Alan G. Hevesi
COMPTROLLER

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OFFICE NEW YORK STATE COMPTROLLER

DIVISION OF STATE SERVICES

DEPARTMENT OF HEALTH

MULTIPLE MEDICAID PAYMENTS FOR MANAGED CARE RECIPIENTS

Report 2004-S-48

AUDIT OBJECTIVE

Our objective was to determine whether multiple payments were made for individuals who were assigned more than one Medicaid identification number (ID) and enrolled with a managed care plan.

AUDIT RESULTS – SUMMARY

The Department of Health (Department) administers the State's Medicaid program, which provides medical assistance to needy individuals. Medicaid pays providers by one of two methods: the fee-for-service method, in which a provider is paid for each Medicaid-eligible service, and the capitation method, in which a managed care plan (Plan) is paid a monthly fee based on each individual's demographic information. The Plan receives this monthly payment even when an enrolled Medicaid eligible individual does not receive medical care during the month. The Plan is responsible for ensuring eligible recipients have access to all covered health services and for paying the actual service providers.

We identified a significant amount of multiple payments being made for individuals who were assigned more than one Medicaid ID. Statewide we found, using a conservative approach, $45 million in potentially inappropriate payments for individuals who have more than one ID. In an era where the cost of Medicaid is experiencing significant growth and federal and State policy makers are looking for ways to fund the Medicaid program, the amount of multiple payments we identified warrants immediate corrective action.

Department officials acknowledged that the problem of individuals having more than one ID has existed for at least 15 years. However, it was not until 2004 that they established a work group to address the issue of individuals who have more than one ID. The work group has developed criteria for identifying individuals with more than one ID, but we determined the criteria are inadequate to properly identify all such individuals. We developed two methodologies to identify individuals with more than one ID.

We used computer software to identify all instances involving managed care where an individual had more than one ID. We then provided a number of local districts with a sample of the instances we identified for further analysis to determine the accuracy of our findings. The local districts confirmed that inappropriate payments were made for 96 percent of our sampled instances under our first methodology (multiple Medicaid IDs who shared the same social security number) and 71 percent of sampled instances in our second methodology (multiple Medicaid IDs where other recipient demographic information suggests duplicate payments were made on behalf of the same individual).

Our report contains three recommendations for improving Department oversight and enhancing the controls in place for assigning Medicaid IDs. We recommend the Department conduct a comprehensive analysis of duplicate Medicaid IDs. Also, we recommend the Department recover $212,000 in overpayments and determine whether there were multiple payments made for the other 57,985 recipients.

This report dated February 7, 2006 is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at:
(518) 474-3271 or
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, NY 12236

BACKGROUND

The Department of Health (Department) administers the State's Medicaid program, which provides medical assistance to needy individuals. These individuals receive medical care from providers, such as hospitals and clinics. Medicaid pays providers by one of two methods: the fee-for-service method, in which a provider is paid for each Medicaid-eligible service, and the capitation method, in which a managed care plan (Plan) is paid a monthly fee based on each individual's demographics (age, gender, Medicaid eligibility). The Plan receives this monthly payment even when an enrolled Medicaid eligible individual does not receive medical care during the month. The Plan is responsible for ensuring eligible recipients have access to all covered health services and for paying the actual service providers.

The Department determines the basic package of medical services to be offered by Plans. In addition, the Department has established a standard contract for the local social services district (local district) to use as its basis for contracting with the Plans. Each local district enters into separate contracts with the Plans. The Department provides the Plans with a monthly roster containing all individuals for whom the Plans are responsible for providing care to, and for whom the Plans can be reimbursed. Plans accept the roster as an official enrollment list. The Department has guidelines for enrolling individuals into Plans. In most local districts, individuals have at least three different Plans to choose from.

The Department provides oversight and establishes guidelines for the local districts regarding Medicaid eligibility. However, the local districts are responsible for determining whether an individual meets the Medicaid eligibility requirements. Outside of New York City (City), each individual county is considered a separate local district. The five boroughs of the City are a single local district, under the New York City Human Resources Administration. In addition to Medicaid, individuals can receive other types of assistance, ranging from cash assistance to food stamps. The local districts are also responsible for establishing eligibility for the other assistance programs.

