

Department of Health

Medicaid Program – Improper Managed Care Premium Payments for Recipients With Duplicate Client Identification Numbers

Report 2018-S-24 | July 2019

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

Division of State Government Accountability



Audit Highlights

Objective

To determine whether improper Medicaid managed care premiums were paid on behalf of recipients with duplicate Client Identification Numbers. The audit covered the period January 1, 2014 to June 30, 2018.

About the Program

The Department of Health (Department) administers New York's Medicaid program. Many of the State's Medicaid recipients receive their services through managed care, whereby the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient and, in turn, the MCOs pay for services their members require.

Each individual who applies for Medicaid benefits is assigned a Client Identification Number (CIN), a unique identifier. However, Medicaid recipients may have more than one different CIN assigned to them (herein referred to as "duplicate CINs") during the time they are in receipt of benefits. Consistent with the Department's guidelines, only one CIN should have active managed care eligibility at a time.

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 plan marketplace). Local Districts use the State's Welfare Management System (WMS) to process applicant data through both a downstate WMS system for New York City area recipients and an upstate WMS system for recipients in the rest of the State. The NYSOH system processes its applicants' data.

Regardless of the system from which an individual's eligibility and enrollment information originates, it is transmitted to the Department's eMedNY claims processing system. The eMedNY system relies on the information sent by WMS and NYSOH to update eligibility and enrollment data necessary to make appropriate claim payments. When an individual is assigned duplicate CINs, each with its own record of eligibility and managed care enrollment within eMedNY, Medicaid is at risk of making improper concurrent monthly premium payments for each CIN.

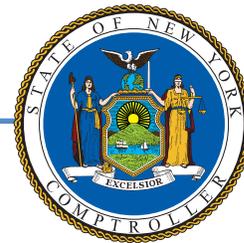
Key Findings

- Medicaid made over \$102.1 million in improper managed care premium payments on behalf of recipients with duplicate CINs. According to officials we spoke to at the Local Districts, incorrect/missing recipient demographic information and limited access to the multiple eligibility systems during application lead to improper duplicate CINs.
- The Department, Local Districts, MCOs, and the State Office of the Medicaid Inspector General all have processes to identify and resolve duplicate CINs; however, their systems are not fully integrated. There is no central tracking database for duplicate CINs, further limiting the coordination of efforts among these entities.

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- The Department recently allocated additional resources to duplicate CIN research and resolution and created a unit for this purpose. However, during our audit period, this unit was primarily responsible for researching potential duplicates involving at least one CIN created by NYSOH, not cases that only involved non-NYSOH-created duplicate CINs. Further, we found this unit did not consider the active eligibility status of the potential duplicate CINs or the cost of associated managed care premiums when prioritizing cases for review.

Key Recommendations

- Review the \$102.1 million in improper premium payments we identified and make recoveries, as appropriate.
- Ensure Local Districts make timely and accurate updates to demographic information on all Medicaid cases (at the time when caseworkers receive such information) to allow proper CIN assignment for new applications and efficient reconciliation of existing duplicates.
- Evaluate the feasibility of building a central tracking database of potential duplicate CINs that shows the status of each case and can be shared among all the stakeholders in the duplicate CIN research and resolution process.
- Ensure that the unit dedicated to duplicate CIN research and resolution takes steps to improve efficiency and timeliness, including, but not limited to, expanding the prioritization methodology to include active eligibility status of the potential duplicate CINs and the cost of associated managed care premium payments, and establishing a benchmark for the time it takes to resolve duplicate CINs.
- Evaluate the feasibility of creating a control to prevent confirmed duplicate CINs from being reused in the future.



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

July 29, 2019

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

Following is a report of our audit of the Medicaid program entitled *Improper Managed Care Premium Payments for Recipients With Duplicate Client Identification Numbers*. This 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

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Glossary of Terms

Abbreviation	Description	Identifier
ACS	New York City Administration for Children's Services	<i>Agency</i>
Act	Patient Protection and Affordable Care Act of 2010	<i>Law</i>
CIN	Client Identification Number	<i>Key Term</i>
DEMI	Department's Division of Eligibility and Marketplace Integration	<i>Division</i>
Department	Department of Health	<i>Auditee</i>
eMedNY	Department's Medicaid claims processing system	<i>System</i>
HRA	Human Resources Administration	<i>Agency</i>
Local Districts	Local Departments of Social Services	<i>Key Term</i>
MCO	Managed care organization	<i>Key Term</i>
NYSOH	NY State of Health	<i>System</i>
OMIG	Office of the Medicaid Inspector General	<i>Agency</i>
SDX	State Data Exchange	<i>System</i>
SSA	Social Security Administration	<i>Agency</i>
SSN	Social Security number	<i>Key Term</i>
WMS	Welfare Management System	<i>System</i>

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, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about \$62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3 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.

The State's Local Departments of Social Services (Local Districts) determine eligibility and enrollment for certain segments of the Medicaid program. Typically, Local Districts accept applications from the following: residents age 65 or over, persons of any age living with a disability or blindness, persons receiving Medicare but who are not a parent or caretaker relative of minor children, and former foster care young adults under age 26. Local Districts also determine eligibility and enrollment for various other public assistance programs, such as cash assistance, food stamps, and home energy assistance.

Local Districts use the Welfare Management System (WMS) to process applicant data for the various public assistance programs, including Medicaid. 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.

