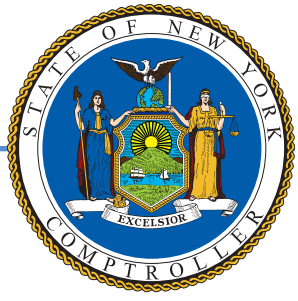
Department of Health

Medicaid Program: Improper Medicaid Payments Involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers

Report 2019-S-22 | September 2020

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

Division of State Government Accountability



Audit Highlights

Objective

To determine if improper Medicaid payments were made on behalf of recipients with multiple Client Identification Numbers (CINs) where at least one CIN was enrolled in fee-for-service. The audit covered the period from January 1, 2014 to March 31, 2019.

About the Program

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

Each individual who applies for Medicaid benefits is assigned a CIN, a unique identifier. However, recipients may have more than one CIN assigned during the time they are in receipt of benefits, such as one CIN under FFS enrollment and a different CIN under managed care enrollment. Only one CIN should have active eligibility at a time to prevent duplication of payments.

Individuals have several options for enrolling in Medicaid, including through Local Departments of Social Services (Local Districts) and the NY State of Health (NYSOH, the State's online health insurance marketplace). Local Districts use the State's downstate Welfare Management System (WMS) to process enrollment data for individuals in New York City and the upstate WMS for individuals in the rest of the State. The NYSOH system processes its own enrollment data. Additionally, the New York City Administration for Children's Services processes Medicaid enrollments for individuals in foster care in New York City, but must use the upstate WMS. The eMedNY system relies on the information sent by the WMS and NYSOH systems to update its enrollment data, which is necessary to make accurate payments. When an individual is assigned multiple CINs, each with its own record of eligibility, Medicaid is at risk of making improper payments for the duplication of benefits.

Key Findings

- Medicaid made $47.8 million in payments on behalf of recipients with multiple CINs for the period January 1, 2014 through March 31, 2019, which included:
  - $32.6 million in improper premiums for inappropriate managed care enrollments of recipients concurrently enrolled in FFS foster care under different CINs;
  - $12.7 million in improper premiums for managed care enrollments of recipients concurrently enrolled in FFS under different CINs (in each case, one of the concurrent enrollments was improper; the circumstances identified provide a basis for recovering premiums);
  - $2.5 million in potential duplicate FFS payments made on behalf of recipients with concurrent FFS enrollments under different CINs.
- Multiple CINs are often the result of incorrect/missing recipient demographic information, use of multiple eligibility systems during enrollment (e.g., upstate WMS, downstate WMS, NYSOH), and limitations in the enrollment process for foster care recipients.

- The Office of the Medicaid Inspector General (OMIG) recovers improper premium payments for foster care recipients with multiple CINs. By the end of our fieldwork, $16.6 million of the improper payments identified were voided. However, OMIG does not have a process to recover improper premium payments for non-foster care recipients with concurrent FFS enrollment or improper FFS payments for recipients with multiple FFS enrollments.

Key Recommendations

- Review the improper payments identified and make recoveries, as appropriate.
- Correct the multiple CIN cases identified to prevent future improper payments.
- Evaluate controls to prevent the creation of multiple CINs for recipients in foster care.
- Begin recovering improper premiums for non-foster care recipients with concurrent FFS enrollment and improper FFS payments for recipients with concurrent FFS enrollments.

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

September 17, 2020

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for 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 Medicaid Payments involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers*. The audit was performed 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.

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
ACS	New York City Administration for Children's Services	*Agency*
CIN	Client Identification Number	*Key Term*
Contract	Medicaid Managed Care Model Contract	*Key Term*
DEMI	Department's Division of Eligibility and Marketplace Integration	*Division*
Department	Department of Health	*Auditee*
eMedNY	Department's Medicaid claims processing system	*System*
FFS	Fee-for-service	*Key Term*
HRA	Human Resources Administration	*Agency*
Local Districts	Local Departments of Social Services	*Key Term*
MCO	Managed care organization	*Key Term*
NYSOH	NY State of Health, the State's online health insurance marketplace	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
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. For the State fiscal year ended March 31, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.5 percent.

