

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK MADE UNALLOWABLE
PAYMENTS TOTALING
MORE THAN \$10 MILLION FOR
MANAGED CARE BENEFICIARIES
ASSIGNED MULTIPLE MEDICAID
IDENTIFICATION NUMBERS**

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Amy J. Frontz
Deputy Inspector General
for Audit Services

February 2020
A-02-18-01020

Office of Inspector General

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Report in Brief

Date: February 2020

Report No. A-02-18-01020

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

A prior OIG audit found that New York made more than \$7 million in unallowable Federal Medicaid payments to different managed care organizations (MCOs) for the same month for beneficiaries assigned more than one Medicaid identification (ID) number. A recent analysis of Medicaid data showed that New York continued to make these improper payments despite the improvements it made to its processes for identifying beneficiaries with multiple Medicaid ID numbers.

Our objective was to determine whether New York claimed Federal Medicaid reimbursement for managed care payments made to different MCOs on behalf of beneficiaries who were assigned multiple Medicaid ID numbers.

How OIG Did This Audit

Our audit covered Medicaid managed care payments totaling \$25.8 million (Federal share) for 11,098 beneficiary-matches that New York made to different MCOs for calendar years 2014 through 2017. We reviewed a stratified random sample of 103 of these beneficiary-matches. For purposes of this audit, we defined a beneficiary-match to be when (1) more than one Medicaid ID number was associated with the same Social Security number (SSN) or (2) no SSN was provided but select personal information (i.e., first four characters of the first name, entire last name, date of birth, and sex) was identical for more than one Medicaid ID number.

New York Made Unallowable Payments Totaling More Than \$10 Million for Managed Care Beneficiaries Assigned Multiple Medicaid Identification Numbers

What OIG Found

New York improperly claimed Federal Medicaid reimbursement for Medicaid beneficiaries who were assigned more than one Medicaid ID number. Specifically, for 102 of the 103 beneficiary-matches in our sample, New York made managed care payments to different MCOs for the same beneficiary for the same month under different Medicaid ID numbers.

The assignment of multiple Medicaid ID numbers and resulting improper payments occurred because (1) New York's procedures for identifying whether a Medicaid applicant had already been assigned a Medicaid ID number were not always followed, (2) system queries were not adequate to ensure that all individuals with existing Medicaid ID numbers were identified, and (3) staff did not use all available resources to ensure that qualified applicants were not issued multiple Medicaid ID numbers.

On the basis of our sample results, we estimated that New York improperly claimed \$11.5 million in Federal Medicaid reimbursement for managed care payments made to different MCOs on behalf of beneficiaries assigned more than one Medicaid ID number. We reduced this estimate to \$11.3 million because New York recovered some managed care payments made on behalf of beneficiaries covered in our review after the start of our audit.

What OIG Recommends and New York's Comments

We recommend that New York (1) refund \$11.3 million to the Federal Government; (2) identify and recover improper managed care payments made to different MCOs on behalf of beneficiaries with multiple Medicaid ID numbers prior to and after our audit period, and repay the Federal share of the amounts recovered; and (3) strengthen its procedures for determining whether an individual applying for Medicaid already has a Medicaid ID number.

In written comments on our draft report, New York did not specifically indicate concurrence or nonconcurrence with our recommendations. New York generally agreed with our finding; however, it stated that one unallowable beneficiary-match identified in our draft report was not a duplicate because the associated Medicaid ID numbers were assigned to different beneficiaries. New York also described steps it has taken or planned to take to improve the identification of beneficiaries assigned multiple Medicaid ID numbers. After reviewing New York's comments, we maintain that our finding and recommendations are valid. Regarding the one beneficiary-match that New York asserted was not a duplicate, we maintain that the Medicaid ID numbers were associated with one individual who used two names and one SSN.

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INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit found that the New York State Department of Health (State agency) made more than \$7 million in unallowable Federal Medicaid payments to different managed care organizations (MCOs) for the same month for beneficiaries assigned more than one Medicaid identification (ID) number.¹ The State agency has since taken steps to improve its processes for identifying beneficiaries assigned multiple Medicaid ID numbers and recovering the associated improper Medicaid payments. However, a recent OIG analysis of Medicaid data indicated that the State agency continued to make unallowable Medicaid payments to different MCOs for beneficiaries assigned more than one Medicaid ID number.²

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for managed care payments made to different MCOs on behalf of beneficiaries who were assigned multiple Medicaid ID numbers.