Under the federal Patient Protection and Affordable Care Act of 2010 (Act), the State developed the NY State of Health (NYSOH), an online marketplace where individuals may obtain health insurance coverage, including Medicaid. The Act expanded the criteria to qualify for Medicaid and created new rules for determining income-based eligibility. As such, NYSOH typically processes eligibility for individuals whose Medicaid coverage is based primarily on income level. Low-income pregnant women, children, and adults under 65 must apply for coverage through NYSOH by submitting an application online, by telephone, or in person through a Navigator or Certified Application Counselor. The Department contracted with a vendor to build the NYSOH system and is in charge of overseeing its implementation. NYSOH first started accepting applications in October 2013. Of the approximately 7.3 million recipients enrolled in Medicaid during State fiscal year 2017-2018, about 3.7 million enrolled through NYSOH.

For eligibility verification and benefit-tracking purposes, each individual who applies for benefits under Medicaid or another public assistance program is assigned a Client Identification Number (CIN), a unique identifier. Medicaid recipients may have more than one different CIN assigned to them (herein referred to as “duplicate CINs”) during the time they are in receipt of benefits; however, only one of the CINs should have active eligibility at a time. Concurrent active eligibility under more than one CIN for the same recipient should be terminated to prevent duplication of benefits.

Regardless of the system (WMS downstate, WMS upstate, or NYSOH) from which an individual’s Medicaid eligibility and enrollment information originates (including the assignment of CINs), it is transmitted to the Department’s eMedNY claims processing system. The eMedNY system relies on the information sent by WMS and NYSOH to update eligibility and enrollment data necessary to make appropriate Medicaid payments.

The Department uses two methods to pay for Medicaid services: fee-for-service and managed care. Under the fee-for-service method, health care providers are paid directly, through eMedNY, for each eligible service rendered to Medicaid recipients. Under managed care, the Department makes monthly premium payments to managed care organizations (MCOs) for Medicaid recipients enrolled in their plans. In return, MCOs arrange for the provision of health care services and reimburse providers for services provided to their enrollees.

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 with duplicate CINs is enrolled in managed care under more than one CIN. OMIG audits of duplicate CINs involve duplicate managed care premium payments made to the same MCO as well as duplicate premium payments made to different MCOs.

Audit Findings and Recommendations

Our audit identified over \$102.1 million in Medicaid overpayments for managed care premiums made on behalf of 65,961 recipients with duplicate CINs over the period from January 1, 2014 through June 30, 2018.

Duplicate CINs for Medicaid recipients has been a long-standing concern for the Department, and the introduction of NYSOH in 2013 created new challenges in this area. Although NYSOH was required to implement an automated process for checking existing CIN assignments (including in WMS upstate and WMS downstate) to avoid duplicate CINs, system flaws and incorrect or incomplete applicant demographic information have led to additional duplicates.

The Department, Local Districts, and OMIG also have processes to identify potential risks, to confirm and resolve duplicate CIN cases, and to recover improper managed care premium payments. Potential duplicates are continuously researched within WMS upstate, WMS downstate, and NYSOH using data analytics, automatic reports produced by eMedNY, and referrals from other sources, such as MCOs. Unfortunately, because the systems and processes are not fully integrated, many duplicate CIN cases have not been identified, have not been resolved in a timely manner, or remain unresolved.

Better coordination among all stakeholders (Local Districts, the Department, and OMIG) would improve process efficiency. A central oversight entity could help ensure best practices are shared across all parties through more streamlined communication. The creation of a centralized tracking database could also help all stakeholders share the status of cases and confirm and resolve duplicate CINs more efficiently.

Weaknesses in Duplicate CIN Prevention Processes

WMS Clearance Process

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 WMS downstate, WMS upstate, and NYSOH systems. Depending on Clearance results, a caseworker creates a new CIN or, if the individual already had a CIN assigned, selects the existing one.

The process produces a Clearance Report of all existing CINs with matching demographics. Matches are scored based on demographic attributes

matched. The Clearance process is more likely to identify all existing CINs for the applicant when more accurate demographic information is entered during application. For example, a combined match on name, SSN, date of birth, and gender will be given the highest score of 106, and, if the existing CIN is in the same WMS system being used (Human Resources Administration [HRA] uses WMS downstate, all other Local Districts use WMS upstate), the system will assign the existing CIN of the matched recipient. If any of the attributes do not match or are missing, the score is lower. The SSN carries the most weight in the match scoring. Typically, Medicaid eligibility policy requires that all individuals applying for benefits (with exceptions, for example, for certain non-citizens) provide an SSN or apply for one. Applications missing the SSN produce low-score matches and require manual review by Local District caseworkers. Although potential CIN matches outside the WMS system being used are displayed, they cannot be selected. For example, a caseworker using WMS downstate may see a matching CIN of a recipient in WMS upstate, but it cannot be selected and a new, likely duplicate CIN will be created. Table 1 illustrates the type of information a caseworker might see when processing an application in WMS downstate.

Table 1 – Illustration of WMS Downstate Clearance Report

CLEARANCE REPORT							
APPLICANT INFORMATION	SSN	LAST NAME	FIRST NAME	DATE OF BIRTH	GENDER	CIN	SCORE
	123-45-6789	Doe	Jane	12/31/18	Female	AB12345C	
CLIENT ID							
MATCH	123-45-6789	Doe	Jane	12/31/18	Female	AB12345C	106

POSSIBLE MATCHES							
	123-45-6789	Doe	Jane		Female	BB12345D	104

UPSTATE WMS MATCH – for information only							
	123-45-6789	Doe	Jane		Female	XY12345W	104

The Clearance Report in WMS is meant to assist Local Districts’ manual enrollment process, but Local District caseworkers are ultimately responsible for the proper assignment of CINs and accurate eligibility. If an upstate match is found during Clearance of a downstate application, as previously stated, the caseworker cannot select the matching CIN of the recipient in WMS upstate; however, the caseworker also cannot close the eligibility of the matching duplicate upstate CIN. Rather, the caseworker is expected to reach out to the upstate Local District to request that the duplicate CIN’s corresponding eligibility be closed. If the eligibility is not closed or not closed promptly and an individual is assigned more than one CIN – each with its

own record of eligibility and managed care enrollment within eMedNY – it increases the risk that Medicaid will make inappropriate concurrent monthly premium payments.

