Department of Health

Medicaid Program: Improper Premium Payments Made on Behalf of Managed Care Members Residing Outside the State

Report 2022-S-42 | September 2025

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine if the Department of Health (DOH) improperly paid Medicaid managed care premiums on behalf of members who resided outside of New York. The audit covered the period from July 2017 through October 2024.

About the Program

DOH administers New York State's Medicaid program. Medicaid members must be residents of New York to receive benefits. Individuals enroll in Medicaid through the NY State of Health (NYSOH, the State's online health insurance marketplace) or through Local Departments of Social Services. Medicaid eligibility determination systems are required to routinely provide data to be sent through the federal Public Assistance Reporting Information System (PARIS). PARIS is a service that conducts matches on the enrollment data of public assistance programs—including Medicaid—across all 50 states, the District of Columbia, and Puerto Rico to determine if an individual is receiving duplicate benefits in more than one location. PARIS uses a beneficiary's Social Security number (SSN) as the unique identifier for matches.

Most of the State's Medicaid members are enrolled in managed care plans, which are responsible for ensuring members have access to a range of health care services and reimbursing providers for those services. In exchange, DOH pays the plans a monthly premium for each enrolled member. If a member who is enrolled in a managed care plan no longer resides in New York, they should be disenrolled from their plan and the plan must return premiums paid for periods when the member was not a resident.

Key Findings

We found various issues with the State's identification of members who resided outside of New York, some of which DOH rectified during the audit. Among the issues, we identified additional data sources DOH could use to complement the PARIS match and certain review processes for PARIS matches that needed improvement. Together, these indicated Medicaid paid almost $1.2 billion in managed care premiums for Medicaid members who may have resided outside of New York. Additionally, most Medicaid members are enrolled through NYSOH, yet we found DOH did not start submitting NYSOH-enrolled member data for PARIS matching until May 2017 (nearly 3 years after NYSOH started). Then, DOH did not start reviews of the NYSOH PARIS match results until more than 2 years later in October 2019 and, as a result, $1.5 billion in premiums was paid from 2017 to 2019 on behalf of unreviewed members. Overall, Florida, New Jersey, and Pennsylvania represented the other state residencies for 35% of the premium payments in our total audit results.

Following is a breakdown of the $1.2 billion in findings:

- $509 million represented premiums paid for 155,181 members who may have resided outside of New York according to data sources other than PARIS, such as the U.S. Postal Service's National Change of Address (NCOA) information.
  - For example, a member appeared on a May 2020 NCOA report with a forwarding address in Florida. The member had no Medicaid services since February 7, 2020, but Medicaid made 45 monthly premium payments totaling $100,859 on behalf of the member from June 2020 through February 2024. The member was still active and enrolled in managed care as of the end of the audit fieldwork.

- In response to the audit findings, DOH agreed to explore the use of other data sources, including NCOA, to identify out-of-state members. We further suggest DOH engage with the federal government about its willingness to incorporate other data that helps establish residency into the PARIS matching process at the federal level.

- $375 million represented premiums paid for NYSOH-enrolled members who were identified on a PARIS match but were not reviewed by DOH to confirm residency because of flaws in NYSOH's processing of PARIS matches that caused the omissions. Also, 631,514 NYSOH-enrolled members were not submitted for a PARIS match because their SSNs were incorrectly logged in NYSOH as unverified. As a result of the audit, DOH identified the cause of the NYSOH error and officials stated a solution was implemented in March 2024.
- $299 million represented premiums paid for members whose eligibility was ended due to PARIS matches but the improper premiums were not recovered ($234 million), or the member's eligibility was flagged to be closed but was not officially ended and premiums continued to be made ($65 million).
- While all states, the District of Columbia, and Puerto Rico participate in the PARIS match, not all of them participate every quarter, which can impact the effectiveness of the identification of out-of-state members.

Key Recommendations

- Verify the residency of members identified by a PARIS match who were not reviewed, as well as members identified as potentially residing outside of the State by data sources other than PARIS, and recover improper premium payments, as appropriate.
- Review the $299 million in premium payments for members whose eligibility was closed or not properly closed, and make recoveries, as appropriate.
- Enhance processes used to identify members living outside of the State and recover improper premium payments.

Office of the New York State Comptroller
Division of State Government Accountability

September 9, 2025

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Premium Payments Made on Behalf of Managed Care Members Residing Outside the State*. The audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
CMS	Centers for Medicare & Medicaid Services	*Agency*
eMedNY	Medicaid claims processing and payment system	*System*
Local District	Local Department of Social Services	*Agency*
MDW	Medicaid Data Warehouse	*System*
NCOA	U.S. Postal Service's National Change of Address	*System*
NYSOH	NY State of Health	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
OTDA	Office of Temporary and Disability Assistance	*Agency*
PARIS	Public Assistance Reporting Information System	*System*
SSN	Social Security number	*Key Term*
WMS	Welfare Management System	*System*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (DOH). During the State fiscal year ended March 31, 2024, New York's Medicaid program had approximately 9.1 million members (of whom about 7 million [77%] were enrolled in managed care at some point during the year), and Medicaid claim costs totaled about $87.5 billion (comprising $45.8 billion in managed care premium payments and $41.7 billion in fee-for-service health care payments). The federal government funded about 56.8% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.2%.

Certain Medicaid applicants can apply through the NY State of Health (NYSOH) while others need to apply through their Local Department of Social Services (Local District). NYSOH is the State's online health care marketplace and is the system of record for all NYSOH Medicaid applications and enrollments. Local Districts use the statewide Welfare Management System (WMS) to record Medicaid eligibility and enrollment information for Local District applicants.

DOH uses two methods to pay for Medicaid services: fee-for-service and managed care. Under fee-for-service, DOH, through its Medicaid claims processing and payment system (eMedNY), makes Medicaid payments directly to health care providers for services rendered to Medicaid members. Under the managed care method, DOH makes monthly premium payments to managed care plans for each enrolled Medicaid member and, in turn, the managed care plan is responsible for ensuring members have access to a comprehensive range of medical services and reimbursing providers for those services.

Federal and State regulations require Medicaid members to be residents of the state in which they receive Medicaid benefits, with some exceptions, such as for members who are placed in an out-of-state facility. Generally, under federal regulations, a person's state of residence is the state in which the individual is living and intends to reside. If a member enrolled in managed care is identified as no longer residing in New York, DOH's Managed Care Model Contract states the member should be disenrolled from their managed care plan effective the first day of the first full month in which they lived outside the State or the effective date of their health insurance (e.g., Medicaid enrollment) outside of New York. The Managed Care Model Contract also requires managed care plans to return overpayments to DOH, including premium payments for members determined to be residing out of state.

Federal regulations require state Medicaid programs to promptly review information they have received or obtained that may affect eligibility, and to redetermine eligibility for Medicaid members between regular renewals of eligibility whenever information is received that could affect the eligibility of the members. Federal law requires that, as a condition of funding, state Medicaid programs have eligibility determination systems that provide for data matching with the Public Assistance Reporting Information System (PARIS), a computer data matching system administered by the federal Administration for Children & Families (within the U.S. Department of Health

and Human Services). PARIS uses a member's Social Security number (SSN) as the unique identifier to be matched against the enrollment data of multiple public assistance programs (such as Medicaid, SNAP [Supplemental Nutrition Assistance Program], and TANF [Temporary Assistance for Needy Families]) across the 50 states, the District of Columbia, and Puerto Rico to determine if a person is receiving duplicate benefits in two or more locations for the purposes of identifying improper payments and reducing fraud and abuse.

In New York, the Office of Temporary and Disability Assistance (OTDA) facilitates a quarterly PARIS match process and provides the results to DOH. To do this, OTDA extracts member data for all active Medicaid members from WMS, combines it with a DOH extract of data for all active members enrolled through NYSOH, and submits it to PARIS (for matching). OTDA receives a return file of all PARIS match results and creates separate files to be used by NYSOH and Local Districts for match processing.

