THOMAS P. DiNAPOLI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 20, 2015

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Managed Care Payments for
Certain Medicaid Recipients
Report 2014-F-7

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Improper Managed Care Payments for Certain Medicaid Recipients* (Report 2010-S-66).

Background, Scope, and Objectives

Medicaid is a federal, state, and local government program that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. The New York State Medicaid program is administered by the Department of Health (Department). For the year ended December 31, 2013, New York's Medicaid program had approximately 5.3 million recipients and Medicaid costs totaled about $49 billion, of which about $23 billion was attributable to managed care costs for approximately 4 million recipients.

Under managed care, Medicaid pays managed care plans a monthly premium for each recipient enrolled in such plans. Managed care plans then arrange for the provision of services their members require and reimburse health care providers directly for services provided to their enrollees. State law precludes certain categories of recipients from participation in managed care programs. During our initial audit, these categories included children whose medical care was covered under the foster care daily rate program and individuals who received services in long-term care settings (such as State-operated psychiatric centers and residential treatment facilities).

At the time of our initial audit, 58 local social services districts (one for the five boroughs of New York City and 57 at the counties outside of New York City) were responsible for enrolling individuals in Medicaid. The local districts were also responsible for enrolling Medicaid recipients in managed care plans and ensuring that enrollment information was kept up-to-date.

We issued our initial audit report on July 24, 2012. The audit objective was to determine whether the Department made Medicaid managed care payments for foster and long-term care recipients who were not eligible for enrollment in managed care. Our initial audit determined that, for the five years ended June 30, 2010, Medicaid made $15.6 million in improper managed care payments on behalf of 14,899 recipients who, by State law, were precluded from enrollment in managed care programs. Many of the improper payments were attributable to recipients who were enrolled in Medicaid under multiple client identification numbers (CINs). We recommended that the Department investigate the $15.6 million in improper Medicaid managed care payments, take steps to prevent the issuance of multiple identification numbers to Medicaid recipients, and strengthen efforts to oversee and monitor Medicaid managed care enrollments.

The objective of our follow-up was to assess the extent of implementation, as of September 30, 2014, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made progress in addressing the problems we identified in the initial audit report. This included the recovery of $6.4 million in improper Medicaid managed care payments. However, further actions are still needed. Of the initial report's five recommendations, two were implemented, two were partially implemented, and one was not implemented.

Follow-Up Observations

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.

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.

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.

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.

Recommendation 5

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

- *periodic formal analyses 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 of 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.

Major contributors to this report were Sal D'Amato, Mostafa Kamal, and Joe Gillooly.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Dennis Buckley
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. James Cox, Medicaid Inspector General