The federal Centers for Medicare & Medicaid Services oversees state Medicaid programs, and the Department of Health (Department) administers the program under Title XIX of the Social Security Act through its Office of Health Insurance Programs.

Individuals may enroll in Medicaid through Local Departments of Social Services (Local Districts) and, as of October 2013, the NY State of Health (NYSOH, the State's online health insurance marketplace). Local Districts use the Welfare Management System (WMS) to process applicant data and to update individuals' enrollment information, which is ultimately communicated to eMedNY, the Department's Medicaid claims processing and payment system. NYSOH communicates with eMedNY and other systems (e.g., the federal Social Security Administration) to coordinate the enrollment activities associated with NYSOH-enrolled individuals. The eMedNY system relies on the information sent by WMS and NYSOH to update its eligibility and enrollment data necessary to make appropriate Medicaid payments.

WMS is overseen by the Office of Temporary and Disability Assistance and is composed of two components: a downstate system for New York City area recipients and an upstate system for recipients in the rest of the State. Human Resources Administration (HRA) is the Local District that handles Medicaid enrollments for New York City. HRA updates individuals' enrollment through the downstate WMS system, while the other 57 Local District offices update enrollment using the upstate WMS system. Generally, the New York City Administration for Children's Services (ACS) processes Medicaid applications and enrollments for children and young adults in foster care in New York City. However, because of WMS' design, ACS updates individuals' enrollment on the upstate WMS system.

For eligibility verification and benefit-tracking purposes, each individual who applies for Medicaid benefits or another State public assistance program is assigned a Client Identification Number (CIN), a unique identifier. Medicaid recipients may have more than one CIN assigned to them (herein referred to as "multiple CINs") during the time they are in receipt of benefits; however, only one CIN should have active eligibility at a time. Through a process known as Clearance, Local District caseworkers determine whether an individual applying for Medicaid coverage already has an existing CIN. The Clearance process matches the applicant's demographic information, such as name, date of birth, Social Security number (SSN), and gender to that of all existing CINs in the downstate WMS, upstate WMS, and NYSOH systems. Depending on the Clearance results, a caseworker either creates a

new CIN or, if the individual already has a CIN assigned, selects the existing one. Concurrent active eligibility under more than one CIN for the same recipient should be terminated to prevent duplication of benefits.

The Department uses two methods to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department pays health care providers directly, through eMedNY, for each eligible service rendered to Medicaid recipients who are enrolled with FFS coverage, including children and young adults in foster care. Under managed care, the Department makes monthly premium payments to managed care organizations (MCOs) for Medicaid recipients who are enrolled with managed care coverage. In return, MCOs arrange for the provision of health care services and reimburse providers for services provided to their recipients.

The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. As such, it has a role in recovering inappropriate Medicaid payments that occur when a recipient has multiple CINs.

Audit Findings and Recommendations

In our audit 2018-S-24, *Improper Managed Care Premium Payments for Recipients With Duplicate Client Identification Numbers*, issued July 2019, auditors found Medicaid made over $102 million in improper managed care premium payments on behalf of recipients with multiple CINs who were enrolled in managed care. According to Local District officials interviewed during the audit, multiple CINs were often the result of incorrect/missing recipient demographic information, the use of multiple eligibility systems during application (e.g., upstate WMS, downstate WMS, and NYSOH), and the enrollment process for foster care recipients.

The current audit examined Medicaid payments on behalf of recipients with multiple CINs where at least one CIN was enrolled in FFS. Our audit identified another $47.8 million in Medicaid payments made on behalf of 20,912 such recipients for services provided from January 1, 2014 through March 31, 2019. Improper payments occurred because the recipients had concurrent active eligibility under more than one CIN, which allowed for the duplication of Medicaid benefit payments, including:

- $32.6 million for improper managed care premiums paid on behalf of recipients concurrently enrolled in FFS foster care under different CINs (in each case, the managed care enrollment was improper);
- $12.7 million for improper managed care premiums paid on behalf of recipients concurrently enrolled in FFS who received inpatient care, home health care, nursing home care, and clinic services under different CINs (in each case, one of the concurrent enrollments was improper; the circumstances identified provide a basis to recover premiums); and
- $2.5 million for potentially duplicate FFS payments on behalf of recipients enrolled in FFS under different CINs (in each case, one of the FFS enrollments was improper).

