

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEW YORK STATE MADE  
UNALLOWABLE MEDICAID  
MANAGED CARE PAYMENTS  
FOR BENEFICIARIES ASSIGNED  
MULTIPLE MEDICAID  
IDENTIFICATION NUMBERS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Gloria L. Jarmon  
Deputy Inspector General

April 2013  
A-02-11-01006

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*New York State claimed approximately \$7.3 million in Federal Medicaid reimbursement for managed care payments that were unallowable.*

### WHY WE DID THIS REVIEW

We identified a potential vulnerability in New York State's Medicaid managed care program. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification number. As a result, Medicaid managed care organizations (MCO) received duplicate monthly Medicaid payments for these beneficiaries.

Our objective was to determine whether the New York State Department of Health (Health Department) claimed Federal Medicaid reimbursement for managed care payments in compliance with Federal requirements.

### BACKGROUND

Federal law authorizes payments to States for eligible Medicaid beneficiaries enrolled in an MCO and prohibits payments to MCOs for beneficiaries whose Medicaid eligibility has not been properly determined. The Health Department electronically maintains eligibility information in its Welfare Management System, which operates as two separate systems—one for beneficiaries residing in New York City and one for beneficiaries residing elsewhere in New York State.

An individual requesting Medicaid services (applicant) in a State must provide his or her Social Security number (SSN) to the State. Excluded from this requirement are pregnant women, newborns born to women receiving Medicaid, and individuals who qualify for emergency medical assistance. That State must then verify with the Social Security Administration that the SSN was furnished to the applicant and determine whether any others were issued to that individual. In addition, the State must include in each applicant's case file facts to support the Medicaid eligibility determination.

### HOW WE CONDUCTED THIS REVIEW

We limited our review to certain Medicaid managed care payments the Health Department made to different MCOs for the same beneficiary. From the 24,298 beneficiary matches with payments totaling approximately \$64 million (\$32 million Federal share) that the Health Department claimed for the period January, 1, 2005, through April 30, 2010, we reviewed a random sample of 150 beneficiary matches. For purposes of this review, we defined a beneficiary match to be that either (1) more than one Medicaid identification number was associated with the same SSN or (2) no SSN was provided but select personal information (i.e., first four characters of the first name, last name, date of birth, and sex) was identical for more than one Medicaid identification number.

## **WHAT WE FOUND**

The Health Department did not always claim Federal Medicaid reimbursement for managed care payments in compliance with Federal requirements. Of the 150 beneficiary matches in our random sample, the Health Department complied with Federal requirements for 43 but not for the remaining 107. These deficiencies occurred because the Health Department operated two eligibility systems that did not identify potential beneficiary matches between the systems. In addition, local departments of social services did not (1) use all available resources within the systems to ensure that beneficiaries were not issued multiple Medicaid identification numbers, (2) ensure that applicants provided valid SSNs when required, and (3) maintain documentation to support eligibility determinations.

On the basis of our sample results, we estimated that the Health Department improperly claimed at least \$7,324,452 in Federal Medicaid reimbursement for managed care payments that did not comply with Federal requirements. In addition, we estimated that the Health Department claimed \$546,296 in Federal Medicaid reimbursement for managed care payments where applicants did not provide a valid SSN or there was no case file documentation to support the eligibility determination.

## **WHAT WE RECOMMEND**

We recommend that the Health Department:

- refund \$7,324,452 to the Federal Government;
- use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State; and
- ensure that it complies with certain Federal requirements by requiring local departments of social services to ensure that applicants provide valid SSNs when required and to maintain documentation to support eligibility determinations, which could have resulted in additional savings of \$546,296 to the Medicaid program.

## **HEALTH DEPARTMENT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the Health Department partially concurred with our first recommendation and generally concurred with our second and third recommendations. The Health Department stated that cases for which the applicant did not provide a valid SSN or the case record was not provided represent “eligibility errors” and that Federal laws and regulations do not allow for the recovery of payments caused by these errors. The Health Department also disputed a portion of the remaining recommended disallowance because the associated unallowable claims duplicated recoveries that its Office of the Medicaid Inspector General was

in the process of making. Finally, the Health Department described steps that it has taken or planned to take to ensure that no beneficiary is issued multiple Medicaid identification numbers.