Audit Findings and Recommendations

DOH relies on PARIS to identify Medicaid members residing in another state, the District of Columbia, or Puerto Rico. However, DOH did not begin reviewing PARIS matches for NYSOH-enrolled members until October 2019—over 5 years after NYSOH enrollments began ($1.5 billion). Further, we found not all NYSOH-enrolled members were included in the files DOH sent for PARIS matching, and NYSOH inappropriately rejected certain match results from its processing ($375 million). As a result, we identified about $1.88 billion in premium payments on behalf of members DOH did not review to verify New York residency—$1.5 billion of which occurred in the period before DOH began reviewing PARIS matches.

We also found deficiencies with the processing of PARIS matches for Local District WMS-enrolled members that, if corrected, would help prevent improper premium payments. DOH ensures there is a resolution for each WMS-enrolled member identified on a PARIS match as to whether the member is eligible for benefits or not. However, there is insufficient oversight to ensure the eligibility is actually ended for members found to be residing outside the State, which resulted in $65 million in corresponding premium payments.

Further, DOH has not established adequate controls to ensure improper premium payments are recovered for periods where members were determined to be residing out of state. As a result, we found DOH failed to recover $234 million in premium payments for members' coverage periods that were closed due to a confirmed PARIS match.

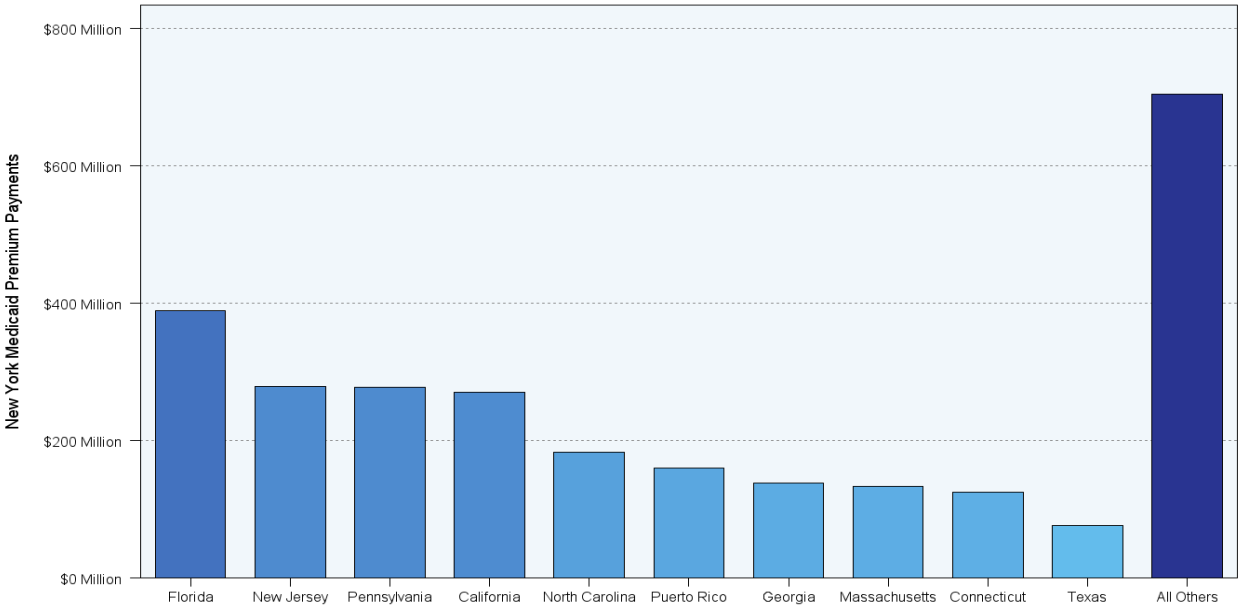
We identified additional data sources that could be used to complement the PARIS match process, including certain sources DOH already has access to, such as the U.S. Postal Service's National Change of Address (NCOA) information. In total, we identified $509 million in managed care premiums paid on behalf of members who potentially resided outside of New York according to these data sources.

The following table provides a breakdown of the audit findings.

Finding Category	Number of Premiums Paid	Amount of Premiums Paid
NYSOH PARIS Processing		
Delays prevented participation in PARIS as well as processing of PARIS matches	3,310,113	$1.5 billion
NYSOH improperly rejected PARIS matches for processing	753,027	375 million
Local District PARIS Processing		
Member eligibility designated (marked) as closed, but was not officially closed	75,254	65 million
Additional Indicators of Out-of-State Residency		
U.S. Postal Service's NCOA	691,003	323 million
eMedNY address data, Florida voter registry, Medicare plan service areas	338,483	186 million
OMIG Activity and Recoveries		
NYSOH member eligibility closed, but improper premiums not recovered	497,716	198 million
WMS member eligibility closed, but improper premiums not recovered	57,836	36 million
Totals*	**5,723,432**	**$2.7 billion**

* Premiums may be included in more than one category. There were 5,566,995 non-duplicated premiums totaling over $2.6 billion.

The following chart shows Medicaid managed care premiums paid when members resided outside of New York, by the member's location according to PARIS and other sources used to indicate out-of-state residency. Florida, New Jersey, and Pennsylvania were the top three states that represented 35% of the premium payments.



Note: The chart does not include $3.9 million in premiums paid for Medicaid members who were identified as potentially residing outside of New York based solely on their Medicare managed care plan service area data because a member's Medicare managed care plan service area can cover multiple states. Therefore, their out-of-state residency could not be classified to one location.

NYSOH PARIS Processing

Delays in PARIS Processing

NYSOH started enrolling eligible Medicaid applicants on January 1, 2014. Although NYSOH technical system documentation states participation in the PARIS match was supposed to begin in August 2014, DOH did not submit the first NYSOH extract file of members to OTDA until May 2017 (2.75 years late), and NYSOH processing of PARIS match results did not begin until October 2019 (5.17 years late). According to DOH officials, various system issues and other priorities caused the delay.

We reviewed the fourth quarter 2017 through second quarter 2019 PARIS match results and found DOH did not process 242,694 matches to determine whether the members were residing outside of New York. Consequently, we determined Medicaid paid over $1.5 billion for 3,310,113 managed care premiums, during the audit period through October 2024, on behalf of these members after their Medicaid start dates in the other states. This included almost $283 million on behalf of members who did not receive any New York Medicaid services, or members whose next service claim after the Medicaid start date in the other state was a service that occurred outside of New York. (Note: This more narrow analysis did not include situations where members

moved out of New York and health care providers billed New York Medicaid for the individuals, e.g., if a member moved to a bordering state but continued to use their New York doctor and New York benefits.)

DOH may have already lost the opportunity to recover many of these premiums due to lookback regulations. However, DOH should use a risk-based approach, prioritizing reviews of payments made for members who did not receive New York Medicaid services and premium payments within the lookback window, to confirm periods the members resided outside New York, close any corresponding Medicaid eligibility, and recover improperly paid premiums.

Rejected PARIS Matches

DOH's processing of PARIS match results for members enrolled through NYSOH has been automated since October 2019. When OTDA receives the return file of all PARIS match results, it creates a separate file to be used by NYSOH for automated determinations of whether NYSOH-enrolled members resided outside of New York. However, we found certain PARIS matches are rejected from NYSOH's automated processing. As a result, we determined Medicaid made 753,027 premium payments totaling $375 million on behalf of members whom NYSOH did not process due to the rejections ($325 million in Medicaid start date issues + $50 million in member validation issues).

Matches with an invalid Medicaid start date in the matching state are rejected. According to DOH officials, they reject these records because it calls into question the validity of the match. However, matches with a blank Medicaid start date are not rejected. Federal regulations require state Medicaid programs to promptly review information they have received or obtained that may affect eligibility and to redetermine eligibility for members whenever this information is received. Since the PARIS match results are an indication members may be receiving medical assistance, public assistance, or other public benefits in another state, DOH should ensure all matches are reviewed.