OMIG has an audit process to identify improper managed care premium payments on behalf of FFS foster care recipients with multiple CINs. At the conclusion of our fieldwork, $16.6 million of the $32.6 million in improper payments we identified had been voided. However, OMIG does not have a process to identify and recover improper managed care premium payments on behalf of non-foster care FFS recipients with multiple CINs or improper FFS payments on behalf of FFS recipients with multiple CINs. We recommend a process be developed to identify and recover those improper payments going forward. We also recommend the Department and OMIG review the overpayments identified by the audit and make recoveries, as appropriate. Additionally, the Department should review and resolve all the multiple CINs we identified to prevent future overpayments.

Foster Care-Related Overpayments

Upon enrollment into foster care, individuals receive Medicaid services under FFS, and are ineligible for enrollment in the managed care program. Prior to foster care, however, these individuals may have been enrolled in, and assigned a Medicaid CIN for, managed care. When this prior CIN is not identified and/or deactivated

during foster care enrollment, Medicaid is at risk of inappropriately paying managed care premiums for foster care recipients with concurrent FFS and managed care enrollment. The Medicaid Managed Care Model Contract (Contract) states that the Department can recover premium payments made on behalf of recipients who are receiving foster care services. Our audit determined Medicaid improperly paid $32.6 million in managed care premium payments for 12,151 recipients who were concurrently enrolled in foster care.

The process of enrolling children and young adults into foster care can contribute to the creation of multiple CINs. When enrolling foster care children and young adults, ACS – like NYSOH and Local District caseworkers – uses the Clearance process to determine if a person already has an active Medicaid CIN. The SSN is critical for identifying an existing CIN, but, for many foster care applicants, the SSN is unknown and it is not required at the time of foster care enrollment. If ACS is unable to find an existing CIN during Clearance, it will create a new and possibly multiple CIN. In this scenario of multiple active CINs, Medicaid is at risk of inappropriately paying managed care premiums on behalf of foster care recipients who are already enrolled in managed care. At the time of our audit, 5,026 of the 12,151 foster care recipients in our findings population were enrolled in Medicaid foster care without a SSN. (Note that the SSN may be updated after enrollment and therefore some recipients with a SSN at the time of our audit may not have had one on initial enrollment.)

ACS' use of the upstate WMS to issue foster care CINs also contributes to the creation of multiple CINs. During the Clearance process, matching CINs in the downstate WMS will be displayed but cannot be selected for use. As a result, even if ACS becomes aware of a downstate CIN during the Clearance process (which it often may not, due to the lack of a SSN), the CIN cannot be selected and another is created. Because many Medicaid recipients are enrolled in managed care, it increases the risk that Medicaid will make inappropriate monthly premium payments for recipients concurrently enrolled in foster care.

For example, we identified one Medicaid recipient enrolled in the downstate WMS system with active managed care coverage dating before our audit. Using the upstate WMS system, another (multiple) CIN was created for this recipient (with matching SSN, first and last name, and date of birth as the existing CIN) and the recipient was enrolled in foster care in January 2014. During our audit scope, we identified 57 improper managed care premium payments totaling $60,823 for the period the recipient was also in foster care. At the conclusion of our audit fieldwork, the multiple CINs had not yet been linked in eMedNY (linking enables eMedNY to treat a person's multiple CINs as the same individual to prevent improper payments).

As shown in the following table, the majority of the foster care-related multiple CIN cases we identified (79 percent) involved a managed care CIN in the downstate WMS system.