We asked officials from HRA, the Local District that handles Medicaid enrollment for New York City, about issues that lead to duplicate CINs being assigned to the same individual. The officials cited challenges with lack of recipient demographic information and limited access to WMS upstate.

HRA officials stated that, while caseworkers are instructed to manually review all potential matches from the Clearance Report, including those with lower scores, it is often difficult to confirm a match when some attributes are missing or outdated. For example, for a match with the same name and date of birth that is missing the SSN, a caseworker might need to compare the applicant's address or other available information to the existing case. If the existing case shows outdated information, such as an old address, the caseworker is even less likely to successfully identify the match. HRA officials stated they have sent reminder letters to Local District caseworkers emphasizing the importance of timely updates to existing WMS cases for all information related to the CIN Clearance process.

According to HRA officials, another issue contributing to duplicate CINs is the enrollment of foster care children and young adults, which is administered by the New York City Administration for Children's Services (ACS). Under certain scenarios, ACS issues new CINs to recipients even if a CIN already exists (e.g., if the CIN only exists in WMS downstate). To complicate the process further, all ACS CINs for New York City residents are only added to WMS upstate according to WMS' design; therefore, Local District caseworkers subsequently processing applications for such individuals in WMS downstate are not able to select pre-existing ACS CINs on the Clearance Report.

In addition to manual Medicaid enrollments processed by caseworkers, certain enrollments are automated. The State Data Exchange (SDX) identifies individuals with Supplemental Security Income, a federal income supplement program designed to help aged, blind, and disabled people who have little or no income. These individuals typically qualify for Medicaid based on their lower levels of income. The SDX system compares the applicant's SSN to the SSNs of all known Medicaid recipients to determine if it should reuse an existing CIN or assign a new one. While this process is somewhat similar to Clearance, in the absence of manual review, an SSN is necessary for the computer match to work. In the absence of an SSN match, a new CIN is created.

NYSOH Clearance Process

The introduction of NYSOH in 2013 created new challenges for CIN Clearance. The Act affected how information provided by applicants is verified by pushing states to use electronic data sources to automate verifications and make real-time decisions. Additionally, NYSOH was required to have an automated process for checking existing CIN assignments (in WMS) to avoid duplicate CINs. The Act also required NYSOH to verify whether an applicant had already been determined to be eligible for Medicaid coverage.

In response to the new requirements, the Department enhanced the CIN Clearance process by introducing an automatic match. As part of the eligibility determination, NYSOH checks to see if the applicant already exists in the NYSOH system and has a CIN. If no CIN is found, NYSOH checks against WMS upstate and WMS downstate. As with WMS, the CIN Clearance in NYSOH is based on the key demographic attributes of the recipient and a scoring algorithm; however, the CIN assignment is completely automated. The NYSOH system requires, at a minimum, a match on the SSN and one other demographic attribute for successful Clearance. NYSOH's existing match scoring is presented in Table 2.

Table 2 – NYSOH Clearance Match Scoring

Score	SSN	Complete Name		Date of Birth			Gender
		Last Name	First Name	YYYY	MM	DD	
106	X	X	X	X	X	X	X
104	X	X	X				
103	X	X		X	X		
102	X			X	X	X	
101 (not used in CIN Clearance)		X	X	X	X	X	X

If a match is found with a score of 102 or more, NYSOH will use the existing CIN. A match with a score of 101 or less will result in an applicant being assigned a new CIN. Because the process is automated, no further steps are taken, unlike with the WMS Clearance process, where a caseworker will continue to attempt to verify a low-scoring match using additional demographic information.

The examples in Table 3 further illustrate NYSOH’s automated Clearance process.

Table 3 – Illustration of NYSOH’s Automated Clearance Process

Example 1: NYSOH Clearance Finds and Uses Existing CIN							
	SSN	Last Name	First Name	Date of Birth	Gender	CIN	Score
Applicant Information	123-45-6789	Doe	Jane	12/31/2018	Female		
Possible Matches	123-45-6789	Doe	Jane	12/31/2018	Female	AB12345C	106

Example 2: NYSOH Clearance Finds and Does Not Use Potential Matching CIN Due to Missing SSN							
	SSN	Last Name	First Name	Date of Birth	Gender	CIN	Score
Applicant Information	987-65-4321	Anyone	John	1/1/2018	Male		
Possible Matches		Anyone	John	1/1/2018	Male	ZY54321X	101

In Example 1, NYSOH Clearance was able to find an existing CIN (AB12345C) with matching demographics, and the system assigned the existing CIN to the applicant. In Example 2, the potential matching CIN is missing an SSN and, as a result, NYSOH Clearance would not match the applicant to that CIN. In this case, a new – potentially duplicate – CIN would be created.

Although universal CIN Clearance across all three systems improved access to information, certain internal system issues were not accounted for when NYSOH was originally developed, resulting in new problems that contributed to the creation of duplicate CINs. For example, when applicants submitted multiple applications with different demographic information, NYSOH would assign duplicate CINs for such applicants. Also, when an individual moved between two counties, NYSOH would typically assign a new CIN instead of reusing the existing one. Department officials stated those issues have since been resolved.