We found NYSOH rejected 87,393 records from the third quarter 2019 through first quarter 2023 PARIS match results because the Medicaid start date in the other state was invalid on the return file. Medicaid made 629,920 premium payments totaling almost $325 million on behalf of these members after the date of the PARIS match. Further, almost $143.8 million of the payments were made on behalf of members who did not receive any New York Medicaid services between the date of the PARIS match and the date of the premium payment. DOH should review the rejected matches to determine if any members were residing outside of New York and recover improper premium payments, as appropriate.

The NYSOH automated system also uses certain criteria to validate records on the PARIS match results file. Records that fail validation are rejected and not processed to determine if the members were residing in another state. For example, the automated system validates the accuracy of the PARIS result by confirming the individual's SSN and month and year of birth match. However, based on our review

of a subset of the data—the first quarter 2022 through fourth quarter 2022 match results—we found DOH rejected 7,538 matches even though the individuals had active Medicaid eligibility and each individual's SSN and month and year of birth matched. We reviewed 13 of the 7,538 rejected matches and found all of them were improperly rejected, as follows:

- Seven matches were rejected due to a defect that caused the NYSOH system to interpret expired New York residency documentation as valid. According to NYSOH, residency documentation provided in response to a previous PARIS match should expire after 1 year. In total, 5,166 PARIS match records had been rejected due to this defect since 2020. According to DOH officials, this system defect was corrected in September 2024.
- Four matches were rejected due to inconsistencies between data in different NYSOH tables. NYSOH data used in validating PARIS match results comes from a different table than the NYSOH data sent for PARIS matching, and inconsistencies between these tables caused certain match results to fail validation. According to DOH officials, they were working to develop a fix to address this issue.
- One match was rejected because the member had multiple active NYSOH member identifiers (members should only have one identifier). According to DOH officials, this issue was fixed in July 2024.
- One match was rejected because the member had two NYSOH member identifiers, one active and one inactive. In response, DOH officials indicated that they were analyzing the impact of a potential system fix and had expected the analysis to be done by November 2024.

Medicaid made 123,107 premium payments totaling almost $50 million on behalf of the 7,538 rejected matches after the members' Medicaid start dates in the other states. Of these, 27,452 payments totaling almost $10.4 million were made on behalf of members who did not receive any New York Medicaid services between the matching state's Medicaid start date and the date of the premium payment. DOH should review the rejected matches to determine if any members were residing outside of New York and recover improper premium payments, as appropriate.

Members Not Included in PARIS Processing

NYSOH-enrolled members with an SSN that has not been verified by the Social Security Administration are excluded from the extract file sent to OTDA for the PARIS match. During our fieldwork, we questioned certain NYSOH members with an unverified SSN and, as a result of our audit inquiries, DOH identified a system defect that caused some NYSOH members to incorrectly appear as if their SSN was unverified—even though it had been—causing them to be excluded from the PARIS match. As of December 14, 2023, there were 631,514 members affected by this defect. If members are not included in the PARIS match, DOH is unlikely to identify if they moved to another state and Medicaid is at risk of making significant improper premium payments. According to DOH officials, a fix for the defect was implemented in March 2024.

Improper Clock Resolutions

NYSOH's automated process creates a clock for certain PARIS-matched members, which allows members 10 days to prove their New York State residency. The "clock" is considered resolved if the member provides documentation to prove their residency before the clock expires. Resolved matches that reappear on subsequent PARIS reports are not investigated for a period of 1 year.

A member's eligibility is automatically closed if they fail to provide proof of State residency prior to the clock expiring. Our audit identified multiple system issues that prevented the clock from properly expiring for certain members. For example, the clock did not expire for certain members who were released from correctional facilities. DOH officials were unable to tell us how many members were impacted, but as of June 17, 2024, they identified 239 members who could be impacted on future PARIS matches. According to officials, work to correct this issue had been initiated to prevent future occurrences.

A second issue also prevented the clock from expiring for members who incorrectly had more than one NYSOH account (members should only have one account). In total, 2,314 clocks created by the PARIS match process did not expire when they were supposed to due to this issue. According to DOH officials, this issue was corrected on July 25, 2024.

We also found DOH should improve NYSOH's residency verification steps during the 10-day clock period. We selected a random sample of 10 members from the first quarter 2023 PARIS match whose cases were resolved before the clock expired, and determined what information the members provided. We found seven of the member matches were resolved due to a Life Status Change on their NYSOH applications. According to DOH officials, a Life Status Change occurs when a member reviews their application, and the member's "clock" is considered resolved without any additional verification of residency. Of the seven Life Status Changes we reviewed, four resulted from no changes to the members' applications, two were due to changes to the members' income, and one was from a change to the member's New York address. The remaining three members (of 10) submitted documentation supporting their in-state residency.

DOH officials consider Life Status Changes to be a verification of residency because the NYSOH application includes members' residential address information, and members must attest all information on the application is accurate when performing a Life Status Change. However, we question this policy for members identified as potentially residing out of state by a PARIS match. For instance, one member (in our sample of 10) submitted documentation to DOH in response to receiving a verification of residency letter, and DOH rejected the documentation as inadequate. Subsequently, the member updated the income information on their NYSOH application, which was considered a Life Status Change, and attested to their application information. As a result, the PARIS match was considered resolved. Changes made to a member's application, especially those unrelated to residency,

provide no assurance that the member is currently residing in New York and can result in improper managed care premium payments.

Local District PARIS Processing

Local Districts are required to resolve PARIS matches for members whose enrollments are on WMS. When OTDA receives the return file of all PARIS match results, it creates two files of PARIS match results for Local Districts: one for New York City (NYC) and one for the rest of the State. The NYC PARIS match results are submitted for automated processing by the Office of Information Technology Services, and members are sent a letter requesting proof of residency. (Note: Some NYC PARIS match results are not part of the automated process and require NYC Local District officials to complete manual investigations.) All Local Districts outside of NYC retrieve the PARIS match results from a DOH PARIS match database and perform their own investigations to determine if the members currently reside in New York.

Local Districts are required to resolve any pending matches within 90 days and enter the results of their investigations into the DOH PARIS match database. Possible results include “Eligible for Benefits in NYS” or “Closed/Removed by Match.” If a PARIS match results in “Closed/Removed by Match,” the Local District must end the member’s in-state Medicaid eligibility and determine if the member received concurrent Medicaid benefits for an entire month in both New York and the other state. If so, Local Districts must notify both the managed care plan and the Office of the Medicaid Inspector General (OMIG) of the member’s retroactive disenrollment date (a member’s eligibility is closed back to a date in the past). The retroactive disenrollment process initiates the recovery of past premium payments made on behalf of the member. OMIG is responsible for ensuring the recovery of these payments.

As part of our audit, we visited Local District offices in Albany County, Erie County, and NYC to learn about the processes used to resolve PARIS matches. At each Local District, we reviewed a random sample of PARIS matches processed from third quarter 2017 through fourth quarter 2022 that fell into two categories: 30 members who were marked “Eligible for Benefits in NYS” and 29 members who were marked “Closed/Removed by Match” but whose Medicaid eligibility did not appear to be closed in DOH’s Medicaid Data Warehouse (MDW).

Inconsistencies in PARIS Match Investigations Between Local Districts

DOH has not established standard requirements for Local Districts to follow when completing PARIS match investigations. According to DOH officials, guidance for Local Districts is available on DOH’s website and directives are announced to Local Districts via email. The most recent PARIS guidance, posted in February 2019, includes guidelines to assist Local Districts in the development of procedures for investigating and resolving PARIS matches. However, these guidelines are

best practices, not requirements, and none of the three Local Districts we visited were aware this guidance was available. Instead, each Local District had their own procedures for completing the PARIS match process and we observed inconsistencies between them.

According to DOH guidelines, a residency verification letter should be sent to members who appear on a PARIS match, and Local Districts should close eligibility for members who do not respond to the verification letter. According to officials we interviewed, NYC and Erie close Medicaid eligibility for members who fail to respond to the letter, but Albany does not. Of note, Erie Local District officials stated they do some research to determine if the members are still residing locally prior to sending the verification letter and may not send letters if they are able to verify New York State residency for the members.

