:

- Stratum 1: inpatient hospital admissions with total payments less than or equal to $4,700 = 2,511 inpatient hospital admissions totaling $13,223,300 ($6,612,655 Federal share).

- Stratum 2: inpatient hospital admissions with total payments greater than $4,700 and less than or equal to $15,500 = 1,208 inpatient hospital admissions totaling $18,754,819 ($9,389,189 Federal share).

- Stratum 3: inpatient hospital admissions with total payments greater than $15,500 and less than or equal to $90,000 = 248 inpatient hospital admissions totaling $14,880,571 ($7,447,311 Federal share).

- Stratum 4: inpatient hospital admissions with total payments greater than $90,000 = 17 inpatient hospital admissions totaling $4,583,154 ($2,291,577 Federal share).

SAMPLE SIZE

We selected a sample of 107 inpatient admissions as follows:

- 30 admissions from stratum 1,
- 30 admissions from stratum 2,
- 30 admissions from stratum 3, and
- 17 admissions from stratum 4.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each of the first three strata. After generating 30 random numbers for each of these strata, we selected the corresponding frame items. We selected all 17 sample units in stratum 4.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the total amount of unallowable Medicaid fee-for-service payments that the State agency made for inpatient hospital services.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum	Inpatient Admissions in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Inpatient Admissions With Unallowable Fee-for-Service Payments	Value of Unallowable Fee-for-Service Payments (Federal Share)
1	2,511	$6,612,655	30	$78,033	30	$78,033
2	1,208	9,389,189	30	216,304	30	216,304
3	248	7,447,311	30	904,665	30	904,665
4	17	2,291,577	17	2,291,577	17	2,291,577
Total	**3,984**	**$25,740,732**	**107**	**$3,490,579**	**107**	**$3,490,579**

Estimated Value of Unallowable Services (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$25,011,364
Lower limit	23,406,895
Upper limit	26,615,834

APPENDIX D: STATE AGENCY COMMENTS

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

October 10, 2013

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Ref. No. A-02-12-01007

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General draft audit report number A-02-12-01007 entitled, "New York State Made Unallowable Medicaid Fee-For-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care."

Thank you for the opportunity to comment.

Sincerely,

Michael J. Nazarko

Michael J. Nazarko
Deputy Commissioner
for Administration

Enclosure

cc: Jason A. Helgerson
James C. Cox
Diane Christensen
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New York State Department of Health
Comments on the
U.S. Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-12-01007 Entitled,
New York State Made Unallowable Medicaid
Fee-For-Service Payments for Beneficiaries Also
Enrolled in Medicaid Managed Care

The following are the New York State Department of Health's (Department) comments in response to the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-12-01007 entitled, "New York State Made Unallowable Medicaid Fee-For-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care."

Recommendation #1:

Refund $23,406,895 to the Federal Government.

Response #1:

The Department does not agree with the recovery of $23,406,895 to the Federal Government for the audit period October 1, 2006 through November 30, 2011. The Office of the Medicaid Inspector General's (OMIG) analysis (which the Department has independently confirmed) reveals that the total recovery will be significantly less than the $23.4 million originally estimated by the OIG because the Federal government's refund calculation methodology is solely based on the recoupment of the fee-for-service (FFS) claims paid during the audit period. We disagree with this analysis because at least 60 of the 107 individuals in the sample were ineligible for enrollment in Medicaid Managed Care (MMC) Plans during the audit period, and billed the FFS claims correctly. In these instances, it is the monthly per member per month capitation payment made to the MMC Plan that should be recovered, not the FFS payment. Therefore, the recoupment amounts will be less than the Federal Government's estimates as stated in the draft audit report #A-02-12-01007.

The Department will work with OMIG to recover all inappropriate payments and any Federal share of these overpayments will be refunded to the Federal government.

Recommendation #2:

Use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State.

Response #2:

The Department continues to make every possible effort to eliminate the creation of duplicate Client Identification Numbers (CIN) for Medicaid consumers. Duplicate CIN identification

processes to correct duplicate CIN situations are in place on the eligibility side. With the advent of the new marketplace, New York State of Health (NYSOH), new processes are being implemented to minimize or eliminate the creation of multiple CINs for enrolled individuals. The eligibility system for NYSOH will phase in the entire Medicaid population and eventually the human services programs such that one system will be used to generate CINs. DOH will be doing a "Central Clearance" of all three systems (NYSOH, Welfare Management System (WMS) Upstate/Downstate) to prevent duplicate CINs to the maximum extent possible. However, the data matching is more challenging given the differences for the collection and storage of data between the old WMS and new NYSOH.

For managed care enrollments, CIN identified as being duplicates are blocked from batch enrollments (enrollment broker or auto assignment from the WMS). The Department has developed a coding process with a hierarchy of checks and sends duplications to the counties to be corrected. The bulk of the duplication errors have already been processed, or will be in the near future, however, the Department will continue to clean-up duplications on an on-going basis.