The Welfare Management System (WMS) is the central registry for all data about recipients who receive some form of public assistance in the State. There are two separate systems, one for the upstate counties and another for the City. When a person is first approved for assistance, such as Medicaid, local district staff enroll that person on WMS and issue a recipient identification number (ID). Medicaid uses the ID as one of the important fields to determine the appropriateness of Medicaid payments made under fee-for-service and managed care programs. If the person is subsequently approved for another assistance program, the person should only be assigned one active ID. Thus, a Medicaid enrollee who also receives food stamps should have only one recipient ID for any given period of time.

Typically, individuals may determine which Plan they want to enroll in, and the local districts use WMS to record the Plan. However, 24 local districts have a mandatory managed care enrollment process for all Medicaid individuals. In these local districts, if an individual does not select a Plan within the allotted time, they are automatically assigned to a Plan. Certain individuals in these local districts are excluded or exempt from the mandatory enrollment process if they meet specific criteria. For example, individuals with AIDS are exempt from automatic assignment.

The number of individuals enrolled in a Plan has grown significantly over the last few years. As of July 31, 2004, approximately 1.9 million individuals receiving Medicaid were enrolled in a Plan. During the 12 month period ended June 30, 2004, the Department spent approximately $5.4 billion for managed care services for Medicaid recipients.

AUDIT FINDINGS AND RECOMMENDATIONS

Identifying and Preventing Multiple Payments

Because of the complexity of the Medicaid eligibility determination process and the number of programs administered by local districts, individuals may inadvertently be assigned more than one ID. Department management has conflicting responsibilities in its oversight of the eligibility determination process. Department management's primary objective is to ensure individuals needing medical care appropriately receive it. Department management is also concerned that Medicaid applications are processed in a timely manner. However, while the Department should ensure timely eligibility determinations, it must also provide the oversight to identify and prevent multiple payments.

Department officials acknowledged that the problem of individuals having more than one ID has existed for at least 15 years. However, it was not until 2004 that they established a work group to address this issue. Statewide we found, using a conservative approach, $45 million in potentially inappropriate payments for individuals who have more than one ID and are enrolled in a Plan during our four-year audit period. The Department needs to take immediate action to address this issue.

Reasons for Multiple IDs

Local districts are responsible for determining an individual's eligibility for Medicaid and for ensuring that an individual has only one active ID. The Department should properly monitor local district activities to ensure they are properly carrying out their responsibilities. We interviewed officials at seven local districts to determine why recipients are sometimes assigned more than one ID. During our four-year test period, the major control over assigning more than one ID to an individual was the WMS produced clearance report. For each individual applying for benefits, this report contains up to 100 potential cases where the individual has a similar social security number and name as other Medicaid qualified individuals. For individuals who have common names, it is possible for over 100 cases to be identified. The clearance report only identifies upstate matches or New York City matches, as the two systems are separate and do not communicate. This increases the potential of individuals receiving more than one active ID.

Local district employees are responsible for reviewing the clearance report and determining whether the individual applying is the same individual as someone on the clearance report. Overall, local district officials felt the clearance report helped them in assigning the appropriate ID. However, one official stated it is a complex process and it is easy for workers to make mistakes using this report.

A key field within the clearance report is the social security number and as such the accuracy of this information is important. Local district employees are instructed to ask for an individual's social security number, but they cannot require the individual to show

their social security card. To identify invalid social security numbers, a WMS computer match is done with the Social Security Administration. This match is completed by Office of Temporary and Disability Assistance officials. Some local district officials complained the process takes too long to get information. This allows individuals with incorrect social security numbers on WMS to go undetected, and allows more than one ID to be assigned to the same individual.

In addition, some local district officials stated multiple IDs are sometimes assigned when individuals apply for more than one assistance program (e.g., if a person receiving Medicaid subsequently meets the requirements for receiving cash assistance). The local district could assign another active ID if the individual's demographic information is entered onto WMS in a slightly different way than previously entered for the other program, such as Medicaid. In such cases, WMS would not alert the local district that an active ID already exists for this individual.

In addition, local district officials stated newborn children frequently are mistakenly given more than one ID. Officials explained there are numerous reasons why newborn enrollment presents a problem to the local districts. Local districts routinely establish an ID for a child before they are born. In addition, the Department itself can update newborn eligibility information. Hospitals are required to report to the Department the birth of children born to women receiving Medicaid benefits. This allows the Department to identify all children who are Medicaid eligible. The Department then establishes an ID for these children. Therefore the potential exists that both the local district and the Department might establish an ID for the same individual.