BACKGROUND

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. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New York's Medicaid Managed Care Program

In New York, the State agency administers the Medicaid program. The State agency uses two methods to pay for Medicaid services: fee-for-service and managed care. Under the fee-for-service program, healthcare providers are paid for each eligible service provided to a Medicaid beneficiary. Under the managed care program, the State agency pays MCOs a monthly fee

¹ *New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers* (A-02-11-01006, issued April 15, 2013). This audit covered managed care payments made on behalf of Medicaid beneficiaries with more than one Medicaid ID number during the period January 1, 2005, through April 30, 2010.

² The New York State Office of State Comptroller (OSC) recently issued a report that also identified this issue (Report 2018-S-24, issued July 2019).

(capitation payment) to ensure that each enrolled beneficiary has access to a comprehensive range of medical services.

The State agency's CMS-approved MCO contract states that the State agency shall not allow, under any circumstance, duplicate Medicaid payments for an enrollee and has the right to recover duplicate Medicaid payments made for persons enrolled in the Medicaid managed care program under more than one Medicaid ID number.

New York's Medicaid Enrollment Process

In New York, individuals can apply for Medicaid in person, at local departments of social services offices (local districts) overseen by the State agency, or online through New York's State-based marketplace, known as New York State of Health (the Marketplace). Depending on how an individual applies for Medicaid, the local district or the Marketplace is responsible for determining whether applicants meet eligibility requirements, assigning a Medicaid ID number, and ensuring that applicants have only one active Medicaid ID number.

Local District Enrollment

Beneficiary information for individuals applying for Medicaid at a local district is maintained in the State agency's Welfare Management System (WMS). The WMS operates as two systems—one for beneficiaries residing in New York City and one for beneficiaries residing elsewhere in New York State. As part of the enrollment process, local district staff review a WMS-generated report on potential beneficiary-matches.³ If the report shows that the applicant has an existing Medicaid ID number, the local district is to use that Medicaid ID number—not issue a new one.

Marketplace Enrollment

Beneficiary information for individuals applying for Medicaid through the Marketplace is maintained in the Marketplace's data repository. As part of the enrollment process, the applicant's information is automatically run through the data repository and compared with information on current Medicaid beneficiaries to determine whether the applicant already exists in the Marketplace's system (i.e., has a Medicaid ID number). If the system does not find a Medicaid ID number assigned to the applicant, the applicant's information is run against demographic information in the WMS. This produces a list of potential beneficiary-matches that Marketplace staff are instructed to review prior to issuing a Medicaid ID number.

State Agency Guidance

Because of gaps in enrollment processes that could allow an individual with an existing Medicaid ID number to go undetected and have a new Medicaid ID number assigned to them,

³ This report is created by matching applicants' demographic information (i.e., name, date of birth, Social Security number (SSN), and sex) to that of all existing Medicaid ID numbers in WMS and the Marketplace data repository.

the State agency issued guidance in April of 2013 that encouraged local districts to use additional resources to determine whether an applicant already has a Medicaid ID number.⁴

HOW WE CONDUCTED THIS AUDIT

We limited our audit to Medicaid managed care payments the State agency made to different MCOs for the same beneficiary under the different Medicaid ID numbers for the same month.⁵ Specifically, we identified 11,098 beneficiary-matches with payments totaling \$44,925,533 (\$25,826,158 Federal share) that the State agency claimed for the period January 1, 2014, through December 31, 2017. We reviewed a stratified random sample of 103 beneficiary-matches. For purposes of this audit, we defined a beneficiary-match to be when (1) more than one Medicaid ID 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, entire last name, date of birth, and sex) was identical for more than one Medicaid ID 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.

FINDING

MANAGED CARE PAYMENTS MADE ON BEHALF OF BENEFICIARIES WITH MORE THAN ONE MEDICAID IDENTIFICATION NUMBER

The State agency's CMS-approved MCO contract states that the State agency shall not allow, under any circumstance, duplicate Medicaid payments for an enrollee and has the right to recover duplicate Medicaid payments made for persons enrolled in the Medicaid managed care program under more than one Medicaid ID number.