System for Foster Care CIN	System for Managed Care CIN	Overpayment Amount	Number of Recipients With Multiple CINs	Percent of Total Foster Care Multiple CINs
Upstate WMS	Downstate WMS	$28,899,596	9,527	78.40%
Upstate WMS	NYSOH	2,927,382	2,441	20.09%
Upstate WMS	Upstate WMS	673,605	80	0.66%
NYSOH*	Downstate WMS	70,972	53	0.44%
NYSOH*	NYSOH	25,863	45	0.37%
NYSOH*	Upstate WMS	17,380	4	0.03%
Downstate WMS	Upstate WMS	192	1	0.01%
Totals		**$32,614,990**	**12,151**	**100%**

*The Former Foster Care Youth Program is a provision of the Affordable Care Act that allows young adults discharged from the foster care program to remain on Medicaid until age 26. Such individuals can enroll through NYSOH.

In August 2018, ACS and HRA established a three-year data-sharing agreement (with two optional one-year extension periods) to address the issue of multiple CINs for foster care recipients. The agreement allows the two agencies to periodically share information about recipients with multiple CINs who may have more than one active Medicaid enrollment at a time. HRA uses information received from ACS to reconcile multiple CINs and to determine if it can close Medicaid enrollment for its cases. HRA stated the agreement has helped to resolve over 13,000 cases involving multiple CINs. However, the temporary data-sharing agreement only addresses reconciliation of multiple CINs. The agreement does not address the creation of multiple CINs for children enrolled in foster care, which continues to put the Medicaid program at risk of overpayments.

OMIG has an audit process to identify foster care recipients with multiple CINs enrolled in both managed care and FFS. At the conclusion of our fieldwork, $16.6 million of the improper payments we identified were voided.

Recommendations

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

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

Other Overpayments

According to the Contract, effective March 1, 2014, the Department has the right to withhold or recover premium payments made to an MCO on behalf of a recipient where FFS claims were also paid for MCO benefit-covered services during the same payment month and where the recipient has multiple CINs. Our audit identified $12.7 million in improper managed care premium payments made on behalf of 7,662

recipients who received inpatient, home health, nursing home, and clinic services through FFS under a different CIN. The FFS payments were for MCO benefit-covered services.

For example, our analysis found that, on behalf of one recipient, Medicaid made a $5,185 managed care premium payment for November 2018 and in the same month made a FFS payment of $4,020 for nursing home services (which were a covered benefit under managed care) under a different CIN. Pursuant to the Contract, we determined Medicaid overpaid $5,185 for the managed care premium. Although over $250,000 of the $12.7 million in overpayments we identified were voided at the conclusion of our audit fieldwork, OMIG officials stated that they did not have a specific process to identify improper managed care premium payments on behalf of non-foster care recipients with concurrent FFS enrollment.

We also identified $2.5 million in payments on behalf of 1,999 recipients with multiple CINs and concurrent enrollments in FFS. We found 13,392 potentially duplicate claims for clinic, inpatient, home health, nursing home, foster care, practitioner, and pharmacy services. For example, we identified one recipient with a CIN created in upstate WMS with eligibility beginning June 1, 2013 and ending June 11, 2015. The recipient was in a nursing home for the entire eligibility period. A second CIN for this recipient was created in downstate WMS in August 2015 (after the eligibility of the first CIN was already closed). However, eligibility was retroactive beginning on June 1, 2013 and continued until the recipient's death on January 14, 2019. Using the second CIN, the nursing home billed Medicaid for retroactive care dating back to the beginning of the recipient's eligibility – which included a period of service that Medicaid had already paid for under the first CIN. As a result, Medicaid made overpayments of $93,925 to the nursing home for the overlapping period. We contacted the nursing home, which agreed it had been overpaid and would void the improper claims. However, at the end of our fieldwork, the claims had not yet been voided.

OMIG also did not have a process to identify overpayments resulting from multiple CINs enrolled in FFS. According to OMIG officials, they are in the process of addressing this area.