Expenditures Resulting from Multiple IDs

Although Department officials have started to identify individuals who have multiple IDs, we believe the criteria they are using are inadequate to properly identify all instances where more than one ID exists for the same individual. The Department is identifying instances when both IDs shared all the same criteria (social security number, first four characters of first name, last name, date of birth, and gender). In order to be selected under the Department's existing methodology, all of the criteria would have to be identical among the IDs. We do not believe the methodology the Department is using will adequately identify all of the inappropriate Medicaid payments resulting from an individual having more than one ID. The selection criteria used by the work group is too restrictive and consequently of the $45 million in potentially inappropriate payments we identified, we believe the Department's methodology would only identify about $12 million.

The work group has forwarded, to upstate local districts, reports of instances where the Department has identified individuals having more than one ID. Local districts are to review the cases and close out the inappropriate IDs, and seek recovery of all inappropriate payments from the managed care plans. In addition, the Department has provided local districts with a letter detailing the problem, with some suggested general approaches to reducing the number of errors pertaining to multiple IDs. Department officials believe their efforts have helped reduce the error rate in upstate counties. To address the issue of multiple payments occurring in the City, where the majority of errors exist, the Department intends to take an automated approach to correct the identified cases. As of April 4, 2005, Department

officials were still in the process of developing this approach.

To determine the extent to which multiple payments were made during our four-year testing period (July 1, 2000 through June 30, 2004), we used computer-assisted audit techniques to analyze certain recipient and Medicaid expenditure information. We developed two distinct methodologies to identify individuals with more than one ID. Both methodologies use Medicaid specific information, such as social security number, name and date of birth. In our first methodology, we identified potential multiple payments based primarily on an analysis of social security numbers. However, local districts do not capture social security number information for all individuals. For example, pregnant women do not have to provide a social security number. As such, we developed a second methodology using other recipient specific information, such as name and date of birth, to identify multiple payments.

For both methodologies, we followed the same steps to develop our findings. We used computer software to identify all instances where an individual had more than one ID. We then reviewed Medicaid expenditure information for the period to determine whether multiple payments were paid for these recipients under their different IDs. We provided a number of local districts with a sample of instances for further analysis to determine the accuracy of our findings.

We did not determine which of the multiple payments were inappropriate. Each set of multiple payments has to be reviewed to determine which payment should have been paid, and we recommend Department management take such action. Therefore, we calculated the potential overpayment of the multiple managed care payments as the average of the managed care claims. When the identified overpayments pertained to managed care and fee-for-service claims, we limited the overpayment amount to that of the managed care claim, which would generally be the less costly of the two payments.

Analysis Based On Social Security Number

We identified potentially inappropriate payments based on multiple IDs having the same social security number. In addition, we manually compared the recipient demographic information (name, date of birth, gender and address) to determine whether the IDs belonged to the same individuals. Specifically, we found 34,218 instances where the same individuals had more than one ID, and Medicaid made $24.8 million in multiple payments on behalf of these individuals, as follows.

We identified approximately $18 million in multiple managed care payments to Plans for the same individual. For $9 million of these payments, the same Plan received both of the managed care monthly fees.

We also found multiple payments where the same individual was enrolled in both managed care as well as the fee-for-service programs for the same month. These multiple payments consisted of about $6.8 million in managed care payments and approximately $19 million in fee-for-service payments (inpatient and clinic). In these instances, Medicaid made multiple payments for the same service, once directly to the fee-for-service provider and again to the managed care provider as part of the monthly fee. In order to properly determine the amount of potential overpayments, we developed computer programs to eliminate all of the non-covered services from our analysis (i.e.,

services not covered by the managed care payments, and therefore would be appropriate to be covered by a fee-for-service payment). Depending on whether the managed care or fee-for-service claim is determined to be incorrect, the amount of the overpayment ranges from $6.8 million to $19 million. To be conservative, we used $6.8 million to calculate our potentially inappropriate payment totals.

To determine whether the instances we identified actually belong to the same individuals, we selected a sample of 161 instances for further review. We judgmentally selected our sample from seven local districts: Albany County, Erie County, Nassau County, New York City, Rensselaer County, Suffolk County and Westchester County. We chose these seven local districts because they represented a geographical cross section of the State and their caseloads ranged from large to small.

We provided each of the seven local districts with their respective sample. We asked local district officials to review each instance to determine whether the IDs belong to the same individual. Local districts officials concluded for 154 of 161 instances (96 percent), the payments were made on behalf of same individual. The duplicate monthly premiums paid on behalf of these 154 individuals during our four-year test period totaled approximately $150,000.