⁴ These resources include a search function in the State agency's web-based system for claiming Medicaid reimbursement and a WMS query that identifies individuals already assigned a Medicaid ID number who relocated to another New York county.

⁵ Managed care payments made to the same MCO for the same beneficiary under different Medicaid ID numbers for the same month are being reviewed separately and were excluded from this audit.

For 102 of the 103 beneficiary-matches in our sample, the State agency made improper Medicaid managed care payments on behalf of beneficiaries who were assigned more than 1 Medicaid ID number.⁶ Specifically:

- For 58 beneficiary-matches, the associated case files indicated that both the Marketplace and a local district assigned Medicaid ID numbers.
- For 20 beneficiary-matches, the associated case files indicated that the Marketplace assigned multiple Medicaid ID numbers.
- For 15 beneficiary-matches, the associated case files indicated that the same local district assigned multiple Medicaid ID numbers.
- For 10 beneficiary-matches, the associated case files indicated that different local districts assigned multiple Medicaid ID numbers.^{7, 8}

The assignment of multiple Medicaid ID numbers and resulting improper payments occurred because (1) the State agency's procedures for identifying whether a Medicaid applicant had already been assigned a Medicaid ID number were not always followed, (2) the WMS and the Marketplace data repository queries were not adequate to ensure that all individuals with existing Medicaid ID numbers were identified, and (3) local district and Marketplace staff did not use all available resources to ensure that qualified applicants were not issued multiple Medicaid ID numbers.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$11,541,515 in Federal Medicaid reimbursement for managed care payments made to different MCOs on behalf of beneficiaries assigned more than one Medicaid ID number.⁹ In response to the OSC report (see footnote 2), the New York State Office of Medicaid Inspector General (OMIG) informed us that it has started recovering some of the identified managed care payments made on behalf of beneficiaries with more than one Medicaid ID number. As a result, we reduced our estimate of improper Federal Medicaid reimbursement by \$284,147, to

⁶ The remaining beneficiary-match involved twins for whom the local district entered the same SSN when it enrolled each individual in the Medicaid program and issued the Medicaid ID numbers. Therefore, the associated payments were for two different Medicaid beneficiaries and allowable.

⁷ For these 10 beneficiary-matches, the associated beneficiary moved from one New York State county to another, reapplied for Medicaid benefits at the new county's local district office, and was issued a new Medicaid ID number. However, the former local district had not closed the Medicaid ID number that it had issued.

⁸ The total exceeds 102 because the beneficiary associated with 1 beneficiary-match was assigned 2 Medicaid ID numbers by the Marketplace and 1 by a local district.

⁹ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

\$11,257,368, which reflected payments in our sampling frame that had been recovered by OMIG as of September 2019.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund \$11,257,368 to the Federal Government;
- identify and recover improper managed care payments made to different MCOs on behalf of beneficiaries with multiple Medicaid ID numbers prior to and after our audit period, and repay the Federal share of the amounts recovered; and
- strengthen its procedures for determining whether an individual applying for Medicaid has already been assigned a Medicaid ID number by ensuring that:
 - its system queries identify all individuals with existing Medicaid ID numbers and
 - local district and Marketplace staff follow guidance on identifying individuals with Medicaid ID numbers and use all available resources to identify and prevent the issuance of multiple Medicaid ID numbers to the same individual.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not specifically indicate concurrence or nonconcurrence with our recommendations. The State agency generally agreed with our finding; however, it stated that 1 of the 102 unallowable beneficiary-matches identified in our draft report was not a duplicate because the associated Medicaid ID numbers were assigned to 2 different beneficiaries. The State agency also described OMIG's continued efforts to identify beneficiaries assigned multiple Medicaid ID numbers and recover any inappropriate managed care payments made to different MCOs on behalf of these beneficiaries. Finally, the State agency described steps it has taken or planned to take to improve the identification of beneficiaries assigned multiple Medicaid ID numbers, including implementing changes to the Marketplace, issuing guidance to local districts, and implementing an internal quality improvement process to monitor local districts' handling of multiple Medicaid ID numbers. The State agency's comments are included in their entirety as Appendix D.