Albany officials explained they generally do not require documentation to prove New York residency and instead try to meet with members face to face. Albany officials will only close a member's eligibility if they verify the member was residing outside the State. In contrast, Erie and NYC require members who respond to the letter to provide documentation proving State residency. The documentation must be dated within the last 3 months for Erie and within the last year for NYC.

NYC PARIS Match

As stated previously, NYC does not use the DOH database to retrieve PARIS matches. Instead, OTDA produces a file of NYC PARIS match results for automated processing by the Office of Information Technology Services. Generally, members identified by the PARIS match are automatically sent a letter requesting proof of residency. If the member does not respond within 10 days, the ending of their Medicaid eligibility is automatically initiated. Members who respond must provide evidence of their State residency to NYC Local District officials to retain eligibility. Certain NYC PARIS matches, such as foster care cases and members on a public assistance case with other members who were not in the PARIS match results (multiple members may share a Medicaid case number), are not part of the automated process and require NYC Local District officials to complete a manual investigation.

In addition to the random sample of PARIS matches selected for the NYC Local District discussed previously, we reviewed eight additional members who were marked "Eligible for Benefits in NYS" and who should have received a manual investigation. NYC Local District officials were unable to provide evidence to show six of the eight members were investigated. Additionally, although they had support to demonstrate an investigation of the other two members was performed, they obtained no proof of State residency. DOH officials stated that they follow up via email with Local Districts to ensure all PARIS matches are resolved; however, they do not monitor to ensure resolutions were handled properly.

Lack of Case Closures

We found Local Districts did not take sufficient steps to end Medicaid eligibility timely for members confirmed to be residing out of state. For the third quarter 2017 through fourth quarter 2022 PARIS match results, we found DOH's PARIS match database had 23,573 records of members who were marked by Local Districts as "Closed/Removed by Match." However, we determined the eligibility of 4,837 (21%) of these members was not closed within 120 days according to information in the MDW (90 days to resolve the match with an extra 30 days to close the member's eligibility). As a result, Medicaid made 75,254 premium payments totaling over $65 million on behalf of these members after their Medicaid start dates in the other state.

According to DOH, some cases may be closed due to a PARIS match but then reopened after a member reaches out to their Local District. At the three Local Districts we visited, we reviewed a random sample of 29 PARIS matches marked "Closed/Removed by Match" in the DOH database but which did not appear to be closed in the MDW. We found:

- 22 of the 29 matches (76%) were marked appropriately, and the members' active Medicaid coverage was not closed but should have been. For example, Erie reviewed one member who was on the PARIS match in December 2021, which indicated the member had Medicaid benefits in Pennsylvania since July 2021. The member did not reply to a residency verification letter and Erie's investigation found the member was working in Pennsylvania. Although Erie marked this match as "Closed/Removed by Match" in May 2022, the member's Medicaid eligibility was not closed until April 2024. For the period July 2021 through April 2024, Medicaid inappropriately made 34 premium payments totaling $7,541 on behalf of this member.
- 7 of the 29 matches (24%) were marked appropriately, and the members' active Medicaid coverage was accurate. For example, one member responded late to the Local District's request for residency verification, so they were marked "Closed/Removed by Match," but the member was later cleared when they provided a closing letter from the matching state.

We provided our audit findings to DOH during the audit. In response, DOH stated it reviewed a sample of 55 of the 4,837 members and concluded that the eligibility for 23 members was appropriately not closed (13) or was closed by the Local District and subsequently reopened (10). We disagreed with DOH's conclusions for six members, as follows:

- DOH stated two (of the 13) members were residing in nursing facilities in New York and therefore their eligibility was appropriately not closed. However, we found one member's last nursing home claim occurred over 7 months prior to the PARIS match. This member appeared on the PARIS match for Pennsylvania and only had one paid Medicaid service claim following that match, and that health care provider was in Pennsylvania. The second member was discharged from a nursing home almost 2 months prior to the PARIS match and had no Medicaid service claims after the PARIS match date. Further,

they appeared on additional PARIS matches showing Louisiana residency. For the remaining 11 that DOH found were appropriately not closed, it appears the Local District's conclusion of "Closed/Removed by Match" was incorrect and DOH should determine why the Local Districts marked the members as "Closed/Removed by Match."

- DOH stated four (of the 10) members' eligibility was closed by Local Districts and the members reapplied for coverage through NYSOH. While we found the eligibility for two members was closed once they reapplied in NYSOH, the two closings and concurrent reapplications did not take place until well after the PARIS matches—approximately 10 months and nearly 3 years after the PARIS matches, respectively. Two other members' eligibility was not closed until over 4 months after the PARIS matches. Accordingly, DOH should recover the premiums paid during the periods that the Local Districts found the members were residing outside of New York, before the reapplications occurred.

All 4,837 individuals were determined to be residing in another state by the Local Districts and marked "Closed/Removed by Match." DOH should work with Local Districts to determine why the Local Districts did not end the members' eligibility timely or if the members were incorrectly marked as "Closed/Removed by Match." Of note, over $11 million (of the $65 million) was made on behalf of members who did not receive any Medicaid services between the matching state's Medicaid start date and the date of the premium payment.

DOH also initiated a formal process after our audit began to spot check WMS PARIS matches and confirm the members' current eligibility matched the Local Districts' determinations in the DOH database. At the conclusion of our audit fieldwork, DOH had only performed one spot check (fourth quarter 2022 match results). The spot check consisted of 138 PARIS matches, representing 2% of the 6,182 WMS PARIS matches investigated by Local Districts that quarter. Although 47% of the members whose eligibility was marked "Closed/Removed by Match" in that quarter were not actually closed within 120 days, DOH's spot check found no issues. As such, it appears DOH's spot check is inadequate. DOH should enhance its review to ensure the correct determinations are made by Local Districts. The review should include verification that Local Districts prepared retroactive disenrollments, where appropriate, so improper premium payments for the periods members resided in other states were recovered.

Additional Indicators of Out-of-State Residency

DOH only uses the PARIS match to identify members residing outside of New York. However, the PARIS match has significant limitations, among them:

- Although the PARIS match is required to receive federal Medicaid funding—and we did find all states, the District of Columbia, and Puerto Rico participate—not all of them participate every quarter, which may delay the identification of out-of-state members.

- Only members receiving medical assistance, public assistance, or other public benefits in another state are included in the PARIS match.

Our audit found additional data sources DOH could use to complement the PARIS match, including:

- The NCOA report
- eMedNY data fields, including an out-of-state address on the member's case, a Medicare managed care plan (for the purpose of this report, this includes Medicare Part D) with an out-of-state service area (according to the Centers for Medicare & Medicaid Services [CMS] data), or an out-of-state policy holder address on a member's commercial third-party insurance plan
- The Florida voter registry

Using the additional data sources listed, we identified over $509 million in premium payments on behalf of 155,181 members who may have been residing outside of New York during the period July 1, 2017 through February 29, 2024. Over $378 million (74%) of these payments were made on behalf of 108,932 members who had no Medicaid claims billed on their behalf since the date the data showed they moved out of state. Of note, DOH already has access to the data sources we used, except for the Florida voter registry (which is publicly available upon request).

Using just one of these indicators, the NCOA report, we identified 95,691 members with an out-of-state forwarding address and 691,003 premium payments totaling $323 million (of the $509 million). The NCOA is a system of record for all change of address requests filed with the U.S. Postal Service. DOH has an eMedNY process that creates a report of forwarding addresses for all Medicaid members each quarter based on data from the NCOA system. CMS publishes Medicaid program guidance for states including guidance relating to state residency requirements. In March 2022, CMS published a letter to state health officials strongly encouraging states to use NCOA data. However, DOH does not use the NCOA report to update member addresses in eMedNY, and DOH does not send the NCOA report to Local Districts or NYSOH as a source to help determine a member's residential address.

We identified an additional 338,483 premium payments totaling $186 million on behalf of 62,267 members who had an out-of-state address according to eMedNY, were identified on the Florida Voter Registry, and/or had a Medicare plan service area that did not cover New York State.