Recommendations

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

4. Develop a process to identify and recover:

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

CIN Linking Issues

Multiple CINs with concurrent active eligibility has been a long-standing issue for the Department. As a result, in March 2017, the Department dedicated more resources to multiple CIN research and resolution by creating the Division of Eligibility and Marketplace Integration (DEMI) unit. The DEMI unit oversees many aspects of multiple CIN detection and resolution and is also responsible for linking confirmed multiple CINs in eMedNY. The linking process enables eMedNY to treat the multiple CINs as the same individual and ensures claim information from multiple CINs is subject to frequency and history checks (regarding services provided) that prevent improper payments. According to the Department, from June 1, 2018 through November 30, 2019, DEMI staff referred 117,083 CIN pairs for linking in eMedNY.

Of the 108,616 payments we identified (totaling $47.8 million), 108,241 (99.7 percent) were made on behalf of 20,741 recipients with multiple CINs that were not linked in eMedNY. Because the multiple CINs were not linked at the time the claims were processed, eMedNY was unable to treat the CINs as the same recipient to prevent improper payments. The Department subsequently linked 4,215 of the 20,741 recipients with multiple CINs by the end of our audit fieldwork. We provided the Department with the remaining 16,526 recipients with multiple CINs we identified for review and linking.

The remaining 375 payments (totaling $140,669) were made on behalf of 171 multiple CINs that were already linked in eMedNY. We found a weakness in the design of eMedNY's controls that allowed these claims to be improperly paid. Department officials agreed to review claims processing controls to resolve the issues we identified and prevent future overpayments.

Recommendations

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

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

Audit Scope, Objective, and Methodology

The objective of the audit was to determine if improper Medicaid payments were made on behalf of recipients with multiple CINs where at least one CIN was enrolled in fee-for-service. The audit covered the period from January 1, 2014 to March 31, 2019.

To accomplish our audit objective and assess relevant internal controls, we interviewed officials and gathered information from the Department, HRA, and ACS; examined the Department's relevant Medicaid policies and procedures; and reviewed applicable federal and State laws, rules, and regulations. We interviewed OMIG officials to gain an understanding of their audit efforts related to our audit objective. We used data from Medicaid Data Warehouse and eMedNY to identify recipients with multiple CINs and to obtain managed care and FFS claims paid on their behalf.

For recipients with multiple CINs in managed care and FFS, we reviewed recipients' managed care plan scope of benefits and removed FFS claims for services that were not covered by managed care. Next, we identified all instances where Medicaid made a managed care premium payment and a concurrent FFS payment for managed care-covered services on behalf of the same recipient in the same month. To identify FFS overpayments on behalf of recipients with multiple FFS enrollments under different CINs, we matched claim type information such as: rate code, date of service, procedure code, diagnostic related group, national drug code, and provider.

To confirm our findings, we provided OMIG with multiple CIN cases that were judgmentally selected based on numerous factors, including the potential overpayment amount, service dates, nature of the service, and various demographic attributes. Because the samples were judgmentally selected, the results cannot be projected to the population as a whole. We shared our methodology and findings with officials from the Department and OMIG during the audit for their review.

Statutory Requirements

Authority

The audit was performed 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 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. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these duties do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this final report and have included them in their entirety at the end of it. In their response, Department officials agreed with many of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner 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.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

August 12, 2020

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

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2019-S-22 entitled, "Medicaid Program: Improper Medicaid Payments Involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers."

Thank you for the opportunity to comment.

Sincerely,

Lisa J. Pino, M.A., J.D.
Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Elizabeth Misa
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Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2019-S-22 entitled, "Medicaid Program: Improper Medicaid Payments Involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2019-S-22 entitled, "Medicaid Program: Improper Medicaid Payments Involving Fee-for-Service Claims for Recipients With Multiple Client Identification Numbers."

General Comments:

The following comments address specific statements made in sections of the audit report.

Foster Care-Related Overpayments Section

- On page 10 of the report, it states the following in reference to 102 NY State of Health consumers:

  The Former Foster Care Youth Program is a provision of the Affordable Care Act that allows young adults discharged from the foster care program to remain on Medicaid until age 26. Such individuals can enroll through NYSOH.