After reviewing the Health Department's comments on our draft report, we maintain that our findings are valid. However, we revised our recommended recovery to exclude cases for which the applicant did not provide a valid SSN or the case record was not provided. We also revised our third recommendation to indicate potential cost savings if the Health Department ensured that applicants provided valid SSNs and that eligibility determinations were adequately documented.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

We identified a potential vulnerability in New York State's Medicaid managed care program. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification number. As a result, Medicaid managed care organizations (MCO) received duplicate monthly Medicaid payments for these beneficiaries.

### OBJECTIVE

Our objective was to determine whether the New York State Department of Health (Health Department) claimed Federal Medicaid reimbursement for managed care payments in compliance with Federal requirements.

### BACKGROUND

#### The Medicaid Program

The Medicaid program provides medical assistance to low income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

#### New York State's Medicaid Managed Care Program

In New York State, the Health Department administers the Medicaid program. Local departments of social services (local district) are responsible for determining whether individuals applying for Medicaid (applicants) meet eligibility requirements and ensuring that the applicants have only one active Medicaid identification number. Each county is considered its own local district, except the five counties that make up New York City, which are considered a single district.

Under its Medicaid managed care program, the Health Department pays MCOs a monthly fee to ensure that an enrolled beneficiary has access to a comprehensive range of medical services.<sup>1</sup>

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<sup>1</sup> For those beneficiaries not enrolled in the Medicaid managed care program, the Health Department pays Medicaid providers on a fee-for-service basis for every Medicaid-eligible service provided to a beneficiary.

## *Beneficiary Enrollment*

The Health Department electronically maintains eligibility information, including beneficiaries' Medicaid identification numbers, in its Welfare Management System (WMS).<sup>2</sup> The WMS operates as two systems—one for beneficiaries residing in New York City (downstate WMS) and one for beneficiaries residing elsewhere in New York State (upstate WMS). Health Department guidance states that the local district is to check its WMS to determine if an applicant is receiving medical or public assistance benefits and has been issued a Medicaid identification number.<sup>3</sup>

## *Federal Eligibility Requirements*

Federal law prohibits payments to MCOs for a beneficiary whose eligibility was not properly determined<sup>4</sup> and requires an applicant to provide his or her SSN to the State.<sup>5, 6</sup> The State must then verify that the Social Security Administration furnished the SSN to the applicant and determine whether it furnished any other SSNs to that individual.<sup>7</sup> In addition, each State must include in each applicant's case file facts to support the Medicaid eligibility determination.<sup>8</sup>

## **HOW WE CONDUCTED THIS REVIEW**

We limited our review to certain Medicaid managed care payments the Health Department made to different MCOs for the same beneficiary.<sup>9</sup> From the 24,298 beneficiary matches with payments totaling approximately \$64 million (\$32 million Federal share) that the Health Department claimed for the period January 1, 2005, through April 30, 2010, we reviewed a

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<sup>2</sup> The WMS maintains and processes information relating to individuals who have been determined eligible for benefits under all assistance programs, including Medicaid.

<sup>3</sup> The databases for both the upstate and downstate WMS compare the name, date of birth, Social Security number (SSN), and sex of an applicant to all other beneficiaries within the same database and produce a report of individuals with similar SSNs and/or names as the applicant. According to Health Department guidance, local district employees are expected to review these reports to determine whether an individual applying for Medicaid is the same as another individual on the report with an existing Medicaid identification number.

<sup>4</sup> The Social Security Act, section 1903(m)(2)(A)(iii).

<sup>5</sup> To be eligible for Medicaid, an individual requesting services must provide his or her SSN to the State (42 CFR § 435.910(a)).

<sup>6</sup> States are required to provide mandatory coverage to pregnant women, newborns born to women receiving Medicaid, and individuals who qualify for emergency medical assistance. These applicants are excluded from this requirement (42 CFR pt. 435).

<sup>7</sup> 42 CFR § 435.910(g).

<sup>8</sup> 42 CFR § 435.913(a).

<sup>9</sup> We excluded managed care payments the Health Department made to the same MCO for the same beneficiary under different Medicaid identification numbers for the same date of service from our review because these payments are being reviewed by the New York State Office of the Medicaid Inspector General (OMIG).

random sample of 150 beneficiary matches. For purposes of this review, we defined a beneficiary match to be that either (1) more than one Medicaid identification number was associated with the same SSN or (2) no SSN was provided but select personal information (i.e., first four characters of the first name, last name, date of birth, and sex) was identical for more than one Medicaid identification number.

