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OFFICE OF THE STATE COMPTROLLER

September 8, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Medicaid Payments Involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers
Report 2022-F-2

Dear Dr. Bassett:

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 Medicaid Payments Involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers* (Report 2019-S-22).

Background, Scope, and Objective

The Department of Health (Department) uses two methods to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department pays health care providers directly, through eMedNY, the Department's claims processing system. Under managed care, the Department pays managed care organizations (MCOs) monthly premiums and the MCOs arrange for the provision of health care services for Medicaid recipients and reimburse providers.

Individuals may enroll in Medicaid through Local Departments of Social Services (Local Districts) or the NY State of Health (NYSOH), the State's online health insurance marketplace. Local Districts use the State's downstate Welfare Management System (WMS) to process enrollment data for individuals in New York City and use the upstate WMS for individuals in the rest of the State. Although the Human Resources Administration (HRA) is the Local District that handles Medicaid enrollments for New York City, the New York City Administration for Children's Services (ACS) processes Medicaid applications and enrollments for children and young adults in foster care in New York City and uses the upstate WMS system.

Each individual who applies for Medicaid benefits is assigned a Client Identification Number (CIN), a unique identifier. Medicaid recipients may have more than one CIN assigned to them (herein referred to as "multiple CINs") during the time they are in receipt of benefits; however, only one CIN should have active eligibility at a time. Concurrent active eligibility

under more than one CIN for the same recipient should be terminated to prevent duplication of benefits.

We issued our initial audit report on September 17, 2020. The audit objective was to determine if improper Medicaid payments were made on behalf of recipients with multiple CINs where at least one CIN was enrolled in FFS. We found that multiple CINs are often the result of incorrect or missing recipient demographic information, the use of multiple eligibility systems during enrollment, and limitations in the enrollment process for foster care recipients. For the period January 1, 2014 through March 31, 2019, our audit identified $47.8 million in Medicaid payments on behalf of recipients with multiple CINs, as follows: $32.6 million in improper premiums for inappropriate managed care enrollments of recipients concurrently enrolled in FFS foster care under different CINs; $12.7 million in improper premiums for managed care enrollments of recipients concurrently enrolled in FFS under different CINs; and $2.5 million in potential duplicate FFS payments made on behalf of recipients with concurrent FFS enrollments under different CINs. The Office of the Medicaid Inspector General (OMIG) recovers improper premium payments for foster care recipients with multiple CINs, and by the end of our fieldwork, $16.6 million of the $32.6 million in improper payments identified were voided. However, we determined OMIG does not have a process to recover improper payments for non-foster care recipients with concurrent FFS enrollment or improper FFS payments for recipients with multiple FFS enrollments.

The objective of our follow-up was to assess the extent of implementation, as of June 28, 2022, of the six recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Officials have made little progress in addressing the problems we identified in the initial audit report and significant action is still required. In particular, OMIG has done very little to review and recover the outstanding Medicaid overpayments we identified. Of the initial report's six audit recommendations, two have been partially implemented and four have not yet been implemented.

Follow-Up Observations

Recommendation 1

Review the remaining $16 million in managed care payments we identified and make recoveries, as appropriate.

Status – Partially Implemented

Agency Action – OMIG investigates and recovers improper Medicaid payments on behalf of the Department. During the initial audit, we provided OMIG with a file containing the overpayments we identified. As of March 4, 2022, OMIG had only recovered approximately $3.3 million (20%) of the $16 million in improper payments we identified.

According to OMIG officials, all claims identified in the initial audit have been reviewed and OMIG audits are ongoing. However, officials were unable to provide supporting documentation to substantiate this review. Of the $12.7 million in unrecovered claims, we note that OMIG may have already lost the opportunity to recover about $6.3 million (50%) due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the remaining improper payments to prevent further loss of recoveries.

Recommendation 2

Evaluate the feasibility of creating a control to prevent the creation of multiple CINs when recipients are enrolled in foster care.

Status – Not Implemented

Agency Action – Our initial audit determined that ACS' use of the upstate WMS system to process Medicaid enrollment for individuals in foster care in NYC contributed to the creation of multiple CINs. The Department continues to work with HRA and ACS to enhance efforts to identify and resolve cases of multiple CINs involving foster care members. However, although the Department stated it evaluated the feasibility of creating additional controls to prevent multiple CINs for recipients in foster care, it could not provide evidence of these efforts upon our requests.