We also found, however, instances where NYSOH terminated Medicaid eligibility but failed to send a corresponding transaction to eMedNY. As a result, Medicaid eligibility for these recipients continued and improper managed care premiums were paid. Department officials stated that some design flaws are still being rectified. They said they continuously review the NYSOH system for flaws and weaknesses in order to identify potential system enhancements. They are also working to improve the NYSOH Clearance process by evaluating additional criteria for matching scores and adding

a manual review process for certain cases prior to CIN assignment. The Department estimates this enhanced functionality will be completed in the fourth quarter of 2019.

Weaknesses in Duplicate CIN Research and Resolution Processes

The Department, Local Districts, and OMIG have processes to identify potential risks pertaining to duplicate CINs, confirm and resolve duplicate CIN cases, and recover corresponding improper managed care premium payments. These entities continuously research potential duplicates within WMS upstate, WMS downstate, and NYSOH using data analytics, automatic reports produced by eMedNY, and referrals from other sources, such as MCOs. Unfortunately, because the systems and processes are not fully integrated, many duplicate CIN cases have not been identified, have not been resolved in a timely manner, or remain unresolved.

For efficient duplicate CIN prevention and resolution, better coordination among all stakeholders (Local Districts, the Department, and OMIG) is necessary. A central oversight entity could also ensure best practices are shared across all parties through more streamlined communication. Additionally, the creation of a master tracking database of duplicate CIN cases could allow all stakeholders to share the status of duplicate CINs and to confirm and resolve duplicates more efficiently.

The DEMI Unit

In March 2017, the Department dedicated more resources to duplicate CIN research and resolution by creating the Division of Eligibility and Marketplace Integration (DEMI) unit. The DEMI unit oversees many aspects of duplicate CIN detection and resolution, and the Department stated that, long term, it intends for the DEMI unit to be the central oversight entity responsible for duplicate CIN detection and resolution. During our audit scope, the DEMI unit was primarily responsible for researching potential duplicates involving at least one CIN created by NYSOH. Local Districts were responsible for reviewing non-NYSOH-related cases. The largest population of duplicate CINs we identified involved at least one NYSOH-generated CIN.

Each month, the DEMI unit receives an eMedNY report of suspected duplicate CINs to analyze. In addition to the eMedNY report, the unit may receive referrals from Local Districts, OMIG, MCOs, or other agencies. The DEMI unit's goal is to respond to each referral and to report the proper CIN to be used to Local Districts and NYSOH. The DEMI unit also provides MCOs

with guidance on which CINs to use when recipients are enrolled in managed care under duplicate CINs.

During our audit, we found the eMedNY program logic for the report was outdated and did not identify all potential duplicates. For example, the eMedNY logic tests whether the SSN of the recipient has been validated by WMS. WMS uses the federal Social Security Administration (SSA) to determine whether a recipient's reported information (e.g., name, date of birth, SSN) matches SSA information. The eMedNY logic uses the results of the SSA validation to score its potential duplicate CIN matches, assigning a higher score to SSA-verified information. While NYSOH follows an SSN validation process that is similar to WMS', the results are not forwarded to eMedNY and therefore are not factored into the eMedNY score. As a result, potential NYSOH-related duplicates may be assigned inaccurate and lower scores by the eMedNY logic. Additionally, auditors were informed that the logic has not been modified in over ten years.

Prior to the DEMI unit working on duplicate CIN resolutions, many of the suspected duplicate CIN pairs identified by eMedNY went unresolved. As a result, there was a backlog of cases needing review. As part of the duplicate CIN resolution process, DEMI staff research information about suspected duplicates in NYSOH and WMS to determine whether the two CINs are for the same individual and which CIN's eligibility should remain active. Once they verify that an individual was incorrectly assigned a duplicate CIN, they contact the Local District or NYSOH to request that the Medicaid eligibility and corresponding managed care enrollment connected to that duplicate CIN be closed. The longer it takes to resolve duplicate CINs, the greater the potential that eMedNY could make inappropriate payments. In addition to ensuring that duplicated Medicaid eligibility cases are closed, the DEMI unit is responsible for linking confirmed duplicate CINs in eMedNY. Linking enables eMedNY to treat both CINs as the same individual during claims processing, a control that can prevent future overpayments.