The following are three examples of members we identified—using data sources other than PARIS—who were likely residing outside of New York:

- A member appeared on the May 28, 2020 NCOA report with a forwarding address in Florida. The member has had no Medicaid services since February 7, 2020, but Medicaid made 45 premium payments totaling $100,859 on behalf of this member from June 2020 through February 2024. The member was still active and enrolled in managed care as of the end of our audit fieldwork.

- A member appeared on the November 28, 2018 NCOA report with a forwarding address in Massachusetts. The member also updated their mailing address in NYSOH to Massachusetts on March 4, 2019. According to eMedNY, the member had a Medicare plan with a service area of Massachusetts since April 2021. We note that this member was also identified as having benefits in Massachusetts beginning on December 11, 2018 as a result of the March 2019 PARIS match; however, as previously mentioned, NYSOH PARIS matches were not processed until October 2019. The member's Medicaid enrollment was ended May 21, 2021 because they did not respond to a request for proof of residency. Medicaid made 30 premium payments totaling $15,530 since the member's Medicaid start date in the other state, but the member never received a New York Medicaid service.
- A member updated their Medicaid mailing address to Florida on October 27, 2019. The member registered to vote in Florida on November 7, 2019 and appeared on the November 25, 2019 NCOA report with a Florida address. The member enrolled in New York Medicaid in June 2018 and had no service claims since that enrollment, yet Medicaid made 48 premium payments totaling $23,393 on behalf of this member from December 2019 through November 2023 when the member's Medicaid enrollment ended.

In response to our audit, DOH officials stated they are exploring processes to use existing, reliable data sources, including NCOA, to identify out-of-state members who require outreach for residency verification. Furthermore, DOH officials stated they are exploring processes to use claims data to identify members who have not had services over a certain period of time.

OMIG Activity and Recoveries

Even when DOH and Local Districts closed the eligibility of members identified by the PARIS match, DOH and OMIG did not always take sufficient steps to ensure improper premiums were recovered for the periods members resided outside the State. As a result, we identified $234 million in unrecovered premium payments ($198 million for NYSOH members + $36 million for WMS members).

We reviewed managed care premiums for NYSOH-enrolled members whose eligibility was closed as a result of first quarter 2022 through fourth quarter 2022 PARIS match processing and identified 497,716 unrecovered premium payments totaling almost $198 million. We also identified 57,836 unrecovered premium payments totaling $36 million on behalf of Local District-enrolled members whose eligibility was closed due to PARIS matching by a Local District during our audit period. In response to our audit findings, OMIG officials indicated they may have lost the opportunity to recover up to $11.4 million of the improper premiums we identified due to regulatory lookback provisions. We encourage OMIG to expedite a review of this audit's findings to avoid further loss of recoveries.

In 2022, OMIG conducted a review of premium payments for Local District-enrolled members marked "Closed/Removed by Match" by Local Districts. As a result of this

review, OMIG issued 45 PARIS audits covering the period October 2016 through December 2018 with recoveries totaling almost $12.7 million. However, a similar review was not done for NYSOH members.

According to OMIG officials, OMIG also has an ongoing project that looks to identify members with an out-of-state mailing address in the MDW and who have not had any in-state service claims for a minimum of 24 months. If OMIG finds credible evidence that the person is not living in New York, it reaches out to the Local District or NYSOH for confirmation that the person is out of the State. However, OMIG cannot close a member's eligibility. Although OMIG officials indicated this process will ultimately lead to the member's Medicaid coverage ending, no premium recoveries are made.

Recommendations

1. Using a risk-based approach, such as the one described in the body of this report, review the NYSOH members identified by the PARIS match between May 2017 and October 2019 (representing $1.5 billion in premiums paid through October 2024) and, as appropriate, determine their residency, end their Medicaid eligibility, and recover improper premium payments.
2. Correct NYSOH PARIS processing to ensure:
    - NYSOH verifies the residency of all members identified by PARIS matches, including members who:
        - Have invalid Medicaid start dates in the matching state, District of Columbia, or Puerto Rico.
        - Incorrectly fail NYSOH's match validation process (e.g., members whose SSNs and birth dates actually match between NYSOH and PARIS information, and members who have multiple NYSOH identifiers).
        - Update their Medicaid applications with Life Status Changes unrelated to residency;
    - NYSOH accurately includes all members with SSNs that have been verified by the Social Security Administration in the files sent for PARIS matching.
    - The NYSOH PARIS clock properly expires for all members (e.g., members released from correctional facilities and members who inappropriately have more than one NYSOH account).
3. For those NYSOH-enrolled members who were not properly or fully processed for PARIS matching due to the NYSOH defects identified in Recommendation 2, take the necessary steps to determine if any of the members resided outside New York and review the corresponding $375 million in premium payments and make recoveries, as appropriate.
4. Develop a standard process that all Local Districts must follow for processing PARIS matches and notify all Local Districts of the process.

5. Review the members identified by the audit who were marked “Closed/Removed by Match” by Local Districts but whose eligibility was not closed and, where appropriate, ensure their Medicaid eligibility is closed and the corresponding $65 million in retroactive premium payments are recovered.
6. Develop oversight processes to ensure resolutions of WMS and NYSOH PARIS matches are properly processed in a timely manner that include, but are not limited to, ensuring:
    - WMS PARIS matches marked “Closed/Removed by Match” result in the members’ eligibility being closed.
    - Local Districts initiate retroactive disenrollments for periods members resided outside of New York.
    - All improper premium payments are recovered timely.
7. Review the $234 million in improper premiums paid for members whose eligibility was closed and make recoveries, as appropriate.
8. Use NCOA and any other additional data sources, such as the sources referenced in this report, to identify members residing outside of New York.
9. Engage with the U.S. Department of Health and Human Services on whether the Administration for Children & Families can incorporate additional data sources that help establish residency, such as NCOA, into the federal PARIS match.
10. Review the $509 million in premium payments made on behalf of members identified as residing outside of the State according to the data sources other than PARIS and, as appropriate, determine the members’ residency, end their Medicaid eligibility, and recover improper premium payments.
11. When OMIG identifies members with an out-of-state address in the MDW and no in-state service claims, ensure retroactive recoveries of premium payments are made, as appropriate.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine if DOH improperly paid Medicaid managed care premiums on behalf of members who resided outside of New York. The audit covered the period from July 2017 through October 2024.

To accomplish our objective and assess related internal controls, we interviewed DOH, OMIG, and Local District officials; and examined applicable federal and State laws and regulations, DOH's relevant Medicaid policies and procedures, and the Medicaid Managed Care Model Contract. We obtained and reviewed the PARIS match results for WMS and NYSOH members and compared them to MDW and eMedNY data. We used external data sources, including NCOA, the Florida Voter Registry, and Medicare managed care plan service area data, as well as MDW address and third-party insurance data to identify members who may be living outside of New York. We analyzed claim data from the MDW to identify improper premium payments made on behalf of members identified as residing outside of New York. This analysis included improper payments on behalf of members who did not receive any Medicaid services between the Medicaid start date in the matching state and the date of the premium payment. (Note: If the Medicaid start date in the matching state was invalid, missing, or after the PARIS match date, the PARIS match date was used instead.) We also used National Provider Identifier data to identify claims rendered by providers outside of New York.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected both judgmental and random samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the respective populations, even for the random samples. Our samples, which are discussed in the body of our report, include the following.

- To gain an understanding of the PARIS match process, we judgmentally selected three Local Districts (Albany, Erie, and NYC) to visit based on geographical location and each district's number of open Supplemental Security Income cases in third quarter 2018, number of PARIS matches marked "Eligible for Benefits in NYS" during the audit period, and total number of PARIS matches in the audit period. At each Local District, we reviewed a random sample of 10 WMS PARIS matches marked "Eligible for Benefits in NYS," as well as a random sample of 10 WMS matches marked "Closed/ Removed by Match" but that were never closed based on MDW data. Erie had nine total matches marked "Closed by Match" that were not closed in our audit scope, so Erie's sample was limited to these nine matches.
- We selected a random sample of 20 NYC PARIS matches that were selected as part of our sample of recipients marked "Eligible for Benefits in NYS." However, during our site visit, we removed these matches because NYC officials stated the members' eligibility was actually closed by the automated process. Subsequently, officials told us 17 were not closed and were found to be "Eligible for Benefits in NYS." From these 17 matches, we reviewed eight matches that would have required a manual investigation—the remaining nine

(of 17) were not reviewed because they were handled as part of the automated process.