Based on our results, we conclude the methodology we used to identify duplication is valid. We recommend the Department recover all multiple payments made on behalf of the 154 individuals in our sample where we identified IDs having the same social security number. We also recommend the Department follow up on the other 34,057 instances not included in our sample where we identified IDs having the same social security number.

Based on the results of our sample, a small portion of these payments may be legitimate. However, most of these are overpayments that should be recovered. In addition, until Department management takes action to remove the incorrect IDs, additional overpayments will likely be made.

We also contacted five of the larger Plans (Health First PHSP, Health Insurance Plan of Greater New York, HealthNow New York, Metroplus and Neighborhood Health Provider PHSP) which we judgmentally selected. We contacted officials at these Plans to ascertain how they could have received multiple monthly payments for the same individual without detecting these overpayments. Officials at four Plans stated they recently have begun a detection process to identify these instances, while officials at one Plan stated they have no detection process in place and assume every ID reported to them on the roster is a unique individual.

Analysis Based on Other Recipient Specific Information

Because the social security number is not always captured for every Medicaid recipient, we believe it was possible for additional multiple payments to exist that would not be detected by the Department's existing criteria. As such, we developed computer programs that did not rely on social security numbers to identify individuals who were assigned more than one ID. Specifically, we identified instances where the same first four characters of the first name, full last name, and date of birth were being used by different Medicaid IDs.

In total, we found 24,022 instances where the same individuals had more than one ID, and Medicaid made $20.2 million in multiple payments on behalf of these individuals. The multiple payments consisted of $14.7 million in multiple managed care payments and between $5.5 million and $18.6 million in a combination of multiple managed care and fee-for-service payments. Again to be conservative, we used $5.5 million in calculating our potentially inappropriate payment totals.

We judgmentally selected a sample of 94 of the 24,022 instances for further review. We provided the seven local districts with their respective sampled instances and we asked local district officials to determine whether the IDs belong to the same individuals. Local district officials reviewed the instances and concluded that 67 of 94 instances (71 percent) involved the same individuals. The monthly premiums paid on behalf of these 67 individuals during our four-year test period totaled about $62,000. Our sample results demonstrated that for 71 percent of instances reviewed, an inappropriate payment was made. However, we also identified instances where the ID belonged to different individuals. In most of these instances, the IDs were typically for twins.

Recommendations

1. Department management needs to ensure that the work group established to address the issue of multiple IDs identifies and addresses all possible scenarios where duplication can occur. Once these scenarios are identified, management needs to take action to minimize the potential for duplication.

2. Recover the $212,000 in overpayments that was paid for the 221 recipients in our samples where multiple payments were made on behalf of the same individual.

3. Determine the extent to which multiple payments were made for the 57,985 recipients not included in our sample and recover any identified overpayments.

AUDIT SCOPE AND METHODOLOGY

We did our audit according to generally accepted government auditing standards. We audited the effectiveness of the Department's controls relating to the payment of claims for individuals enrolled in Medicaid Plans for the period July 1, 2000 through June 30, 2004. We examined Department policies and procedures; interviewed officials at the Department and seven local districts (Albany County, Erie County, Nassau County, New York City, Rensselaer County, Suffolk County and Westchester County); interviewed responsible officials of five Plans (Health First PHSP, Health Insurance Plan of Greater New York, HealthNow New York, Metroplus and Neighborhood Health Provider PHSP) to verify the validity of identified overpayments, and analyzed information on monthly premiums and other payments made on behalf of Medicaid managed care recipients.

Using computer-assisted audit techniques, we developed programs to identify Medicaid managed care recipients who were assigned more than one ID and where Medicaid made multiple payments on behalf of these individuals. Details about our sampling methodologies are provided in the *Audit Findings and Recommendations* section of this report. We reviewed information from the Medicaid Management Information System (MMIS), which is the centralized, automated medical assistance information and payment system. The information we reviewed included WMS data, which is

regularly incorporated into MMIS. We limited our analysis of Medicaid payments to managed care and fee-for-service (inpatient and clinic) payments, since they represented the greatest financial exposure.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandate duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. 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 management functions do not affect our ability to conduct independent audits of program performance.

AUTHORITY

The audit was done according to the State Comptroller's authority under Article V, Section 1 of the State Constitution, and Article II, Section 8 of the State Finance Law.

