NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

March 20, 2015

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2014-F-7 entitled, "Improper Managed Care Payments for Certain Medicaid Recipients." (2010-S-66)

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2014-F-7 Entitled,
Improper Managed Care Payments for Certain
Medicaid Recipients (2010-S-66)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2014-F-7 entitled, "Improper Managed Care Payments for Certain Medicaid Recipients." (2010-S-66)

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1:

Investigate the $15.6 million in improper Medicaid managed care payments identified in this audit and recover funds where possible and appropriate.

Status - Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. OMIG recovered $6.4 million of the $15.6 million in improper managed care premium payments we identified in our initial audit and anticipates another $800,000 in recoveries pending the outcome of an administrative hearing with one managed care plan. However, OMIG officials informed us that approximately $8.4 million in overpayments were not recovered for various reasons, including the following:

- $5.5 million because managed care plans were considered "at risk" for the provision of services (i.e., a plan paid a health care provider for a service to a Medicaid recipient during a month that our audit determined an improper managed care payment was made);
- $1 million because claims were more than six years old; and
- $443,907 because managed care plans had closed and been liquidated.

We analyzed the $5.5 million in claims that OMIG officials believed were unrecoverable because the managed care plans were considered at risk. Based on our review, we determined the plans were not, in fact, at risk for $4.1 million in claim payments, and the OMIG (at the time of our initial report) could have recovered them. However, by the time of our follow-up, only $1.4 million (of the

$4.1 million) remained recoverable, as many of the claims are now more than six years old and beyond the statutory limit for recovery. Thus, OMIG should take immediate action to recover the $1.4 million in improper payments that still can be recovered.

Response #1:

The OMIG is currently in the process of reviewing the improper payments per this audit. Upon completion of this review, all payments deemed improper and recoverable will be recouped.

Recommendation #2:

Direct that ACS and local districts, particularly the New York City HRA, take the steps necessary to prevent the issuance of multiple identification numbers to Medicaid recipients. The steps should include (but not be limited to) verification that a Medicaid applicant does not already have a Medicaid identification number.

Status - Implemented

Agency Action - Our initial audit determined many of the improper enrollments, with multiple identification numbers for the same person, were primarily attributable to a lack of oversight by two New York City agencies: the Administration for Child Services (ACS) and the Human Resources Administration (HRA). ACS establishes Medicaid identification numbers for children under the foster care daily rate program in New York City, and HRA establishes Medicaid identification numbers for children enrolling in Medicaid managed care.

In April 2013, the Department issued a General Information System (GIS) message, which directed local districts (including HRA) to take the steps necessary to prevent the issuance of multiple identification numbers to Medicaid recipients. The GIS provided detailed instructions on available tools and various steps to take, including how to verify that a Medicaid applicant does not already have a Medicaid identification number. According to Department officials, they do not have primary State oversight authority over ACS, and therefore they did not direct the ACS to take any remedial action. However, officials did notify the Office of Children and Family Services (the State agency that has primary oversight authority over ACS) of our initial audit's findings so that ACS can take the appropriate actions.

Response #2:

The Department confirms our agreement with this report.

Recommendation #3:

Develop and implement Medicaid exception reports which detail payments for a recipient with multiple identification numbers, when one identification number is linked to managed care and the other to a daily rate for foster care.

Status - Not Implemented

Agency Action - The Department did not develop exception reports that detail payments for a recipient with multiple identification numbers when one identification number is linked to managed care and the other to a daily rate for foster care. The Department generates bi-monthly duplicate CIN reports for local districts to use to identify and eliminate duplicate CINs. However, these reports are not specifically designed to identify recipients with multiple identification numbers, when one number pertains to managed care and another pertains to a foster care daily rate program.

Response #3:

The Department respectfully disagrees with the OSC to develop and implement a new Medicaid exception report as recommended. An exception report to specifically identify recipients with multiple identification numbers, when one identification number is linked to managed care and the other to a daily rate for foster care, was evaluated and subsequently not considered for implementation for several reasons as described below.