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid. In addition, we commend the State agency on its efforts to identify beneficiaries assigned multiple Medicaid ID numbers. Regarding the one beneficiary-match that the State agency asserted was not a duplicate because the associated Medicaid ID numbers were assigned to two different beneficiaries, we maintain that the Medicaid ID

numbers were associated with one individual who used two names and one SSN.¹⁰ In addition, as described in the report, our estimate of improper Federal Medicaid reimbursement reflects payments in our sampling frame that had been recovered by OMIG as of September 2019.

¹⁰ Although the two Medicaid ID numbers had different names associated with them, case record documentation from the associated local district and the State agency confirmed that the two numbers were assigned to the same individual. The State agency should take the necessary steps to recover the improper payments associated with this beneficiary-match and to prevent any future improper payments from occurring.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicaid managed care payments the State agency made to different MCOs for 11,098 beneficiary-matches totaling \$44,925,533 (\$25,826,158 Federal share) for the period January 1, 2014, through December 31, 2017.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS)¹¹ for our audit period. We also established reasonable assurance of the completeness of the managed care payment data by reconciling managed care claim data in the MMIS to the managed care payments reported on the State agency's Form CMS-64, Quarterly Medicaid Statement of Expenditures (CMS-64).

We limited our audit of the State agency's internal controls to those that pertained directly to our objective. Specifically, we obtained an understanding of the procedures for assigning Medicaid ID numbers to eligible beneficiaries and ensuring that the beneficiaries have only one active Medicaid ID number.

We performed fieldwork at the State agency and the New York Marketplace in Albany, New York, the MMIS fiscal agent in Rensselaer, New York, and at 19 local districts throughout New York State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable State agency guidance and the State agency's CMS-approved MCO contract;
- met with State agency, Marketplace, and local district officials to gain an understanding of the procedures for assigning Medicaid ID numbers and for preventing the assignment of multiple Medicaid ID numbers;
- identified a sampling frame of 11,098 beneficiary-matches¹² with managed care payments totaling \$44,925,533 (\$25,826,158 Federal share);

¹¹ The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

¹² We defined a beneficiary-match to be when (1) more than one Medicaid ID 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, entire last name, date of birth, and sex) was identical for more than one Medicaid ID number.

- reconciled the Medicaid managed care payment data reported on the State agency's CMS-64 for our audit period with the managed care claim data obtained from the MMIS;
- selected a stratified random sample of 103 beneficiary-matches from our sampling frame;
- obtained and reviewed case record documentation from the local district(s) and the Marketplace for each sample item to determine whether a beneficiary was issued multiple Medicaid ID numbers;
- reviewed encounter data to determine which managed care payment was unallowable;¹³
- estimated the unallowable Federal Medicaid reimbursement in the sampling frame of 11,098 beneficiary-matches;
- discussed our results with State agency officials; and
- obtained from OMIG a listing of managed care claims that had been refunded after the start of our audit and reduced the estimate of unallowable Federal Medicaid reimbursement by the total of refunded claims in our sampling frame.

See Appendix B for 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.

¹³ 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) or the Marketplace clearly indicated that the beneficiary moved from one local district to another or that the Medicaid ID number was improper.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of managed care payments that the State agency made to different MCOs for beneficiaries with matching information and for whom more than one Medicaid ID number was issued (referred to as beneficiary-match) for the period January 1, 2014, through December 31, 2017.

SAMPLING FRAME

The sampling frame consisted of 6 Access files containing 11,098 beneficiary-matches with managed care payments totaling \$44,925,533 (\$25,826,158 Federal share).¹⁴ The managed care payments were extracted from files maintained at the MMIS fiscal agent.

SAMPLE UNIT

The sample unit was a beneficiary-match.

SAMPLE DESIGN

We used a stratified random sample to evaluate the population of Medicaid managed care payments made on behalf of beneficiaries who were assigned multiple Medicaid ID numbers as shown in Table 1 on the following page:

¹⁴ Our original sampling frame contained 11,280 beneficiary-matches; however, we subsequently had to remove 182 beneficiary-matches from that frame because these matches were included in an incorrect stratum. The removal of these beneficiary-matches was not necessary to create a valid estimate. Rather, they were removed to avoid any confusion about the dollar ranges associated with each stratum. Further, removing these 182 beneficiary-matches is favorable to the State agency because it treats these items as having no improper payment.