REPORTING REQUIREMENTS

We provided a draft copy of the matters contained in this report to Department officials for their review and comment. Their comments were considered in preparing this report and are included as Appendix A. Appendix B contains a State Comptroller's Note, which addresses matters of disagreement included 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 the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising of the steps that were taken to implement the recommendations it contained, and/or the reasons certain recommendations were not implemented.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include David R. Hancox, Kenneth Shulman, Ed Durocher, Paul Alois, Erika Akers, Ron Wharton and Paul Bachman.

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 2, 2005

David R. Hancox
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Hancox:

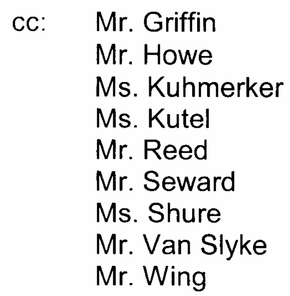
Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2004-S-48) entitled "Multiple Medicaid Payments for Managed Care Recipients."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure


cc: Mr. Griffin
Mr. Howe
Ms. Kuhmerker
Ms. Kutel
Mr. Reed
Mr. Seward
Ms. Shure
Mr. Van Slyke
Mr. Wing

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2004-S-48 Entitled
"Multiple Medicaid Payments for Managed Care Recipients"

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2004-S-48) entitled "Multiple Medicaid Payments for Managed Care Recipients."

Recommendation #1:

Department management needs to ensure that the work group established to address the issue of multiple IDs identifies and addresses all possible scenarios where duplication can occur. Once these scenarios are identified, management needs to take action to minimize the potential for duplication.

Response #1:

The Department has identified all potential scenarios for a possible duplicate common identification number (CIN) and is taking steps to reduce these occurrences. DOH sends each upstate district a monthly written list of cases to investigate. As a result of this process, the number of duplicate CINs in all upstate districts has decreased from over 300 cases in August 2004 to approximately 90 cases. In New York City, the Department will begin a process of mailing written reports for Human Resources Administration action and is working on establishing a systems process for its use. The Human Resources Administration has reminded its staff on the manner in which the Welfare Management System clearance reports are to be used to prevent duplicate CINs.

* Note

Recommendation #2:

Recover the $212,000 in overpayments that was paid for the 221 recipients in our samples where multiple payments were made on behalf of the same individual.

Response #2:

When OSC sends the Office of Medicaid Management (OMM) the work papers supporting its determination that overpayments occurred in 221 cases in the amount of $212,000, the Department will review the material and take appropriate action to recover overpayments consistent with OMM's procedures as initially set forth in our Dear Commissioner letter of May 23, 2005.

Recommendation #3:

Determine the extent to which multiple payments were made for the 57,985 recipients not included in our sample and recover any identified overpayments.

* See State Comptroller's Note: page 14

Response #3:

The Department is of the opinion that the demographic criteria used by OMM is more reliable and accurate than the criteria used by OSC in its match, i.e. a combination of last name, date of birth, first name, social security number, and sex. Anything less could result in closure of a valid case. Additionally, the criteria used to determine whether an overpayment occurred is set forth in the above referenced Dear Commissioner letter. DOH is unsure if this is the same criteria used by OSC in making its determination regarding overpayments, since the Department has not seen those criteria. If OSC re-runs its data consistent with DOH criteria, includes supporting information that will permit a determination that an overpayment has, in fact, occurred and the amount, and provides the information in a useable format, the Department will review the information and take appropriate action.

* Note

* See State Comptroller's Note: page 14

APPENDIX B – STATE COMPTROLLER'S NOTE

We do not agree with Department management's assertion that they have identified all potential scenarios in determining potential overpayments resulting from individuals having more than one ID, nor do we agree with their assertions regarding the reliability and accuracy of their match criteria versus ours. As documented in our report, we concluded the Department's selection criteria is too restrictive. Consequently, of the $45 million in potentially inappropriate payment we identified, we believe the Department's methodology would only identify about $12 million. We base this on the fact that in order to be selected under the Department's methodology, all of the criteria would have to be identical among the ID's including social security number. However, we noted that local districts do not capture social security number information for all individuals and as such we developed a second methodology using other recipient specific information.

In total, we identified 24,022 potential instances of duplication under the second methodology. We tested 94 of these instances to determine whether the IDs belonged to the same individual. Local district officials reviewed the instance and concluded that 67 of the 94 instances (71 percent) involved the same individuals. We agree Department management needs to take care to ensure they are not closing a valid case. However, our testing of the results demonstrates that the Department has not gone to the lengths necessary to identify all possible scenarios where duplication can occur. As such, we maintain the statements contained in the report are correct.