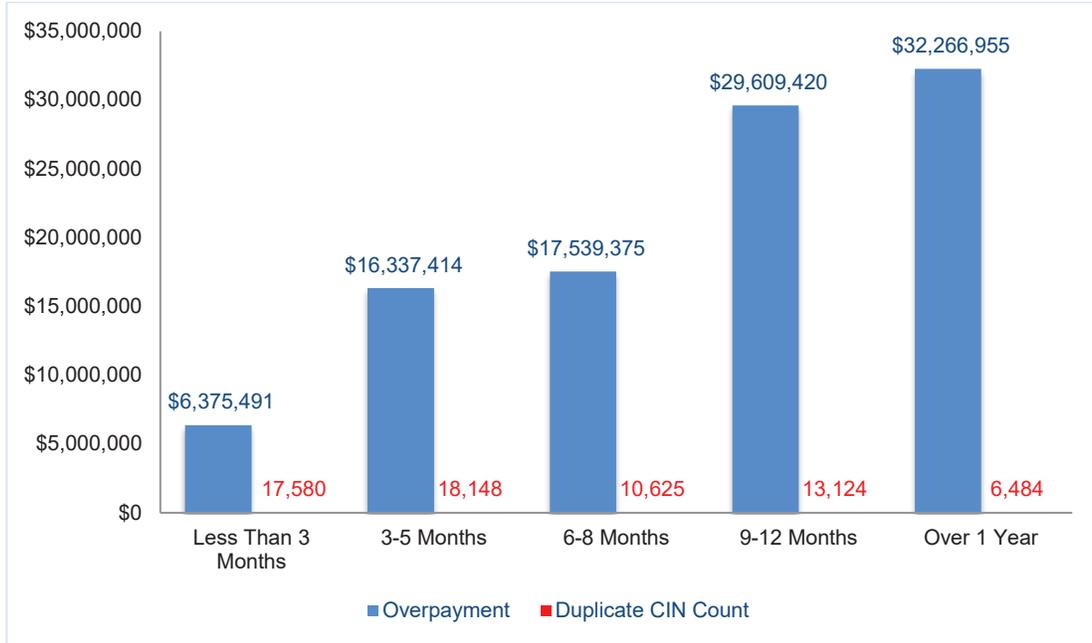
During our audit, we found that the DEMI unit's methodology for prioritizing and resolving cases did not consider the active eligibility status of the potential duplicate CINs or the cost of associated managed care premiums. We identified instances of active suspected duplicate CINs, with eMedNY continuing to pay monthly premiums for both CINs. We believe the DEMI unit should prioritize the research and resolution of such cases over suspected duplicates with less potential to incur inappropriate costs. Additionally, central oversight of these efforts is needed to ensure resolved cases remain resolved, and CINs with terminated eligibility are not reactivated. Subsequent to the audit period, in response to our audit, the DEMI unit implemented several changes to better coordinate duplicate CIN reconciliation and

correction efforts. We note, however, that the DEMI unit's new prioritization methodology did not address our concern regarding active eligibility status of the potential duplicate CINs or the cost of associated managed care premiums.

For example, we identified a Medicaid case involving duplicate CINs created by HRA. An individual had Medicaid eligibility and managed care coverage dating back to before the start of our audit. In August 2015, HRA created another CIN for this individual and authorized managed care enrollment starting November 2015. Because this individual was enrolled in two MCOs, each MCO was receiving managed care premium payments from Medicaid from November 2015 until April 2017. The HRA internal data analysis unit identified the duplicate CIN in July 2016, and nine months later (in April 2017), the eligibility and managed care enrollment for the duplicate CIN was terminated by HRA. In October 2018, HRA reopened the duplicate CIN and re-enrolled the individual into managed care. The duplicate premium payments resumed, and since November 2015, Medicaid had overpaid \$20,245 in managed care premium payments for this individual. During our audit period, this case was not reviewed by the DEMI unit because the CINs were not created by NYSOH. Had this case been prioritized and tracked by a centralized database of duplicate CINs, all parties, including the DEMI unit, would have been aware of this case earlier and could have taken more timely and conclusive action. This example illustrates the complexity of CIN resolution, especially the need for central oversight and improved prioritization of cases, which enforces the timely resolution and closing of cases.

Our audit identified cases when Medicaid made duplicate managed care premium payments for many months because duplicate CINs had overlapping managed care enrollment that had not been terminated timely. Table 4 shows the breakdown of the \$102,128,655 in overpayments identified in our audit relevant to the number of months of duplicate managed care coverage.

Table 4 – Premium Overpayments by Months of Duplicate Managed Care Coverage



MCO Reviews

The Medicaid Managed Care Model Contract was amended on October 1, 2015, requiring all MCOs to review enrollees in their plans on a quarterly basis and determine whether any individual has more than one CIN. Any duplicate CINs identified by the MCOs are expected to be reported within 30 days of identification to the Department (for NYSOH duplicates) or to Local Districts. During our audit, we surveyed four of the larger MCOs to determine their compliance with these requirements. We found that each MCO had its own unique process, and all but one continuously reviewed their enrollees to identify duplicate CINs. One MCO only checked for duplicate CINs during the enrollment process, contrary to the requirements of the Medicaid Managed Care Model Contract.

We provided each MCO with 10 suspected duplicate CINs and asked if they had been previously identified by the MCO. None of the MCOs responded that they had previously identified all the suspected duplicate CINs we provided. In fact, one MCO reported that it had not identified any of the 10 duplicate CINs we provided. In one example, a recipient was enrolled in the same managed care plan with two separate CINs effective August 1, 2014. The MCO did not identify either CIN as a duplicate because the demographic information on one case was incomplete at the time of enrollment. The missing information was updated in July 2015; however, the duplicate

CINs were not resolved until August 2017. During that time, the MCO inappropriately received about \$15,000 in duplicate premiums.

MCOs should contact the Local District that determined the eligibility of a duplicate CIN for resolution, or in cases created by NYSOH, the Department. The following example (while perhaps not typical of all duplicate CINs) illustrates the complexity of the resolution process. One of the MCOs we surveyed reported that it identified a duplicate CIN for a New York City recipient and notified HRA in September 2015. HRA closed the eligibility of one of the CINs in WMS downstate, effective May 2017 (we did not confirm that the eligibility corresponding to that CIN was closed based on the MCO's referral). In June 2017, the remaining active CIN was transferred from WMS to NYSOH. In December 2018 – more than three years after the duplicates were initially identified by the MCO – the duplicate CINs were linked in eMedNY by the DEMI unit (as stated previously, linking enables eMedNY to treat both CINs as the same individual during claims processing to prevent overpayments).

After the period covered by the audit, in October 2018, the Department sent letters to MCOs to clarify their role in the duplicate CIN resolution process. In addition, the Department developed instructions and a report format for MCOs to use in their quarterly reporting of suspected duplicate CINs to the Department.