- To determine why certain NYSOH PARIS match results were rejected from processing, we provided DOH officials with a random sample of 13 members who matched on SSN, name, date of birth, and gender, and whose match indicated "PARIS Processing Criteria Not Met" from first quarter 2022 through fourth quarter 2022. (Note: Our initial sample included 20 members; however, we removed seven members after DOH provided corrected files of NYSOH PARIS results.) We also selected a random sample of 10 PARIS matches from the NYSOH PARIS first quarter 2023 who had a PARIS clock created and where the member retained Medicaid eligibility.

We relied on data from the MDW, eMedNY, WMS, and NYSOH that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit. In addition, we relied on NCOA data obtained from the U.S. Postal Service, Florida voter data obtained from the Florida Division of Elections, and Medicare managed care plan service area data and National Provider Identifier data (self-reported data from providers and maintained by CMS) obtained from CMS, which are recognized as appropriate sources, and used this data for widely accepted purposes. Therefore, this data is sufficiently reliable for the purposes of this report without requiring additional testing. We also obtained data from PARIS and assessed the reliability of that data by performing electronic testing and tracing to and from source data. We determined that the data from this system was sufficiently reliable for the purposes of this report.

We shared our methodology and findings with DOH and the OMIG officials during the audit for their review. We took their comments into consideration and adjusted our analyses as appropriate.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section I of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight of managed care premium payments on behalf of members residing outside of New York.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this report and have included them in their entirety at the end of the report. In their response, DOH officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our responses to certain DOH remarks are included in the report's State Comptroller's Comments, which are embedded in DOH's response.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

July 30, 2025

Christopher Morris, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Christopher Morris:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2022-S-42 entitled, "Medicaid program - Improper Premium Payments Made on Behalf of Managed Care Members Residing Outside the State."

Thank you for the opportunity to comment.

Sincerely,

Johanne E. Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Jennifer Danz
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2022-S-42 entitled, "Medicaid program - Improper Premium Payments Made on Behalf of Managed Care Members Residing Outside the State"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2022-S-42 entitled, "Medicaid program - Improper Premium Payments Made on Behalf of Managed Care Members Residing Outside the State." Included in the Department's response is the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

General Comments:

OSC Use of Judgmental Samples

OSC's used a judgmental sampling approach to draw conclusions on this audit, which means the auditors selected what they would look at based on their professional judgement, opinion, and knowledge. As a result, OSC's findings and conclusions are not representative of the entire population.

State Comptroller's Comment – DOH's statement is misleading. Random and judgmental samples—in this case to gain clarification and to focus on the highest risk—are routinely used and widely accepted to reach audit conclusions. As mentioned in the audit report, the sample reviews were supplemented with reviews of regulations and policies and procedures, interviews with various DOH and Local District officials, assessments of internal controls, and data analysis to reach audit conclusions and recommendations.

Audit Recommendation Responses:

Recommendation #1

Using a risk-based approach, such as the one described in the body of this report, review the NYSOH members identified by the PARIS match between May 2017 and October 2019 (representing $1.5 billion in premiums paid through October 2024) and, as appropriate, determine their residency, end their Medicaid eligibility, and recover improper premium payments.

Response #1

The Department has reviewed a 5,000-member sample from the consumers identified in the May 2017- October 2019 Public Assistance Reporting Information System files. The Department will continue to evaluate the findings and explore sending requests for residency documentation to individuals who are currently enrolled. Any consumer appearing on these files who remained enrolled in Medicaid would have been present on the Q1 2020 Public Assistance Reporting Information System match processed in NY State of Health and had appropriate action taken.

The Department and OMIG will continue their ongoing review of the OSC-identified data to determine accuracy of the member information as well as what, if any, capitation payments are recoverable per the terms of the relevant Medicaid Managed Care Model Contract. NY State of Health is reviewing and making determinations on member eligibility and the need for potential disenrollment. OMIG supports these efforts and will make any necessary recoveries via OMIG's audit process.

Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining when to start the audit process. OMIG will pursue recovery of any identified and remaining overpayments. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. It is important to note that any payments identified by OSC that were made prior to 2019 are no longer recoverable, as they are beyond the six-year lookback period permitted by State regulations.

Recommendation #2

Correct NYSOH PARIS processing to ensure:

- NYSOH verifies the residency of all members identified by PARIS matches, including members who:
    - Have invalid Medicaid start dates in the matching state, District of Columbia, or Puerto Rico.
    - Incorrectly fail NYSOH's match validation process (e.g., members whose SSNs and birth dates actually match between NYSOH and PARIS information, and members who have multiple NYSOH identifiers).
    - Update their Medicaid applications with Life Status Changes unrelated to residency;
- NYSOH accurately includes all members with SSNs that have been verified by the Social Security Administration in the files sent for PARIS matching.
- The NYSOH PARIS clock properly expires for all members (e.g., members released from correctional facilities and members who inappropriately have more than one NYSOH account)

Response #2

In March 2024, the Department resolved the issue found during this audit where not all eligible Medicaid members were being sent on the Public Assistance Reporting Information System file.

The issue where an expired document was preventing a Public Assistance Reporting Information System clock to be set was resolved in September 2024.

The defect where a consumer received the ineligible reason code of, "Individual Duplicate Coverage," preventing the Public Assistance Reporting Information System clock from expiring, was resolved in July 2024.

The issue regarding resolving the Department of Corrections and Community Supervision life cycle is not a defect but an artifact of the required Center for Medicare and Medicaid Services extensions. A monthly data correction is being performed for the limited number of affected cases. Once the Center for Medicare and Medicaid Services extensions are completed, this issue will no longer occur.

The Department is exploring the necessary changes to handle matches with invalid start dates and multiple matches. The Department also will investigate the feasibility of a policy change related to accepting the Life Status Change as attestation of residency.

Recommendation #3

For those NY State of Health enrolled members who were not properly or fully processed for PARIS matching due to the NY State of Health defects identified in Recommendation 2, take the necessary steps to determine if any of the members resided outside New York and review the corresponding $375 million in premium payments and make recoveries, as appropriate.

Response #3

The current Public Assistance Reporting Information System match will include consumers who are currently enrolled and were impacted by the defects listed in Recommendation number two. The Department will review the consumers impacted by the listed defects to ensure they are properly identified, and appropriate action taken.

OMIG continues its review of the capitation payments for the members identified by OSC and included in this recommendation. OMIG continues to pursue additional data sources to validate the out-of-state residency of Medicaid managed care enrollees who have left the state, which would be of particular importance for members who were not properly or fully processed for Public Assistance Reporting Information System matching.

Recommendation #4

Develop a standard process that all Local Districts must follow for processing PARIS matches and notify all Local Districts of the process.

Response #4

The Department will explore options for modifying the guidelines used by Local Departments of Social Services to ensure individuals identified on the Public Assistance Reporting Information System match who are determined to no longer be New York State residents are appropriately closed and disenrolled from their managed care plans. In addition, the Department will continue to collaborate with the OMIG to ensure districts successfully provide notification of such disenrollments and, when appropriate, premiums are recouped.

Recommendation #5

Review the members identified by the audit who were marked “Closed/Removed by Match” by Local Districts but whose eligibility was not closed and, where appropriate, ensure their Medicaid eligibility is closed and the corresponding $65 million in retroactive premium payments are recovered.

Response #5

The Department reviewed approximately 3,000 members, accounting for approximately $63 million of the reported $65 million in overpayments. The remaining members are still under investigation. It was discovered that while these individuals were on the Public Assistance Reporting Information System report and marked closed by the counties, a subsequent review of their individual situations prevented disenrollment in many cases.