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

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

## FINDINGS

The Health Department did not always claim Federal Medicaid reimbursement for managed care payments in compliance with Federal requirements. Of the 150 beneficiary matches in our random sample, the Health Department complied with Federal requirements for 43 but not for the remaining 107. Of these 107 beneficiary matches, 12 contained more than 1 deficiency:

- For 98 beneficiary matches, the associated beneficiary had more than one Medicaid identification number.
- For 16 beneficiary matches, the local district issued a Medicaid identification number to an applicant who did not have a valid SSN and was required to have one.
- For seven beneficiary matches, there was no case record for at least one of the Medicaid identification numbers.

These deficiencies occurred because the Health Department operated two eligibility systems that did not identify potential beneficiary matches between the systems. In addition, local districts did not (1) use all available resources within WMS to ensure that beneficiaries were not issued multiple Medicaid identification numbers, (2) ensure that applicants provided valid SSNs when required, and (3) maintain documentation to support eligibility determinations.

On the basis of our sample results, we estimated that the Health Department improperly claimed at least \$7,324,452 in Federal Medicaid reimbursement for managed care payments that did not comply with Federal requirements. In addition, we estimated that the Health Department claimed \$546,296 in Federal Medicaid reimbursement for managed care payments where applicants did not provide a valid SSN or there was no case file documentation to support the eligibility determination (eligibility errors). For the beneficiary matches with eligibility errors, we are not recommending recovery because under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid eligibility quality control program.

## **BENEFICIARIES HAD MORE THAN ONE MEDICAID IDENTIFICATION NUMBER**

Sections 2(d)(2)(A) and (B) of the Improper Payments Information Act of 2002 define an improper payment as any payment that should not have been made, including any duplicate payment.<sup>10</sup>

For 98 of the 150 beneficiary matches that we sampled, the Health Department improperly claimed Federal Medicaid reimbursement for managed care payments made on behalf of beneficiaries issued multiple Medicaid identification numbers. Specifically, the Health Department made managed care payments to different MCOs for the same beneficiary under different Medicaid identification numbers for the same date of service. Specifically:

- **Beneficiaries were issued multiple Medicaid identification numbers by the same local district offices.** For 59 beneficiary matches, case records indicated that beneficiaries applied multiple times for medical and/or public assistance benefits and were issued more than 1 Medicaid identification number by the same local district office.
- **Beneficiaries were issued multiple Medicaid identification numbers by different local district offices.** For 24 beneficiary matches, case records indicated that beneficiaries moved to another county in New York State, reapplied for Medicaid benefits at the new county's local district office, and were issued a new Medicaid identification number, but the old local district office had not closed the Medicaid identification number that it had issued.
- **Newborns were issued multiple Medicaid identification numbers.** For 15 beneficiary matches, case records indicated that a second Medicaid identification number was issued to a newborn even though the child already had an active Medicaid identification number.<sup>11</sup>

The improper payments made on behalf of these beneficiaries occurred because local districts did not use all available resources within both the downstate WMS and the upstate WMS to determine if an applicant already had a Medicaid identification number.<sup>12</sup> Health Department guidance states that local district employees should review a WMS-generated report on potential beneficiary matches to determine if an applicant is receiving medical or public assistance benefits and has been issued a Medicaid identification number. These reports, however, do not identify matches between the downstate WMS and upstate WMS. Local district employees have the ability to manually search both systems to determine if an applicant in their district is

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<sup>10</sup> The Improper Payments Information Act is codified at 31 USC § 3321 note.

<sup>11</sup> Both the Health Department and local districts may assign a Medicaid identification number to a newborn.

<sup>12</sup> We reviewed beneficiaries' encounter data (if any) to determine which managed care payments were proper. If a beneficiary had a medical encounter during a month in which the Health Department paid managed care payments to two MCOs on the beneficiary's behalf, we allowed the managed care payment to the MCO that paid for the medical encounter.

currently enrolled in any medical or public assistance program or whether a newborn already has a Medicaid identification number. However, local district employees did not effectively use these tools. In addition, some beneficiary matches were not identified by either the WMS-generated report or the manual WMS searches because the local district employees did not always correctly enter applicants' identifying information into the WMS.

## **MEDICAID ELIGIBILITY ERRORS**

### **Beneficiaries Did Not Have a Valid Social Security Number**

Section 1903(m)(2)(A)(iii) of the Social Security Act requires that MCO services be provided for the benefit of eligible individuals and prohibits Federal payments to States for MCO services when an individual's eligibility was not properly determined. Federal regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her SSN to the State. The State must contact the Social Security Administration to verify that the number furnished was the correct number and the only one issued to the individual.