Local Districts

According to the Department, Local Districts are responsible for researching and resolving duplicate CINs. As discussed earlier in this report, the three separate eligibility systems (WMS upstate, WMS downstate, and NYSOH) are not fully integrated, and this presents challenges to Local Districts' resolution of duplicate CINs. We asked officials from HRA about challenges with the duplicate CIN resolution process, and they attributed many of their internal duplicate CINs to incomplete case demographics in WMS. As noted earlier, incorrect or missing demographic information increases the likelihood a duplicate CIN will be created during the application process.

Further, as previously highlighted, another challenge is presented by foster care recipient cases, which do not always have SSNs on file. After the period covered by the audit, in August 2018, ACS and HRA established a data-sharing agreement to allow the two agencies to periodically share information about recipients with duplicate CINs who might have more than one active Medicaid enrollment at a time. HRA will use this information to reconcile duplicate CINs and to determine if it can close Medicaid eligibility for its cases.

According to HRA officials, suspected duplicate CINs are identified through referrals from the Department and MCOs as well as through internal data analysis. All potential duplicates involving a WMS downstate CIN are considered for review, including those involving a NYSOH-established CIN. Once duplicates are confirmed, the eligibility for all but one CIN must be closed. While HRA can identify and resolve duplicate CINs, unlike the DEMI unit, they do not link them in eMedNY. Instead, they use the CIN consolidation function within WMS, a process used to retain one CIN with the correct demographic data and close the eligibility of all others. We found that, while HRA does not directly link the duplicate CINs in eMedNY, a process exists where HRA can send the consolidated cases for linking in eMedNY. There are no controls in the system to prevent the eligibility of a duplicate CIN from being reopened during future Clearance (i.e., when individuals applying for Medicaid are assigned a new CIN or an existing CIN).

Although every duplicate CIN case in WMS should be updated with the most current information by the time the eligibility is closed, officials admitted that many case updates are not being done. Prompt updates help ensure more effective Clearance and prevent future duplicate CINs. We encourage HRA and all other Local Districts to prioritize the research of potential duplicate CINs and to ensure that each case is properly updated with the most current and complete information by the time the eligibility is closed. Additionally, the Department should work with Local Districts to develop a control to prevent reactivation of previously confirmed duplicate CINs. This control could potentially be incorporated into the Clearance process to improve the accuracy of the eligibility determination.

Payment Recovery Efforts

OMIG and the Local Districts have a role in recovering inappropriate Medicaid payments caused by duplicate CINs. OMIG has developed a matching methodology to identify suspected duplicates in cases when both CINs are concurrently enrolled in managed care, and two managed care premiums have been paid for the same period on behalf of the recipient. OMIG's methodology for identifying a duplicate CIN is different from that used by the Clearance process and from eMedNY suspected duplicate CIN reports.

OMIG uses a recipient's address, phone number, and other demographics to identify potential duplicates. Once identified, OMIG provides reports of suspected duplicates to the Local Districts for review, and the Local Districts are expected to remove the Medicaid eligibility of the incorrect CINs. The Local Districts are then responsible for sending the list of CINs with terminated eligibility back to OMIG so OMIG can initiate recovery of improper

premium payments. If the duplicate CINs were both enrolled with the same MCO, recovery is straightforward: either the MCO returns the inappropriately paid managed care premium by canceling out (voiding) the existing claim, or the MCO submits a payment directly to OMIG. However, if the duplicate CINs were enrolled with different MCOs, OMIG has to do a more comprehensive analysis of the medical services paid by each MCO.

At the time of our audit, OMIG completed audits of duplicate CINs through December 31, 2014 for improper managed care premium payments made to the same MCO and through December 31, 2013 for improper premium payments involving different MCOs. According to OMIG officials, OMIG recovery efforts occur after other parties, such as the MCOs and Local Districts, have had an opportunity to recover the overpayments caused by duplicate CINs.

Recommendations

1. Review the \$102.1 million in improper premium payments we identified and make recoveries, as appropriate.
2. Take steps to ensure the DEMI unit and Local Districts resolve the remaining duplicate CIN pairs identified in this audit.
3. Take steps to ensure Local Districts make timely and accurate updates to demographic information on all Medicaid cases (at the time when caseworkers receive such information) to allow proper CIN assignment for new applications and efficient reconciliation of existing duplicates.
4. Implement enhanced NYSOH functionality by the expected time frame of the fourth quarter of 2019 to prevent the creation of future inappropriate duplicate CINs.
5. Establish a central oversight entity responsible for all duplicate CIN detection and resolution, and evaluate the feasibility of building a central tracking database of potential duplicate CINs that shows the status of each case and can be shared among all the stakeholders in the duplicate CIN research and resolution process.
6. Ensure that the DEMI unit takes steps to improve the efficiency and timeliness of duplicate CIN research and resolution, including, but not limited to, expanding the prioritization methodology to include active eligibility status of the potential duplicate CINs and the cost of associated managed care premium payments, and establishing a benchmark for the time it takes to resolve duplicate CINs.

-
7. Evaluate the feasibility of updating the logic used by eMedNY's duplicate CIN reports to include additional criteria for identifying and properly scoring potential duplicate CIN matches.
 8. Monitor all MCOs' compliance with the requirement to identify and report duplicate CINs to the Department and Local Districts. Ensure non-compliant MCOs (including the MCO we identified) promptly take corrective steps to perform the reviews quarterly and report duplicate CINs within 30 days of identification.
 9. Monitor duplicate CIN resolutions among HRA and ACS subsequent to the new data-sharing agreement, and take further corrective actions, if necessary.
 10. Evaluate the feasibility of creating a control to prevent confirmed duplicate CINs from being reused in the future.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper managed care premium payments for recipients with duplicate CINs. The audit covered the period from January 1, 2014 through June 30, 2018.

