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STATE OF NEW YORK  
**OFFICE OF THE STATE COMPTROLLER**

October 14, 2010

Richard F. Daines, M.D.  
Commissioner  
NYS Department of Health  
Corning Tower Building  
Empire State Plaza  
Albany, NY 12237

Re: Report 2010-F-21

Dear Dr. Daines:

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 (Department) to implement the recommendations contained in our audit report, *Inappropriate Payments For Medicaid Recipients Residing And Enrolled In Other States* (Report 2008-S-4).

**Background, Scope and Objective**

New York State's Medicaid program is administered by the Department. In the program, medical services are provided to low-income individuals who meet the program's eligibility requirements. Local social services districts (57 counties and New York City) are responsible for enrolling individuals in Medicaid and ensuring that the individuals meet all eligibility requirements. Medicaid payments are made to participating medical service providers or participating managed care plans.

When a Medicaid recipient is enrolled in a managed care plan, the plan is paid a monthly premium to provide a comprehensive range of medical services to the recipient. The plan is paid the monthly premium until the recipient is no longer eligible for Medicaid or no longer resides in the area covered by the plan. When a Medicaid recipient is not enrolled in a managed care plan, the medical service provider is reimbursed on a fee-for-service basis for the services provided to the recipient. The fee levels are established by the Department.

Each state has its own Medicaid program, and a state may make unnecessary Medicaid payments if it provides Medicaid coverage to individuals who actually reside in other states. For example, if a state does not disenroll an individual from a Medicaid managed care plan after the individual moves to another state, the state will continue, unnecessarily, to pay monthly managed care premiums on behalf of the individual. If the individual enrolls in another state's Medicaid

program, both states could be paying such premiums at the same time, thus inflating the cost of Medicaid coverage for that individual.

To help prevent such situations, each quarter, the U.S. Department of Health and Human Services (HHS) reviews the enrollment data for public assistance programs such as Medicaid, identifies the individuals who appear to be enrolled in such programs in two or more states at the same time, and distributes a report listing these individuals to the affected states. In New York State, these quarterly reports (called Public Assistance Reporting Information System, or PARIS, reports) are received by the State Office of Temporary and Disability Assistance (OTDA). OTDA is to forward the listing of potentially duplicate Medicaid-only enrollments to the Department, and the Department is to forward the potentially duplicate enrollments to the local social services districts (local districts), including the Human Resources Administration (HRA) in New York City.

The local districts are then expected to investigate the enrollments to determine whether they were, in fact, duplicate, and if so, whether the individuals need to be disenrolled from New York's Medicaid program. The local districts are to report the results of their investigations to the Department, and the Department is to determine whether any inappropriate Medicaid payments were made by New York State on behalf of these individuals. If so, the Department is to seek the recovery of these payments.

Our initial audit report, which was issued on March 3, 2009, determined if the Department ensured that local districts and HRA adequately investigated instances where New York State Medicaid program enrollees were also enrolled in another state's Medicaid program. Our objective also was to determine if the Department recovered inappropriate New York State Medicaid payments made for enrollees who no longer resided in the State and were covered under another state's Medicaid program. We found that the Department had not taken steps to effectively ensure that local social service districts and HRA acted in a timely manner to either investigate the enrollees identified on the reports or to remove them from New York's Medicaid program. For example, the Department had not worked with the local social service districts and HRA to establish policies, procedures and time frames for completing investigations. The Department also had not set up monitoring mechanisms to track the actual timeliness of the completion of investigations. Additionally, we found the Department had not recovered inappropriate New York State Medicaid payments made for enrollees who no longer resided in the State and were covered under another state's Medicaid program. The objective of our follow-up was to assess the extent of implementation as of September 22, 2010, of the five recommendations included in our initial report.

### **Summary Conclusions and Status of Audit Recommendations**

We found that Department officials have made progress in correcting the problems we identified. However, additional improvements are needed. Of the five prior audit recommendations, three recommendations have been implemented, one recommendation has been partially implemented, and one recommendation has not been implemented.

In the original audit, we identified \$14.3 million in fee-for-service payments to providers for services provided to recipients who remained active in New York's Medicaid program despite being simultaneously enrolled in at least one other state's Medicaid program. We recommended that the Department examine these fee-for-service payments and the providers pertaining to these payments

to ensure these cases do not involve fraud. During our follow-up, we found that the Department officials have not addressed this recommendation. The possibility still remains that payments of this nature are an attempt to defraud the program by submitting claims for individuals who are known to have left the state. During our follow-up, we identified an additional \$4.7 million in fee-for-service payments for individuals who were enrolled in another state's Medicaid program during the period in which the fee-for-service claim was made. As such, we now estimate \$19 million as the potential overpayment amount attributable to this audit finding.