For 16 of the 150 beneficiary matches that we sampled, the Health Department made managed care payments on behalf of beneficiaries who did not have a valid SSN. Specifically:

- **Beneficiaries did not furnish a Social Security Number.** For 13 beneficiary matches, beneficiaries did not furnish an SSN and were required to for at least 1 Medicaid identification number.
- **Beneficiaries furnished an invalid Social Security Number.** For three beneficiary matches, beneficiaries furnished an SSN that did not belong to them for at least one Medicaid identification number.

### **Case Records Not Provided**

Federal regulations (42 CFR § 435.913(a)) require the State to include facts to support the State's decision on individuals' Medicaid applications in each applicant's case file.

For 7 of the 150 beneficiary matches that we sampled, the Health Department made managed care payments on behalf of beneficiaries for whom there was no documentation to support the local districts' eligibility determinations.<sup>13</sup>

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<sup>13</sup> For five beneficiary matches, there was no case record for one of the Medicaid identification numbers, and for two beneficiary matches, there was no case record for either of the Medicaid identification numbers.

## **CONCLUSION**

On the basis of our sample results, we estimated that the Health Department improperly claimed at least \$7,324,452 in Federal Medicaid reimbursement for managed care payments that did not comply with Federal requirements. In addition, we estimated that the Health Department claimed \$546,296 in Federal Medicaid reimbursement for managed care payments with eligibility errors. For the beneficiary matches with eligibility errors, we are not recommending recovery because under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid eligibility quality control program.

The Health Department operated two eligibility systems that did not identify potential beneficiary matches between the systems. In addition, local districts did not (1) use all available resources within the WMS to ensure that beneficiaries were not issued multiple Medicaid identification numbers, (2) ensure that applicants provided valid SSNs when required, and (3) maintain documentation to support eligibility determinations.

## **RECOMMENDATIONS**

We recommend that the Health Department:

- refund \$7,324,452 to the Federal Government;
- use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State; and
- ensure that it complies with certain Federal requirements by requiring local districts to ensure that applicants provide valid SSNs when required and to maintain documentation to support eligibility determinations, which could have resulted in additional savings of \$546,296 to the Medicaid program.

## **HEALTH DEPARTMENT COMMENTS**

In written comments on our draft report, the Health Department partially concurred with our first recommendation and generally concurred with our second and third recommendations. The Health Department stated that cases for which the applicant did not provide a valid SSN or the case record was not provided represent "eligibility errors" and that Federal laws and regulations do not allow for the recovery of payments caused by these errors when detected outside of the State's Medicaid Eligibility Quality Control program.

The Health Department also disputed a portion of the remaining recommended disallowance because associated unallowable claims duplicated recoveries that its OMIG was in the process of making. Specifically, the Health Department and OMIG developed a process to recover inappropriate capitation payments made to different plans for the same beneficiary under

different Medicaid identification numbers and have identified duplicate plan payments made for dates of service between October 1 and December 31, 2009. Upon completion of this first 3-month period, each successive 1-year period will be reviewed annually. The Health Department requested that we either adjust our audit universe to exclude all paid claims with a date of service after September 30, 2009, or remove all sample items that OMIG has identified as part of its recovery process.

Finally, the Health Department described steps that it has taken or planned to take to ensure that no beneficiary is issued multiple Medicaid identification numbers.

The Health Department's comments are included in their entirety as Appendix D.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Health Department's comments, we maintain that our findings are valid. However, we have revised our recommended recovery to exclude eligibility errors. We also revised our third recommendation to indicate potential cost savings if the Health Department ensured that applicants provided valid SSNs and that eligibility determinations were adequately documented. We did not adjust our audit universe, nor did we remove the sample items that the Health Department identified as being in the process of being recovered by OMIG. On the basis of information provided by OMIG, we determined that none of our sample claims had been recovered. Therefore, we have no assurance that the improper payments we identified will be refunded in their entirety.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered Medicaid managed care payments the Health Department made for 24,298 beneficiary matches totaling \$64,243,884 (\$32,159,089 Federal share) during the period January 1, 2005, through April 30, 2010 to different MCOs.<sup>14</sup>

We limited our review of the Health Department's internal controls to those applicable to our objective. Specifically, we obtained an understanding of the Health Department's procedures for assigning Medicaid identification numbers to eligible beneficiaries and for ensuring beneficiaries have valid SSNs.