Table 1: Sample Design

Stratum Number	Description	Frame Medicaid Paid Amount	Frame Federal Share Paid Amount	Frame Count	Sample Size
1	Match by SSN and related information ≤ \$1,439.09	\$6,504,026	\$3,477,954	5,477	15
2	Match by SSN and related information > \$1,439.09 and ≤ \$3,186.32	10,036,978	5,471,690	2,593	17
3	Match by SSN and related information > \$3,186.32 and ≤ \$6,419.48	9,529,012	5,609,518	1,235	17
4	Match by SSN and related information > \$6,419.48 and ≤ \$16,070.49	8,446,838	5,307,566	570	17
5	Match by SSN and related information > \$16,070.49	7,089,473	4,239,777	162	17
6	No SSN match, but match by select information	3,319,205	1,719,652	1,061	20
Totals		\$44,925,533*	\$25,826,158*	11,098	103†

* The individual strata values do not add up to the total amount due to rounding.

† Our sample included 2 of the 182 beneficiary-matches removed from the original sampling frame (see footnote 14). We removed these 2 beneficiary-matches, which reduced our sample size from 105 to 103.

SAMPLE SIZE

We selected a sample of 103 beneficiary-matches as described above in Table 1.

SOURCE OF RANDOM NUMERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiary-matches in each of the six strata. After generating random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of improper Medicaid managed care payments at the lower limit of the two-sided 90-percent confidence interval.

Lower limits calculated in this manner are designed to be less than the actual improper payment total 95 percent of the time. We also used this software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

Stratum	Beneficiary-Matches in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Beneficiary-Matches	Value of Unallowable Claims (Federal Share)
1	5,477	\$3,477,954	15	\$12,320	15	\$6,192
2	2,593	5,471,690	17	37,452	17	18,919
3	1,235	5,609,518	17	78,831	17	33,411
4	570	5,307,566	17	160,424	17	77,562
5	162	4,239,777	17	417,208	16	192,178
6	1,061	1,719,652	20	21,842	20	10,768
Total	11,098	\$25,826,158[†]	103[§]	\$728,078[†]	102	\$339,030

[†] The individual strata values do not add up to the total amount due to rounding.

[§] Our sample included 2 of the 182 beneficiary-matches removed from the original sampling frame (see footnote 14). We removed these 2 beneficiary-matches, which reduced our sample size from 105 to 103.

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

Point estimate	\$12,576,979
Lower limit	11,541,515
Upper limit	13,612,443

APPENDIX D: STATE AGENCY 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

January 9, 2020

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
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New York, New York 10278

Ref. No: **A-02-18-01020**

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-18-01020 entitled, "New York Made Unallowable Payments Totaling More Than \$10 Million for Managed Care Beneficiaries Assigned Multiple Medicaid Identification Numbers."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Diane Christensen
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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-02-18-01020 entitled,
“New York Made Unallowable Payments Totaling More Than \$10 Million
for Managed Care Beneficiaries Assigned Multiple Medicaid
Identification Numbers”**

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-02-18-01020 entitled, “New York Made Unallowable Payments Totaling More Than \$10 Million for Managed Care Beneficiaries Assigned Multiple Medicaid Identification Numbers.”

General Comments:

Page 2, Marketplace Enrollment Section

- *Beneficiary information for individuals applying for Medicaid through the Marketplace is maintained in the Marketplace’s data repository. As part of the enrollment process, the applicant’s information is automatically run through the data repository and compared with information on current Medicaid beneficiaries to determine whether the applicant already exists in the Marketplace’s system (i.e., has a Medicaid ID number). If the system does not find a Medicaid ID number assigned to the applicant, the applicant’s information is run against demographic information in the WMS. This produces a list of potential beneficiary-matches that Marketplace staff are instructed to review prior to issuing a Medicaid ID number.*

In NY State of Health, system logic is currently used to complete Client Identification Number (CIN) assignment. The Department will be deploying enhanced system functionality that will require manual intervention by staff in some instances to resolve multiple potential matches with existing CINs prior to the consumer being determined eligible for Medicaid and assigned a CIN in NY State of Health.