Recommendation 3

Review the remaining $15 million in payments ($12.5 million in managed care premiums + $2.5 million in FFS claims) we identified and make recoveries, as appropriate.

Status – Not Implemented

Agency Action – As of March 4, 2022, only $150,019 (about 1%) of the $15 million in overpayments we identified were recovered. In addition, OMIG was unable to provide evidence that the recoveries were made in response to this audit recommendation. In fact, $42,591 in recoveries were due to voided claims. Voided claims can be initiated by providers and are not necessarily based on OMIG recovery actions.

In response to the COVID-19 public health emergency, and in an effort to prevent a loss in medical coverage, federal guidance allowed the State to keep people enrolled in Medicaid without going through the annual renewal process. According to OMIG officials, this prevented them from pursuing recovery of the overpayments we identified because it would require terminating a multiple CIN. However, Department officials indicated that the duplicate CIN recovery and disenrollment process was not affected by the COVID-19 public health emergency because it would not result in members losing coverage, and duplicate CIN cases have been closed throughout the pandemic. Of note, all overpayments identified in our initial audit were for a scope period prior to the pandemic.

Of the $14.8 million in overpayments not yet recovered, OMIG may have already lost the opportunity to recover about $4.7 million (32%) due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the remaining improper payments to prevent further loss of recoveries.

Recommendation 4

Develop a process to identify and recover:

- *Improper managed care premium payments for non-foster care recipients with concurrent FFS enrollment; and*
- *Improper FFS payments for recipients with multiple FFS enrollments under different CINs.*

Status – Not Implemented

Agency Action – In response to the initial audit, OMIG stated it was researching and evaluating the MCO/FFS and concurrent FFS enrollment areas to determine the most efficient audit approach to identify and recover duplicate payments. However, officials stated the COVID-19 public health emergency prevented OMIG from developing such an audit approach, and OMIG was unable to provide evidence that a process was under review.

As stated in the Agency Action section of Recommendation 3, Department officials indicated that the duplicate CIN recovery and disenrollment process was not affected by the COVID-19 public health emergency as it does not cause members to lose coverage (one multiple CIN remains active), and multiple CIN cases have been closed throughout the pandemic. We encourage the Department and OMIG to prioritize the development of a process to identify and recover these types of improper payments to prevent further loss of Medicaid dollars.

Recommendation 5

Review and resolve the remaining 16,526 cases of multiple CINs we identified to prevent future improper payments.

Status – Partially Implemented

Agency Action – Department officials stated that they resolved all cases of multiple CINs identified by our initial audit. However, we found 192 cases where both CINs were still active and not linked, and another 133 cases where the CINs were linked but still active.

After the Department verifies CINs belong to the same individual, coverage is terminated on one CIN and the pair is linked to prevent future Medicaid overpayments. However, the CIN itself cannot be terminated and, as a result, the CIN can be reopened (or unlinked). According to Department officials, many departments are able to link and unlink CINs. As a result, the Department will periodically conduct a review to see if additional actions were taken on CINs after termination. This monitoring is also done to ensure Local Districts have linked CIN pairs. We encourage the Department to review and resolve the 325 (192 + 133) cases of active multiple CINs from our initial report.

Recommendation 6

Correct eMedNY system controls to prevent payment of claims after multiple CINs are linked.

Status – Not Implemented

Agency Action – In response to our audit, the Department implemented new processes to monitor and resolve multiple CINs. However, no action has been taken to correct the eMedNY system to prevent payment of claims after multiple CINs are linked.

The Department stated it met with eMedNY system staff to discuss the viability of correcting system controls to prevent payment of claims after CINs are linked, and it was determined that fixing the issue was not worth the resources. However, officials were unable to provide us with any proof of these discussions. We encourage the Department to further evaluate the correction of eMedNY system controls to prevent future overpayments.

Major contributors to this report were Vicki Wilkins, Kimberly Geary, and Danhua Zhang.

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,

Christopher Morris
Audit Manager

cc: Robert Schmidt, Department of Health
Frank T. Walsh, Jr., Acting Medicaid Inspector General