We conducted fieldwork at 20 local districts throughout New York State, including New York City, from April through October 2011.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and State guidance;
- met with Health Department and local district officials to gain an understanding of the procedures for assigning Medicaid identification numbers and preventing the assignment of multiple Medicaid identification numbers;
- ran computer programming applications at the Medicaid Management Information System fiscal agent that identified a sampling frame of 24,298 beneficiary matches with managed care payments totaling \$64.2 million (\$32.2 million Federal share) during the period January 1, 2005, through April 30, 2010;
- selected a stratified random sample of 150 beneficiary matches from the sampling frame;
- obtained and reviewed case record documentation from the local district(s) for each sample item to determine if a beneficiary was issued multiple Medicaid identification numbers and whether the beneficiary had a valid SSN;<sup>15</sup>

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<sup>14</sup> We excluded managed care payments the Health Department made to the same MCO for the same beneficiary under different Medicaid identification numbers for the same date of service from our review because these payments are being reviewed by the New York State OMIG.

<sup>15</sup> The case file contained a Social Security card for the sample beneficiary or the Social Security Administration's validation process indicated that the SSN was valid.

- reviewed encounter data for beneficiaries found to have multiple active Medicaid identification numbers to determine which managed care payment was unallowable;<sup>16</sup> and
- estimated the unallowable Federal Medicaid reimbursement paid in the total population of 24,298 beneficiary matches.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

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

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<sup>16</sup> Encounter data are the primary records of medical services provided to beneficiaries enrolled in managed care. We did not review encounter data when documentation maintained by the local district(s) clearly indicated that the beneficiary moved from one local district to another or when the local district indicated which Medicaid identification number was improper.

## **APPENDIX B: STATISTICAL SAMPLING METHODOLOGY**

### **POPULATION**

The population consisted of managed care payments that the Health Department made to different MCOs for beneficiaries with matching information and for whom more than one Medicaid identification number was issued (referred to as a beneficiary match) during the period January 1, 2005, through April 30, 2010.

### **SAMPLING FRAME**

The sampling frame consisted of three Access files containing managed care payments totaling \$64,243,884 (\$32,159,089 Federal share) for 24,298 beneficiary matches made during the period January 1, 2005, through April 30, 2010. The managed care payments for the beneficiary matches were extracted from the New York State Medicaid Management Information System.

### **SAMPLE UNIT**

The sample unit was a beneficiary match.

### **SAMPLE DESIGN**

We used a stratified random sample, as follows:

- Stratum 1: managed care payments totaling \$46,999,286 (\$23,521,918 Federal share) for 19,198 beneficiary matches for which the SSN and related beneficiary identifying information (i.e., beneficiary's name, date of birth, and sex) was the same.
- Stratum 2: managed care payments totaling \$16,455,983 (\$8,242,864 Federal share) for 4,676 beneficiary matches for which the SSN was the same but the related beneficiary information was different.
- Stratum 3: managed care payments totaling \$788,615 (\$394,307 Federal share) for 424 beneficiary matches for which no SSN was available and select beneficiary information (i.e., first four characters of the first name, entire last name, date of birth, and sex) was the same.

## **SAMPLE SIZE**

We selected a sample of 150 beneficiary matches, as follows:

- 50 beneficiary matches from stratum 1,
- 50 beneficiary matches from stratum 2, and
- 50 beneficiary matches from stratum 3.

## **SOURCE OF THE RANDOM NUMBERS**

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS) statistical software.

## **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units in each of the three strata. After generating 50 random numbers for each stratum, we selected the corresponding frame items.

## **ESTIMATION METHODOLOGY**

We used the OAS statistical software to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the total amount of unallowable Medicaid managed care payments that the Health Department made.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Multiple Medicaid Identification Numbers  
Sample Details and Results**

<b>Stratum</b>	<b>Beneficiary Matches in Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>No. of Beneficiary Matches With Unallowable Managed Care Payments</b>	<b>Value of Unallowable Managed Care Payments (Federal Share)</b>
1	19,198	\$23,521,918	50	\$53,999	50	\$25,353
2	4,676	8,242,864	50	82,894	5	4,201 <sup>a</sup>
3	424	394,307	50	50,647	43	14,859
<b>Total</b>	<b>24,298</b>	<b>\$32,159,089</b>	<b>150</b>	<b>\$187,540</b>	<b>98</b>	<b>\$44,413</b>

<sup>a</sup> We did not project the value of unallowable transactions related to stratum 2 because it contained only five errors. We added the value of the five errors to the lower limit to calculate the total disallowance of \$7,324,452.