The Departments findings include two major reasons for remaining enrolled:

- Supplemental Security Income: Consumers who are receiving Supplemental Security Income in NY state are eligible for and automatically provided Medicaid coverage as required by (1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120). Since demographic information for these consumers is provided by the Social Security Administration directly into the Welfare Management System, residency is not reviewed for Medicaid eligibility, even if they appear on a Public Assistance Reporting Information System match. Cases closed by Local Districts are automatically reopened by Social Security Administration in the following month on Welfare Management System unless the address is changed at Social Security Administration. This scenario accounted for approximately $37 million of the $65 million in the report.

  State Comptroller's Comment – All members referred to in this recommendation were investigated by the Local District and marked "Closed/Removed by Match," indicating they were found to reside outside of New York. When a Local District determines a Supplemental Security Income member's address is incorrect, which DOH indicates may result in closed cases automatically reopening in the next month, there is a form (*Report of Change – SSI Data*) that can be submitted to the Social Security Administration to update the address. In these cases, DOH should work with the Social Security Administration to ensure the member's information is updated to prevent improper premium payments.

- Re-enrollments: Review of these members showed some who were disenrolled in the districts but had subsequently re-enrolled. This re-enrollment occurred: in the same district, a new district, or in NY State of Health. It appears consumers either moved back to New York or provided information to the Local District or NY State of Health after the original case was set to close. Local district staff would only be aware of the re-enrollment if it occurred in the same district and would not change their Public Assistance Reporting Information System match disposition. Please note, an investigator reviewing Public Assistance Reporting Information System match cases is not the same person handling a reactivation or a new application. This scenario accounted for approximately $10 million of the $65 million in the report.

  State Comptroller's Comment – We acknowledge that members in this population may have resided in another state and then moved back to New York. However, DOH must determine the period the member resided in another state and recover any improper premium payments.

  As noted on pages 15 and 16 of our report, we provided DOH with our audit findings during the audit. DOH officials responded that they reviewed a sample of 55 members we identified as marked "Closed/Removed by Match," and found that 10 members' eligibility had been closed by the Local Districts and the members reapplied for coverage through NYSOH. However, the eligibility for two of these 10 members was closed once

they reapplied in NYSOH, and the closings and reapplications did not occur until well after the PARIS matches—approximately 10 months and nearly 3 years after the matches, respectively. Two other members' eligibility was not closed until over 4 months after the PARIS matches. In these scenarios, DOH should recover the premiums paid during the periods that the Local Districts found the members were residing outside of New York.

OMIG continues to review the capitation payments for members identified by OSC and included in this recommendation. OMIG notes that a potential conflict within the data may exist for members marked as "Closed/Removed by Match" whose eligibility was not closed. This calls into question whether the value in that field is accurate or may have been included in error. OMIG's review of a sampling of members in this data found trends indicating that many members were in fact residing in New York State for all or part of the months identified in the OSC audit.

OMIG has been conducting a standalone Public Assistance Reporting Information System Match audit since 2022, and spent significant time developing its audit procedures to ensure audit findings are accurate. In OMIG's work developing the audit, OMIG noted data quality issues with the information contained in the Public Assistance Reporting Information System Match file, which are reflected in the Best Practices page on the PARIS match website, and notes that, per the experience of Pennsylvania, often the Public Assistance Reporting Information System match generates bad matches due to social security number data entry errors and other states not updating their information.

OMIG's statewide Public Assistance Reporting Information System Match audit is a retrospective review and has been completed for dates of service through December 31, 2019. These audits have recovered $22.3 million in capitation payments. The OSC claims data for dates of service January 1, 2020, to present is still subject to OMIG audit and the potential $59 million identified will be reviewed and, if appropriate, recovered.

OMIG conducted an analysis of OSC's findings in comparison to OMIG's most recent audit scope of January 1, 2019, through December 31, 2019, and identified some trends that raise questions about OSC's findings:

- Outdated other-state eligibility periods: In many cases, OSC defined capitation payments as inappropriate because of an other-state eligibility period that began in the past; in some cases, the other-state eligibility began as far back as 2001. OMIG reviewed a selection of these members and frequently found encounter data and other evidence indicating the enrollee was in New York State for the period identified.

- Other-state eligibility periods with "infinite" end dates: These members require additional scrutiny because they can lead to inflated overlap periods. Local District comments and the "DateResolved" field may offer more precise closure indicators but are not always consistently populated.

OMIG reviewed a sample of 2019 dates of service, with a particular focus on members whose other state Medicaid eligibility was two or more years prior to 2019. OMIG's review found that many of these members were regularly receiving medical services in New York State, indicating that they were residing in the state for some or all of OSC's identified dates of service. The Local Districts' failure to close eligibility for these members may be an indicator that the member

was truly residing in New York State. The "Closed" data indicator in the Public Assistance Reporting Information System file is not always an accurate representation due to data entry errors. As an example, OMIG identified two members who were marked as "Closed" on the Public Assistance Reporting Information System file (2014 and 2016) but had received services in New York State in 2019.

State Comptroller's Comment – As detailed in the report, all members were marked "Closed/Removed by Match" by the Local District due to the third quarter 2017 through fourth quarter 2022 PARIS match, indicating the members resided outside New York during this period. If the start date in the other state is outdated or missing, DOH and OMIG must determine the time frame the member was out of state and recover any related premium payments, as appropriate. For example, in the scenario described in its response, OMIG's review should have considered the members' residence before 2019 (e.g., 2017 and 2018) to confirm if they resided in another state and then moved back to New York.

Additionally, if the DOH PARIS match database contains inaccuracies, DOH and OMIG should collaborate with the Local Districts to identify the cause of the discrepancies and correct the information.

Recommendation #6

Develop oversight processes to ensure resolutions of WMS and NYSOH PARIS matches are properly processed in a timely manner that include, but are not limited to, ensuring:

- WMS PARIS matches marked "Closed/Removed by Match" result in the members' eligibility being closed.
- Local Districts initiate retroactive disenrollments for periods members resided outside of New York.
- All improper premium payments are recovered timely.

Response #6

The Department has improved, and will continue to modify and improve, its oversight processes to ensure timely and correct processing (closing of cases, retroactive disenrollment and recoupment) of all Public Assistance Reporting Information System matches.

Below are some examples of this increased quality control process:

- Increased staff involved in the Quality Review process: The Department increased the staff involved in verifying Public Assistance Reporting Information System reports, returned as "completed" by the local districts, to reflect the actual changes made in the Welfare Management System. Staff were also provided training in confirming if a case was correctly handled.
- Increased spot check: The Department increased the percentage of cases it audits during the "spot check" process from 2% to 10%. The Department now reviews, at a minimum, 10% of cases, per district, to ensure compliance by the districts. This review seeks to ensure districts not only properly closed all appropriate Public Assistance Reporting Information System matches but also if districts followed-up on any possible claims for

recoupment. Follow-up and feedback are provided to the local districts whenever any issues are discovered.

OMIG will perform its own extraction of data from the Medicaid Data Warehouse which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete, confirm the accuracy of the claims detail for use in OMIG audit activities, to determine those overpayments requiring recovery. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. OMIG will recover any identified and remaining overpayments. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #7

Review the $234 million in improper premiums paid for members whose eligibility was closed and make recoveries, as appropriate.

Response #7

OMIG has been conducting a standalone Public Assistance Reporting Information System Match audit since 2022, and spent significant time developing its audit procedures to ensure audit findings are accurate. In OMIG's work developing the audit, OMIG noted data quality issues with the information contained in the Public Assistance Reporting Information System Match file, which are reflected in the Best Practices page on the PARIS match website, and notes that, per the experience of Pennsylvania, often the Public Assistance Reporting Information System match generates bad matches due to social security number data entry errors and other states not updating their information.

OMIG's statewide Public Assistance Reporting Information System Match audit is a retrospective review and has been completed for dates of service through December 31, 2019. These audits have recovered $22.3 million in capitation payments. The OSC claims data for dates of service January 1,2020 to present is still subject to OMIG audit and the potential $212 million identified will be reviewed and, if appropriate, recovered.