To accomplish our audit objective and assess relevant internal controls, we interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures as well as 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 also interviewed officials from HRA and reviewed responses to questionnaires received from four MCOs (judgmentally selected based on total Medicaid premium payments received) to assess their role in resolving cases involving Medicaid recipients with duplicate CINs. We used the Medicaid Data Warehouse and the eMedNY claims processing system to identify recipients with duplicate CINs and to obtain Medicaid managed care premium claims billed on their behalf. To confirm our findings, we provided HRA, the DEMI unit, and NYSOH officials with duplicate CIN cases that were selected based on numerous factors, including the potential overpayment amount and the length of time the cases remained open as well as various demographic attributes.

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 functions 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 report and have included them in their entirety at the end of the report. In their response, Department officials concurred with many of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our responses to certain comments are included in the report's State Comptroller's Comments, which are embedded in the Department's response.

Within 90 days after 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 and State Comptroller's Comments



Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 27, 2019

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 2018-S-24 entitled, "Improper Managed Care Premium Payments for Recipients with Duplicate Client Identification Numbers."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
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**Department of Health
Comments on the Office of the State Comptroller’s
Draft Audit Report 2018-S-24 entitled, “Medicaid Program – Improper
Managed Care Premium Payments for Recipients with Duplicate
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 2018-S-24 entitled, “Medicaid Program – Improper Managed Care Premium Payments for Recipients with Duplicate Client Identification Numbers.”

Recommendation #1

Review the \$102.1 million in improper premium payments we identified and make recoveries, as appropriate.

Response #1

The Office of the Medicaid Inspector General (OMIG) conducts ongoing, second-level reviews, after the local department of social services (Local Districts), NY State of Health (NYSOH), and the New York City Human Resources Administration (HRA) performs their processes to identify and resolve multiple Client Identification Numbers (CINs). This is a lengthy and detailed process that is necessary to allow the other agencies to perform their functions and decrease the chances of work being duplicated. OMIG uses a complex query to detect perfect and imperfect matches that may have been missed by the Local District, NYSOH and HRA during their reviews and identifies periods of overlapping Medicaid Managed Care enrollment.

For the matches identified in OMIG’s review, OMIG works with the Local District, NYSOH, HRA to: (1) confirm imperfect matches, and (2) close one CIN in cases where both CINs remain open. After the Local District, NYSOH, and HRA have completed their review of OMIG-identified matches and report the results to OMIG, Draft Audit Reports are issued to managed care organizations (MCOs) to recover associated overpayments on the identified CIN pairs that are confirmed to be the same individual.

In addition, as of the October 2015 amended Medicaid Managed Care/FHP/HIV SNP/HARP Model Contract (Model Contract) approved by CMS in November 2017, the Mainstream MCOs are required to review and identify cases of multiple CINs on a quarterly basis and report them to the Local Districts/NYSOH. These are then reported to OMIG and included in OMIG audits if the MCO does not void the duplicate capitation payment.

OMIG requested and received OSC’s methodology for identifying multiple CINs in this audit. OSC’s methodology utilizes four criteria to determine whether CINs belonged to the same individual.

The four OSC criteria are: 1) matching on the Social Security Number; 2) matching on first name, last name, and date of birth; 3) matching on first four letters of the first name, full last name, and date of birth; and 4) matching on first name, first four letters of the last name, and

date of birth. OMIG notes, based on the agency's experience conducting multiple CIN reviews, that the last two criteria have proven to be unreliable for determining that multiple CINS belong to the same individual.

State Comptroller's Comment – The criteria we used to identify duplicate CINs were proven to be reliable by the Department. As stated in its response to Recommendation #2, the Department has already closed 98 percent of the duplicate CINs we identified that accounted for the \$102.1 million in improper payments.

The Local District reviews completed to date have demonstrated that many of the OSC-identified matches were in fact CINs assigned to two distinct individuals and not duplicates. The reviews completed and reported to OMIG are for the OSC identified matches that had capitation payment overlap start dates between January 1, 2014 and December 31, 2016 for Medicaid recipients enrolled in different Medicaid Managed Care Plans. The following are some scenarios where two CINs that belong to distinct individuals could be included in OSC's criteria 3 or 4: cases where the individuals had common names (i.e. Smith, Maria, John), the individuals had variations on a common name (i.e. Maria Ortez vs Marie Ortega, Johnathan Smithers vs John Smith), and the individuals were twins (Jayden Colvin and Jayda Colvin).

Due to the criteria that OSC used which resulted in incorrect matches (CINs matched that were actually two distinct individuals), it is likely that the \$102.1 million in overpayments that OSC identified may be inaccurate.

State Comptroller's Comment – As we previously stated, the criteria we used to identify the duplicate CINs were proven to be reliable, and the Department acknowledged it has already closed 98 percent of the duplicate CINs that accounted for the \$102.1 million in improper premium payments identified.

OMIG will review the identified payments and pursue recovery of any payment determined to be inappropriate.

Recommendation #2

Take steps to ensure the DEMI unit and Local Districts resolve the remaining duplicate CIN pairs identified in this audit.

Response #2

The Department will take steps to resolve any remaining duplicate CIN pairs identified in the audit. To date, the Department has taken the appropriate action to close 98 percent or 64,682 of the 65,961 duplicate CINs. The Department previously identified and had already taken the appropriate action to close 82 percent, or 53,929 of the 65,961 duplicate CINs prior to the initiation of the audit.