**Estimated Value of Unallowable Services (Federal Share)**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

<b>Point Estimate</b>	\$9,860,602
<b>Lower Limit</b>	\$7,320,251
<b>Upper Limit</b>	\$12,400,954

**Medicaid Eligibility Errors  
Sample Details and Results**

<b>Stratum</b>	<b>Beneficiary Matches in Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>No. of Beneficiary Matches With Eligibility Errors</b>	<b>Value of Eligibility Errors (Federal Share)</b>
1	19,198	\$23,521,918	50	\$53,999	1	\$0 <sup>b</sup>
2	4,676	8,242,864	50	82,894	6	5,387
3	424	394,307	50	50,647	14	5,008
<b>Total</b>	<b>24,298</b>	<b>\$32,159,089</b>	<b>150</b>	<b>\$187,540</b>	<b>21</b>	<b>\$10,395</b>

<sup>b</sup> There are no dollars associated with this error because they were already included in the stratum 1 total of unallowable managed care payments on the previous page.

**Estimated Value of Eligibility Errors (Federal Share)**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

<b>Point Estimate</b>	\$546,296
<b>Lower Limit</b>	(\$40,781)
<b>Upper Limit</b>	\$1,133,372

## APPENDIX D: HEALTH DEPARTMENT COMMENTS



December 17, 2012

Mr. James P. Edert  
Regional Inspector General for Audit Services  
Department of Health and Human Services - Region II  
Jacob Javitz Federal Building  
26 Federal Plaza  
New York, New York 10278

Ref. No: A-02-11-01006

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-11-01006 on "New York Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Nazarko", is written over a horizontal line.

Michael J. Nazarko  
Deputy Commissioner  
for Administration

enclosure

cc: Jason Helgeson  
James C. Cox  
Diane Christensen  
Stephen Abbott  
Stephen La Casse  
Irene Myron  
John Brooks  
Ronald Farrell  
Michelle Contreras

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**New York State Department of Health  
Comments on the  
Department of Health and Human Services  
Office of Inspector General  
Draft Audit Report A-02-11-01006 on  
New York Made Unallowable Medicaid  
Managed Care Payments for Beneficiaries  
Assigned Multiple Medicaid Identification Numbers**

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The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-11-01006 on "New York Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers."

**Recommendation #1:**

The Department of Health should refund \$8,173,798 to the Federal Government.

**Response #1:**

The OIG audit sample consists of 150 beneficiary matches with federal share payments totaling \$187,540. OIG found that 107 of the matches in the sample had unallowable managed care payments totaling \$54,808, which OIG extrapolated across the claims universe to calculate the \$8,173,798 recommended refund amount.

OIG disallowed a total of 16 cases because the applicant did not provide a valid Social Security Number (SSN) and disallowed another 5 cases because eligibility case records were not provided to OIG for review. However, these 21 cases represent eligibility errors, not claim processing errors, and Federal laws and regulations do not allow for the recovery or disallowance of payments caused by eligibility errors that are detected outside the State's Medicaid Eligibility Quality Control (MEQC) program. Such payments are only recoverable when identified under the traditional MEQC review process because recovery and disallowance authority for such errors only exists in MEQC statute and regulations. Traditional MEQC statute is found in section 1903(u) of the Social Security Act and the corresponding regulations are found at 42 CFR §431.800 - 431.865.

In accordance with 42 CFR § 431.1002, subpart Q, Requirements for Estimating Improper Payments in Medicaid and SCHIP, "States must return to CMS the Federal share of overpayments based on medical and processing errors in accordance with section 1903(d)(2) of the Act and related regulations at part 433, subpart F of this chapter. Payments based on erroneous Medicaid eligibility determinations are addressed under section 1903(u) of the Act and related regulations at part 431, subpart P of this chapter." OIG is aware of this and has stated it in previous audit reports, including on page ii of the Executive Summary of Report A-02-05-01028 (see the last sentence under the Summary of Findings heading). Additionally, the Department is in receipt of CMS correspondence confirming this information, which it will make available to OIG.