### **Follow-up Observations**

#### **Recommendation 1**

*Commit to ensuring effective oversight of the PARIS reporting function.*

Status - Implemented

Agency Action - Department officials indicate that, since our original audit, oversight and review of the PARIS reporting function has been shifted to a different Department bureau. Department officials have also issued guidance to the local districts and HRA, including a 60 business day time frame requirement to complete investigations of matches found on the PARIS reports. In addition, as of June 2009, local districts and HRA are required to report PARIS enrollment resolution information electronically. The 57 local districts access the PARIS match files on a secure network drive and HRA has the file sent directly to them. Each quarter an e-mail is sent to the local districts and HRA notifying them that new files are available and the old files have been removed. Department staff follow up via e-mail and/or phone prior to the end of the 60 day time frame to help ensure that all resolutions are completed timely. According to Department resolution reports, improved oversight of the PARIS reporting function has decreased the amount of unresolved cases from approximately 75 percent to 1 percent of the total cases identified on the PARIS reports since our original audit.

#### **Recommendation 2**

*Work with local social service districts and HRA to develop standard policies, procedures and time frames for completing investigations of enrollees identified on PARIS reports. Also work with local social service districts and HRA to timely and correctly remove ineligible enrollees from the program when investigations result in closed cases.*

Status - Partially Implemented

Agency Action - As previously noted, Department officials have established a time frame of 60 business days for the local districts and HRA to complete investigations of enrollees identified on the PARIS reports. Additionally, Department officials issued letters to local district and HRA officials explaining changes in procedures for accessing PARIS reports electronically. When an investigation is completed, local districts and HRA are instructed to enter a code indicating the recipient's status (for example, code 2 indicates a recipient's case closed/removed by match) and the date the investigation was completed. However, as

of August 2010, the Department has not taken any steps to ensure ineligible enrollees are removed from the program when investigations result in closed cases. Department officials indicated that they are working to develop a process for this purpose.

### **Recommendation 3**

*Provide guidance and direction to HRA concerning investigation of fee-for-service cases represented on PARIS reporting.*

Status - Implemented

Agency Action - In summer 2009, HRA implemented an automated closing process for certain individuals on the PARIS report. HRA's Bureau of Fraud manually investigates cases with household sizes greater than one and reports their resolutions on the Department's electronic resolution database. Cases involving one individual are flagged for automated closing and a letter stating the case will be closed in 10 days is automatically generated and sent to the last known address of the enrollee. The results of these cases are reported to the Department on the electronic database. These procedures apply to both managed care plan and fee-for-service enrollees identified on the PARIS report.

### **Recommendation 4**

*Examine the fee-for-service payments pertaining to PARIS reporting to ensure that these cases do not involve fraud.*

Status - Not Implemented

Agency Action - Department officials stated that, to date, they have not reviewed fee-for-service payments pertaining to PARIS reporting, but they would like to discuss this recommendation with the Office of the Medicaid Inspector General (OMIG) and implement changes. We maintain that such review is important because, since our original audit, we have identified an additional \$4.7 million in potential fee-for-service overpayments for recipients who were enrolled in another state's Medicaid program and found to be living in the other state. Under this scenario, it is possible that providers are fraudulently billing for services not provided.

### **Recommendation 5**

*Identify the premiums that were paid to plans during periods of dual enrollment and recover these premiums, unless the plans can show that they provided medical services to the individuals during the period covered by premiums.*

Status - Implemented

Agency Action - At the time of the original audit, Department officials indicated that since the plans could have been at risk of incurring costs for medical care, the plans were entitled to the premiums and therefore they were unrecoverable. However, the Department has since

reconsidered its original position on this matter and has implemented a change in the Medicaid program's ability to recover premiums from managed care plans. The change would permit recovery of managed care premiums for enrollees who appear on a PARIS report and have eligibility and reside in another state. Recovery would be allowed only when the Medicaid managed care plan provided no services for the entire overlap period. Department officials indicated that the local districts, HRA, and the managed care plans are aware of the state's right to recover premiums. The local districts and HRA will be responsible for determining managed care payments that can be recovered and processing void requests to the managed care plans. As of October 2010, one county has recovered managed care premiums paid for two recipients who were residing in another state and enrolled in that state's Medicaid program.

Major contributors to this report were Karen Bogucki and Amanda Strait.

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 also thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Edward J. Durocher, CIA  
Audit Manager

cc. Mr. Stephen Abbott, Department of Health  
Mr. Stephen LaCasse, Department of Health  
Mr. Thomas Lukacs, Division of the Budget