  Individuals under the age of 26 who are discharged from New York State Foster Care between the ages of 18 and 21 are not able to enroll in coverage in the NY State of Health. Instead, these consumers are referred to the Local District for a Former Foster Care (FFC) Medicaid eligibility determination. Of the 102 NY State of Health consumers OSC identified as eligible for FFC Medicaid, 52 percent were under the age of 18 which means they could not have been deemed as FFC. The remaining 48 percent were age 18 or older but there was no indication in the consumer's NY State of Health account they were previously in Foster Care.

Comment 1

Recommendation #1:

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

Response #1:

The Office of the Medicaid Inspector General (OMIG) is currently performing foster care audits of recipients with multiple Client Identification Numbers (CINs). OMIG will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #2:

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

Response #2:

The Department has system edits in place for the downstate Welfare Management System to prevent the assignment of a CIN if the applicant/recipient has an existing CIN. The Department

Comment 2

has a draft policy that is scheduled for implementation in 2020 that will formalize the oversight role the Department's Division of Eligibility and Marketplace Integration (DEMI) will take in identifying and monitoring correction of duplicate CINs by upstate Local District staff. DEMI is also in the process of updating its CIN correction procedures to help reduce improper managed care premium payments for enrollees placed in foster care.

Recommendation #3:

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

Response #3:

OMIG is reviewing the identified claims and will determine an appropriate course of action.

Recommendation #4:

Develop a process to identify and recover:

- Improper managed care premium payments for non-foster care recipients with concurrent FFS enrollment; and

- Improper FFS payments for recipients under with multiple FFS enrollments different CINs.

Response #4:

- OMIG has an established process to recover inappropriate payments for foster care recipients with Multiple CINs in Managed Care/FFS.

- Regarding non-foster care recipients, OMIG continues to research and evaluate the Managed Care/FFS and FFS/FFS areas to determine the most efficient audit approach to identify and recover duplicate payments in these areas.

- OMIG's development of audits in these areas is ongoing. However, it is important to note that although the Managed Care/FFS scenario is included in the retroactive disenrollment process, only a small number of districts have submitted a low volume of retroactive disenrollment notifications in this area.

- OMIG's evaluation of Multiple CIN-related issues has determined that the Same-Plan and Different-Plan projects present the greatest risk for overpayments. Accordingly, those projects have been prioritized.

Recommendation #5:

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

Response #5:

The Department will review and resolve the remaining cases.

Recommendation #6:

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

Response #6:

The Department does not agree with this recommendation. As promised during the preliminary findings stage of the audit, the Department conducted an evaluation based on OSC's findings. After multiple discussions between eMedNY and program staff, the Department determined that additional system controls are not needed at this time. Claims paid after multiple CINs were linked represent 0.3 percent of the total claims identified in the audit by OSC. Furthermore, as OSC indicated, the Department added additional program resources towards multiple CIN research and resolution, which continues to result in improved processes, earlier linking and the elimination of future overpayments.

Comment 3

State Comptroller's Comments

1. Our statement is true. The Department incorrectly inferred all 102 Medicaid recipients were Former Foster Care (FFC). Our report never made that conclusion. Rather, our report added the general statement about the Former Foster Care Youth Program under the table on page 10 to explain why NYSOH may have been involved for some of the 102 (of the 12,151) cases. Using the Department's eMedNY system, we reviewed the eligibility information for the 102 cases and found all 102 of the CINs were created on the upstate WMS to enroll the recipients in foster care. Furthermore, subsequent enrollment updates associated with these CINs were performed in NYSOH. As our report demonstrates, the use of the upstate WMS to enroll foster care recipients contributes to the creation of multiple CINs and Medicaid overpayments.

2. The Department's response does not indicate it will assess the feasibility of establishing a preventative control to address the largest portion of our findings. Accordingly, we encourage the Department to consider such a control to prevent the creation of a multiple CIN (on the upstate WMS) during foster care enrollment on behalf of recipients who already have a CIN on the downstate WMS.

3. In its response, the Department acknowledges claims in our findings were inappropriately paid after multiple CINs were linked. As such, we encourage the Department to reconsider its position on this recommendation to prevent future overpayments.

Contributors to Report

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