The Department additionally disputes a portion of the balance of OIG's audit sample disallowances because they duplicate recoveries for which the Office of the Medicaid Inspector General (OMIG) is already in the process of recovering. The OIG audit scope included Medicaid managed care payments with dates of payment of January 1, 2005 through April 30, 2010, and OIG was informed at the beginning of the audit that a partial recovery overlap could occur in conjunction with recovery activities undertaken by the OMIG.

Prior to the initiation of the OIG audit, the Department and the OMIG were developing a process to recover inappropriate capitation payments made to two different plans for the same enrollee when the enrollee had more than one Client Identification Number (CIN). The process included making a change to the Medicaid managed care contract which would permit the Department to pursue recoveries of monthly capitation payments in these instances for dates of service beginning with and subsequent to October 1, 2009. The process utilizes plan reported encounter data to determine from which plan to make the recovery. Since a plan could potentially submit encounter data for up to two years following the service date, the actual recovery process was not initiated until after the calendar year ending 2011.

The Department and the OMIG have since initiated this new recovery process and have identified those duplicate plan payments which were paid for dates of service between October 1, 2009 and December 31, 2009. Upon completion of the first three month period, each successive one year period will be completed on an annual basis. Therefore, if the OIG audit was to sample and recover payments with dates of service from October 1, 2009 through April 30, 2010, while the Department and OMIG continue with the current recovery process for these targeted claims, the State would be repaying CMS twice for these inappropriate claims. The Department recovery will require the plans to submit claim voids or cash recoveries which will result in the repayment of the federal share through the routine Medicaid claims reimbursement process.

OIG is requested to either adjust the audit universe period to exclude all paid claims with a service date after September 30, 2009, or to remove from the OIG audit sample the disallowed claims that are part of the OMIG's recovery. If the OIG chooses to remove the duplicate Department recoveries instead of revising the audit universe review period, the OMIG can provide a summary report identifying the adjustments to the OIG audit sample disallowances. If either of the adjustments is not made to the audit, then a reimbursement method would need to be established by which CMS could return the duplicate recoveries made by the OMIG to the Department.

The multiple CIN(s) in the above noted file have already been identified by the OMIG and are currently under review by NYC Human Resources Administration (HRA). Once HRA completes its review, the OMIG will sort the recoverable claims by managed care plan, and each plan will receive an audit report identifying the inappropriate payments, along with a request for repayment. One of the OIG sampled cases (S1-08) is included in the OMIG disputed recoveries, but is not included in the current HRA recovery project. However, that case would be part of the Department's recovery project for the next recovery period (calendar year 2010).

**Recommendation #2:**

The Department of Health should use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State.

**Response #2:**

The Department will continue to provide guidance to all local districts on issues relevant to multiple CIN's, including the proper usage of the upstate and downstate Welfare Management System (WMS) and eMedNY. The Department will issue a General Information System (GIS) communication to all local districts this month reminding them of the importance of avoiding multiple CINs and the capabilities of the WMS cross-county inquiry screens to identify individuals that already have a CIN even when a SSN is not provided. Additionally, the selection and assignment of CIN's will also be incorporated into refresher and new worker training sessions once a contract is in place.

Also, subsequent to the time period of this audit, certain initiatives were put in place to enhance the Department's ability to recover managed care capitation payments for members with multiple CIN's. Section 3.6 of the Medicaid Managed Care (MMC)/Family Health Plus (FHPlus)/HIV Special Needs Plan Model Contract states "...the SDOH always has the right to recover duplicate MMC or FHPlus premiums paid for persons enrolled in the MMC or FHPlus program under more than one CIN whether or not the Contractor has made payments to providers."

**Recommendation #3:**

The Department of Health should ensure that it complies with certain Federal requirements by requiring local departments of social services to ensure that applicants provide a SSN when required and to maintain documentation to support eligibility determinations.

**Response #3:**

The Department disagrees with the implication that it is not compliant with certain Federal requirements, and asserts that it maintains compliance with the Federal requirements. The Department will continue to require that all local districts obtain from appropriate applicants either their SSN or proof that one was applied for, and to also maintain case record information to support eligibility determinations.

The GIS communication noted above will include a reminder to local districts to obtain the SSN from appropriate applicants, and the selection and assignment of CIN's will be incorporated into refresher and new worker training sessions once a contract is in place. Furthermore, in letters dated January 28, 2010 and March 20, 2012, local districts were reminded of the requirement to maintain the case record information used to support applicants' eligibility.