Discussions concluded that a recipient with multiple identification numbers would be included and captured in existing duplicate Client Identification Number (CIN) reports regardless of their program participation. There are additional MOBIUS reports available to the Local Districts which assist the districts in identifying and reconciling multiple identification numbers that include:

- BMWP4004 - Eligible Multiple Client IDs;
- BOWP4001 - Error Report-Multiple CIN;
- BOWP4011 - Suspected Multiple ID;
- BOWP4012 - Suspected Multiple ID DSS Case;
- BOWP4021 - Multiple Current Client Eligibility Update; and
- BOWP4022 - Multiple Original Client Eligibility

Therefore, it was decided that there were sufficient reports to capture this population and thus the Department will not be developing a new Medicaid exception report.

Recommendation #4:

Formally remind long-term care providers, foster care programs, and MCOs to advise local district officials when recipients are no longer eligible for managed care services.

Status - Partially Implemented

Agency Action - In the March 2013 Medicaid Update, the Department reminded long-term care providers to advise local district officials when recipients are no longer eligible for managed care services. However, the Department was unable to show that foster care programs and MCOs (managed care organizations) were formally reminded.

Response #4:

On January 28, 2015 the Department communicated the following to Local District of Social Services (LDSS) Foster Care Directors, LDSS Medicaid Directors and LDSS Managed Care Coordinators:

> The purpose of this email is to clarify the status of Foster Care children in regard to Medicaid managed care and the actions needed to properly process these cases. The Office of the State Comptroller's audit 2014 F-7 has recommended that program directors who oversee Foster Care at the LDSS level be reminded of the importance of proper and timely Medicaid managed care operational policy.
>
> The Centers for Medicare and Medicaid Services approved the Department's mandatory enrollment of Foster Care children into managed care, commencing April 2013. Initial implementation was for districts outside of New York City (NYC). The targeted population was enrollment of children living in the community who were non-agency direct placements by the LDSS. The rollout of mandatory enrollment for the non-agency based children was completed October 1, 2013. Agency based Foster Care children, NYC and non-NYC, remain excluded from Medicaid managed care, as do institutionalized Foster Care children.

All non-agency based (outside of NYC) Foster Care children should be enrolled into Medicaid managed care, unless otherwise exempt or excluded.

In April 2013 the Department issued a policy paper that defined the policies and procedures for both enrollments and disenrollments. Of particular concern to the Department is the generation of duplicate Client Identification Numbers (CIN) for Foster Care children. Audits have revealed that often LDSS open a second CIN for the services case while there is concurrent open CIN with Medicaid coverage that is or becomes enrolled in managed care. The results of this action are twofold: fee for service payments to providers that should be covered by a managed care plan for an enrollable Foster Care child, or managed care capitation payments on the non-services CIN for a Foster Care child who should have been excluded from managed care. Medicaid must not pay fee for service payments for benefits covered by managed care plans nor will it pay capitation payments for excluded individuals. LDSS must carefully examine new and current Foster Care cases to ensure proper enrollment/eligibility policies are being followed.

GIS 13 MA/010 issued November 20, 2007 reminds LDSS Foster Care staff of procedures related to assignment of CINs. Due to the confidential nature of Service cases, prescriptive rules apply to data usage. This requires that LDSS take elevated action in clearance work to eliminate the creation of multiple Medicaid authorizations. Any discovered cases of multiple coverage must be resolved timely and Medicaid payment recoveries made, where appropriate.

Based on this communication, the status of this recommendation should be revised to fully implemented.

Recommendation #5:

Strengthen steps to oversee and monitor Medicaid managed care enrollments. The steps should include (but not be limited to):

- periodic formal analysis of managed care enrollments to identify persons who should be excluded from such programming;
- formal determination of the reasons why local districts issue multiple identification numbers to certain recipients; and
- reminders to local districts to resolve timely the matter recipients with multiple identification numbers, particularly in relation to managed care.

Status - Implemented

Agency Action - The Department formally analyzes managed care enrollments and provides the local districts with reports they can use to exclude ineligible recipients. These reports also serve as a reminder to the local districts to resolve matters pertaining to recipients with multiple CINs. Additionally, in response to our initial audit, the Department determined the reasons for the issuance of multiple identification numbers. This process has helped the Department identify corrective measures which will help limit the issuance of multiple CINs.

Response #5

The Department confirms our agreement with this report.