Page 4, paragraph 1

- *For 102 of the 103 beneficiary-matches in our sample, the State agency made improper Medicaid managed care payments on behalf of beneficiaries who were assigned more than 1 Medicaid ID number.*

One of the 102 CIN pairs identified by OIG is not a duplicate because the CINs are assigned to two different individuals.

The remaining 101 CIN pairs sampled from a targeted universe of cases were identified by the Department through the normal course of business. As of May 28, 2019, 100 CIN pairs were linked in eMedNY, the Department’s claim payment system, to prevent duplicate payments from occurring. The remaining CIN pair will be linked by January 2020.

Recommendation #1:

Refund \$11,257,368 to the Federal Government.

Response #1:

The Office of the Medicaid Inspector General (OMIG) is currently performing audits that overlap OIG's audit scope. OMIG will continue its reviews in this area.

Recommendation #2:

Identify and recover improper managed care payments made to different MCOs on behalf of beneficiaries with multiple Medicaid ID numbers prior to and after our audit period, and repay the Federal share of the amounts recovered.

Response #2:

OMIG will continue performing audits to review and recover inappropriate managed care payments made to different Managed Care Organizations (MCOs) for individuals assigned multiple identification numbers.

Recommendation #3:

Strengthen its procedures for determining whether an individual applying for Medicaid has already been assigned a Medicaid ID number by ensuring that:

- its system queries identify all individuals with existing Medicaid ID numbers and
- local district and Marketplace staff follow guidance on identifying individuals with Medicaid ID numbers and use all available resources to identify and prevent the issuance of multiple Medicaid ID numbers to the same individual.

Response #3:

The Department has undertaken the following system change requests (CRs) in NY State of Health in order to improve the identification of potential duplicate CINs and HX IDs, and minimize the assigning of duplicate ID numbers to consumers:

- *CR 1657 - Modify CIN matches returned and used in CIN Clearance:* Deployed in August 2019, this CR allows the use of additional scores not previously used for matching purposes, specifically a single 101 score and the 105 score used in the CIN clearance process;
- *CR 1705 - Prevent assignment of multiple/duplicate HX IDs and inactivate old HX IDs:* Also deployed in August 2019, this CR addresses issues that contributed to issuing multiple HX IDs and also cleans up the multiple HX IDs that already exist within the system;
- *CR 1909 - Modify CIN Scoring and the other one is Close Gaps in CIN Clearance:* Scheduled for May 2020, this CR modifies the way the system responds to multiple 101 scores with different CINs. When individuals present with multiple 101 matches with different CINs, it displays this information in the back office so that they can be manually investigated; and
- *CR 1882 - Back Office functionality to support inactivation of HX IDs and CINs and perform HX ID corrections:* schedule is to be determined.

The Department will consider the feasibility of incorporating additional edits to strengthen the system queries in the Welfare Management System (WMS).

The Department has expanded its internal work procedures to increase coordination and resolution activities of WMS-only duplicate CINs between the Department and Local Districts. The Department informed Local Districts of prior duplicate CIN audit findings and the updated process at the July 2019 New York Public Welfare Association Summer Conference.

Furthermore, a General Information System (GIS) message was drafted and is in clearance for issuance. In addition to reminding Local Districts of the WMS CIN correction and consolidation procedures, the GIS provides detailed policy guidance for the new quarterly reports that will list duplicate CINs found in WMS that require Local District research and resolution. The Department also implemented an internal quality improvement process to monitor the timeliness, accuracy and efficiency of CIN correction and consolidation by Local Districts.

In July 2019, in order to increase central oversight, The Department developed a new database to identify and monitor duplicate CINs active on Upstate and Downstate WMS. The new database will be maintained in addition to the existing duplicate CIN database used to identify and monitor duplicate CINs that are active on NY State of Health and WMS. The Department will use the new database to generate reports and track the efficiency of Local District duplicate CIN resolution and consolidation activity. The Department will provide quarterly data reports to Local Districts and monitor correction of enrollee demographic data, termination of duplicate coverage and CIN consolidation.

Additionally, the Department will develop and disseminate guidance to appropriate Marketplace staff when it deploys enhanced NY State of Health functionality requiring manual intervention in some instances to resolve duplicate CINs prior to the consumer being determined eligible for Medicaid.