State Comptroller's Comment – While the Department has taken certain steps to close duplicate CINs, it has not taken necessary steps to prevent duplicate CINs from being used again (i.e., some duplicate CINs are reopened and/or not linked in eMedNY) or to promptly recover the \$102.1 million in overpayments that resulted from the duplicate CINs.

Recommendation #3

Take steps to ensure Local Districts make timely and accurate updates to demographic information on all Medicaid cases (at the time when caseworkers receive such information) to allow proper CIN assignment for new applications and efficient reconciliation of existing duplicates.

Response #3

The Department will provide guidance to Local Districts to ensure demographic information on Medicaid cases is updated accurately and timely to allow proper CIN assignment for new applications and efficient reconciliation of existing duplicates.

Recommendation #4

Implement enhanced NYSOH functionality by the expected time frame of the fourth quarter of 2019 to prevent the creation of future inappropriate duplicate CINs.

Response #4

In January 2019, the Department implemented enhanced functionality that increased NYSOH's ability to match consumers who already have public minimal essential coverage. Since this functionality will reduce access to consumers who already have coverage, NYSOH will see a reduction in the number of duplicate CINs created.

The Department continues to work to further refine CR1657 and CR1882 in order to close gaps in CIN clearance and duplicate CIN processing. As a result of these efforts, CR1657 is now slated for production June 2019. Furthermore, CR1882 has been descoped and CR1909 has subsequently been added to better address the back-office functionality necessary for improved CIN management; CR1909 is tentatively scheduled for production 1st Quarter 2020 with a date for CR1882 yet to be determined.

Recommendation #5

Establish a central oversight entity responsible for all duplicate CIN detection and resolution, and evaluate the feasibility of building a central tracking database of potential duplicate CINs that shows the status of each case and can be shared among all the stakeholders in the duplicate CIN research and resolution process.

Response #5

Duplicate CIN resolution when at least one CIN resides in NYSOH has been centralized in the Division of Eligibility and Marketplace Integration (DEMI). DEMI's comprehensive and detailed work procedures include working with various stakeholders including NYSOH, eMedNY, and Local Districts to resolve duplicate CINs. Local District staff follow the guidance on Welfare Management System (WMS)-only duplicate CIN resolution provided to them over the years by the Department. DEMI staff have a process in place to work with OMIG to respond to inquiries and to support the recoupment of capitation payments made in error.

Duplicate CIN data is maintained in the DEMI database when one CIN resides in NYSOH. This allows staff to track duplicate CINs, assign work and generate reports. The Department will consider expanding its tracking database to include duplicate CINs that reside in WMS only.

Recommendation #6

Ensure that the DEMI unit takes steps to improve the efficiency and timeliness of duplicate CIN research and resolution, including, but not limited to, expanding the prioritization methodology to include active eligibility status of the potential duplicate CINs and the cost of associated managed care premium payments, and establishing a benchmark for the time it takes to resolve duplicate CINs.

Response #6

DEMI staff follow written procedures to determine which CIN should remain open and which CIN should be closed. The guidance provides for accurate, efficient and timely processing of identified duplicate CINs. Staff have completed the review of all monthly duplicate CIN reports through May 2019 and are currently reviewing the June 2019 report. Since June 2018, prior to receiving OSC's audit file to research, DEMI staff filter CINs to identify pairs where both CINs have active coverage and then prioritize those CIN pairs over others in the report.

State Comptroller's Comment – The written procedures, dated January 2019, used by the DEMI unit did not address the prioritization of active CINs. We encourage the Department to ensure that active Medicaid eligibility is a factor when considering the prioritization of duplicate CIN consolidation and to ensure the procedures are updated accordingly.

The Department will consider expanding the prioritization methodology to include the cost of associated duplicate managed care premium payments and establishing a benchmark for the time it takes to resolve duplicate CINs.

Recommendation #7

Evaluate the feasibility of updating the logic used by eMedNY's duplicate CIN reports to include additional criteria for identifying and properly scoring potential duplicate CIN matches.

Response #7

The Department will evaluate the feasibility of updating the eMedNY logic used for duplicate CIN reports to include additional criteria for identifying and properly scoring potential duplicate CIN matches.

Recommendation #8

Monitor all MCOs' compliance with the requirement to identify and report duplicate CINs to the Department and Local Districts. Ensure non-compliant MCOs (including the MCO we identified) promptly take corrective steps to perform the reviews quarterly and report duplicate CINs within 30 days of identification.

Response #8

Per the amended October 2015 Model Contract approved by CMS in November 2017, MCOs are required to submit a quarterly multiple CIN report. In May 2018, discussion began between the Department and OMIG to develop a report format and instructions for the MCOs to use to report multiple CINs on a quarterly basis. The final approved report template and letter were sent to the MCOs on October 29, 2018.

The Quarterly Multiple CIN report submission is tracked by the Department. MCOs who fail to submit the report are contacted by Department staff to remind them of their requirement to submit on a quarterly basis and the dates the reports are due.

Recommendation #9

Monitor duplicate CIN resolutions among HRA and ACS subsequent to the new data-sharing agreement, and take further corrective actions, if necessary.

Response #9

The Department will monitor duplicate CIN resolutions among HRA and the New York City Administration for Children's Services subsequent to the new data-sharing agreement, and take further corrective actions, if necessary.

Recommendation #10

Evaluate the feasibility of creating a control to prevent confirmed duplicate CINs from being reused in the future.

Response #10

The Department will evaluate the feasibility of creating a control to prevent confirmed duplicate CINs from being used in the future.

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