OMIG conducted an analysis of OSC's findings in comparison to OMIG's most recent audit scope of January 1, 2019, through December 31, 2019, and identified some trends that raise questions about OSC's findings:

- Outdated other-state eligibility periods: In many cases, OSC defined capitation payments as inappropriate because of an other-state eligibility period that began in the past; in some cases, the other-state eligibility began as far back as 2001. OMIG reviewed a selection of these members and frequently found encounter data and other evidence indicating the enrollee was in New York State for the period identified.

  State Comptroller's Comment – DOH's response is misleading. As detailed in the report, we identified improper premium payments for members whose eligibility was closed due to the third quarter 2017 through fourth quarter 2022 PARIS match. The other state eligibility period is an indicator that a member may have resided out of state during that period. DOH and OMIG are responsible for confirming the time frame the member was out of state and recovering any related premium payments.

- Other-state eligibility periods with "infinite" end dates: These members require additional scrutiny because they can lead to inflated overlap periods. Local District comments and the "DateResolved" field may offer more precise closure indicators but are not always consistently populated.

Recommendation #8

Use NCOA and any other additional data sources, such as the sources referenced in this report, to identify members residing outside of New York.

Response #8

The Department is taking steps to use the National Change of Address file to identify consumers who have changed their New York mailing address to an out-of-state mailing address. Since the National Change of Address file reflects changes to mailing addresses only, the Department cannot terminate a consumer's eligibility until the consumer has had an opportunity to prove their continued state residency. If the Department determines a consumer is no longer residing in New York, their eligibility will be terminated in accordance with state and federal regulations. Recovery of any overpayments to plans will be pursued, as appropriate.

The Department is exploring processes to use existing, reliable data sources to identify consumers who may be residing outside of New York. These data sources include information provided by both private insurers and Medicare. This process would include a demonstration using policyholder addresses to establish a set of consumers who require outreach for verification of their residency. If the Department determines a consumer is no longer residing in New York, their eligibility will be terminated in accordance with state and federal regulations. Recovery of any overpayments to plans will be pursued, as appropriate.

The Department is also exploring the use of Managed Care encounter data to identify consumers who have not utilized care over a specified period, similar to the OMIG process outlined in the report. This data could be used to establish a set of consumers who require outreach for residency verification.

The Florida voter registry is not useable systematically as it requires manual entry of consumer information and cannot be used in a batch capacity, making this an unrealistic tool to identify consumers living out of state.

It should be noted the Department was required to keep consumers enrolled due the Public Health Emergency continuous enrollment requirements. Local districts and NY State of Health were required to keep consumers enrolled until the end of their existing authorization period until they had an opportunity to complete a renewal, even if there was returned mail and the consumer could not be reached. This policy was in effect from March 2020, through July 2023.

State Comptroller's Comment – Under the Families First Coronavirus Response Act, continuous enrollment was required through the end of the emergency period unless the individual requested a voluntary termination of eligibility or the individual ceased to be a resident of the State.

OMIG continues to pursue additional data sources to validate the out-of-state residency of NYS Medicaid enrollees. The challenge persists of ensuring these data sources are accurate and complete, and that the data source is properly matched to a NYS Medicaid enrollee. There is a

significant risk of bad matches due to social security number data entry errors and matching on incomplete data points (the Florida voter file appears to only match on the last four digits of a social security number). When dealing with data sets as large as the Medicaid population in New York State and other large states, there are significant risks of people sharing key demographic indicators like name and date of birth. The 1095b/National Change of Address Report provides some value but is unreliable as a standalone data source due to date-related assumptions, format limitations, and reporting inconsistencies. The effective date reflects the quarterly processing date of the files received rather than actual move dates; furthermore, the true time range of the data that was processed is unknown. The National Change of Address data is in a non-standard Portable Document Format, making large-scale validation difficult without significant manual review, which raises the potential for errors and a reduction in efficient data validation.

OMIG's analysis of the National Change of Address report found a member's confirmed out-of-state move was not indicated on the report at all, and OMIG recovered capitation payments for members with dates of service in 2019, where the member was not listed on the National Change of Address report. An important point worth noting is that the National Change of Address resource is developed and maintained by the United States Postal Service as a resource to assist in the delivery of mail. The National Change of Address report does not guarantee that the member relocated, but simply indicates where a member's mail has been directed.

State Comptroller's Comment – We are pleased DOH is taking steps to use the NCOA file, as it is a valuable resource for identifying members living in other states and preventing improper Medicaid payments.

As stated on page 17 of the report, CMS issued a letter in March 2022 strongly encouraging states to utilize NCOA data and consider it reliable, provided that adequate outreach is completed by the state. Additionally, the 1095-B report referenced in DOH's response is generated by DOH's eMedNY system. Therefore, OMIG should collaborate with DOH to update the report to enhance its usefulness, such as adding the actual move date.

Recommendation #9

Engage with the U.S. Department of Health and Human Services on whether the Administration for Children & Families can incorporate additional data sources that help establish residency, such as NCOA, into the federal PARIS match.

Response #9

The Department, along with the Office of Temporary and Disability Assistance, has engaged with the Administration of Children & Families regarding an increase in frequency of the federal Public Assistance Reporting Information System match. Additionally, there are proposed statutory changes at the federal level requiring the use of National Change of Address data, as well as verified address data from Managed Care Plans, to help ensure accurate residency information for enrollees. The Department will continue to engage with federal partners and ensure compliance with any new federal requirements.

Recommendation #10

Review the $509 million in premium payments made on behalf of members identified as residing

outside of the State according to the data sources other than PARIS and, as appropriate, determine the members' residency, end their Medicaid eligibility, and recover improper premium payments.

Response #10

The Department will explore sending requests for residency verification to consumers identified in this audit as living outside of New York according to data sources other than the Public Assistance Reporting Information System match. If appropriate, the Department will disenroll the consumer from managed care and initiate premium recoupments.

OMIG continues to pursue additional data sources to validate the out-of-state residency of NYS Medicaid enrollees. The challenge persists of ensuring these data sources are accurate and complete, and that the data source is properly matched to a NYS Medicaid enrollee. There is a significant risk of bad matches due to social security number data entry errors and matching on incomplete data points (the Florida voter file appears to only match on the last four digits of a social security number). When dealing with data sets as large as the Medicaid population in New York State and other large states, there are significant risks of people sharing key demographic indicators like name and date of birth. The 1095b/National Change of Address Report provides some value but is unreliable as a standalone data source due to date-related assumptions, format limitations, and reporting inconsistencies. The effective date reflects the quarterly processing date of the files received rather than actual move dates; furthermore, the true time range of the data that was processed is unknown. The National Change of Address data is in a non-standard Portable Document File, making large-scale validation difficult without significant manual review, which raises the potential for errors and a reduction in efficient data validation.

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State Comptroller's Comment – As stated on page 17 of the report, CMS issued a letter in March 2022 strongly encouraging states to utilize NCOA data and consider it reliable, provided that adequate outreach is completed by the state. Additionally, the 1095-B report referenced in DOH's response is generated by DOH's eMedNY system. Therefore, OMIG should collaborate with DOH to update the report to enhance its usefulness, such as adding the actual move date.

While the additional data sources OSC reviewed could be used to complement the Public Assistance Reporting Information System match, they are unreliable as standalone data sets. Of the claims data included in this recommendation, $462 million had a single data source other than Public Assistance Reporting Information System, indicating the member may have been residing outside of New York. These claims require further analysis using additional data sources to determine where the member was residing.

OMIG will continue to review payments and evaluate additional data sources to validate the out-

of-state residency of NYS Medicaid enrollees. The challenge persists of ensuring these data sources are accurate and complete, and that the data source is properly matched to a NYS Medicaid enrollee. OMIG will recover any payments that it identifies as inappropriate. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #11

When OMIG identifies members with an out-of-state address in the MDW and no in-state service claims, ensure retroactive recoveries of premium payments are made, as appropriate.

Response #11

OMIG is developing a process to ensure members identified as having an out-of-state address and no in-state service claims are properly reviewed by the relevant local district staff and captured in the retroactive disenrollment process as appropriate.

OMIG will recover any overpayments identified by this process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

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