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OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

DEPARTMENT OF HEALTH

INAPPROPRIATE PAYMENTS FOR MEDICAID RECIPIENTS RESIDING AND ENROLLED IN OTHER STATES

Report 2008-S-4

AUDIT OBJECTIVES

Our objective was to determine if the Department of Health (Department) ensured that local social service districts adequately investigated instances where New York State Medicaid program enrollees were also enrolled in another state's Medicaid program. Our objective also was to determine if the Department recovered inappropriate New York State Medicaid payments made for enrollees who no longer resided in the State and were covered under another state's Medicaid program.

AUDIT RESULTS - SUMMARY

Federal reports identify individuals who are enrolled in two or more states' Medicaid program during the same period of time. In counties outside of New York City, local social districts are to investigate these individuals to determine if they are ineligible for the State's Medicaid program. The local social service districts are to remove ineligible enrollees from the State's program. In New York City, the Human Resources Administration (HRA) performs these duties. Where feasible, the Department should recover Medicaid payments made after the date that such enrollees became ineligible.

According to the federal reports, during the period April 1, 2004 through May 31, 2008, the Department made $28.4 million in Medicaid payments on behalf of New York State Medicaid enrollees who were also enrolled in another state's Medicaid program. About $14.1 million of these payments represented managed care premiums and about $14.3 million represented fee-for-service payments.

We found that the Department had not taken steps to effectively ensure that local social service districts and HRA acted in a timely manner to either investigate the enrollees identified on the reports or to remove them from New York's Medicaid program. For example, the Department had not worked with the local social service districts and HRA to establish policies, procedures and time frames for completing investigations. In addition, the Department had not set up monitoring mechanisms to track the actual timeliness of the completion of investigations.

In fact, we found 27 local social service districts outside of New York City took longer than 60 days on average to complete their investigations. In New York City, HRA was not performing any investigations related to fee-for-service enrollees even though 11,765 such enrollees were identified on the federal reports for the period December 18, 2006 to November 15, 2007. Not performing investigations in a timely manner or not performing them at all, means that inappropriate Medicaid payments will continue at still greater cost to the State.

We also found that the Department was not taking any steps to recover inappropriate managed care premiums paid on behalf of enrollees who no longer resided in New York State and were enrolled in the Medicaid program of another state. For example, local district investigators outside of New York City confirmed that $3 million of the $14.1 million of managed care premiums previously discussed pertained to such individuals, but the Department had not taken action to recover any of the $3 million from managed care plans. The remaining $11.1 million pertained to New York City enrollees, but HRA had not completed investigations of these enrollees. If the HRA investigations are completed and are consistent with the results of investigations performed outside of New York City, there is even greater potential for revenue recovery.

It is not likely that there is a revenue recovery opportunity for $14.3 million of fee-for-service payments because it appears providers furnished medical services to individuals who were still enrolled in the New York State program. However, we recommend that the Department further investigate the claims and providers pertaining to these payments to ensure that attempts have not been made to defraud New York's Medicaid program by submitting claims for persons who are known to have left the State.

We conclude that the Department must strengthen its oversight of local investigative efforts and local social service districts and HRA must complete investigations in a more timely manner. The Department must pursue recovery of inappropriate Medicaid payments whenever feasible. The State cannot afford to waste millions of dollars of Medicaid payments.

This report, dated March 3, 2009, 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 Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

BACKGROUND

New York State's Medicaid program is administered by the Department of Health (Department). In the program, medical services are provided to low-income individuals who meet the program's eligibility requirements. Medicaid payments are made to participating medical service providers or participating managed care plans.

When a Medicaid recipient is enrolled in a managed care plan, the plan is paid a monthly premium to provide a comprehensive range of medical services to the recipient. The plan is paid the monthly premium until the recipient is no longer eligible for Medicaid or no longer resides in the area covered by the plan.

When a Medicaid recipient is not enrolled in a managed care plan, the medical service provider is reimbursed on a fee-for-service basis for the services provided to the recipient. The fee levels are established by the Department.

Local social services districts (57 counties and New York City) are responsible for enrolling individuals in Medicaid and ensuring that the individuals meet all eligibility requirements. The local districts are also responsible for enrolling Medicaid recipients in managed care plans, and ensuring that enrollment information is kept up to date.

Medicaid payments are made by the Department's automated claims processing system (eMedNY). The payments are made on the basis of claims submitted by the medical service providers and managed care plans. The Department is responsible for overseeing the payment process and recovering any inappropriate payments.

Medicaid is the single most costly program administered by New York State, as the State spends more than $42 billion annually for the medical services covered by the program. These services are provided to approximately 4 million Medicaid recipients. Medicaid is funded jointly by the State, the counties and the federal government. About half the funding is federal.

Each state has its own Medicaid program, and a state may make unnecessary Medicaid payments if it provides Medicaid coverage to individuals who actually reside in other states. For example, if a state does not disenroll an

individual from a Medicaid managed care plan after the individual moves to another state, the state will continue, unnecessarily, to pay monthly managed care premiums on behalf the individual. If the individual enrolls in another state's Medicaid program, both states could be paying such premiums at the same time, thus inflating the cost of Medicaid for that individual.

To help prevent such situations, each quarter, the U.S. Department of Health and Human Services (HHS) reviews the enrollment data for public assistance programs such as Medicaid, identifies the individuals who appear to be enrolled in such programs in two or more states at the same time, and distributes a report listing these individuals to the affected states.

In New York State, these quarterly reports (called Public Assistance Reporting Information System, or PARIS, reports) are received by the State Office of Temporary and Disability Assistance (OTDA). OTDA is to forward the listing of potentially duplicate Medicaid-only enrollments to the Department, and the Department is to forward the potentially duplicate enrollments to the local social services districts.

The local districts are then expected to investigate the enrollments to determine whether they were, in fact, duplicate, and if so, whether the individuals need to be disenrolled from New York's Medicaid program. The local districts are to report the results of their investigations to the Department, and the Department is to determine whether any inappropriate Medicaid payments were made by New York State on behalf of these individuals. If so, the Department is to seek the recovery of these payments.

AUDIT FINDINGS AND RECOMMENDATIONS

Oversight of Investigations

Based on our analysis of PARIS reports for the period April 1, 2004 through May 31, 2008, the State's Medicaid program paid as much as $28.4 million on behalf of enrollees who were also enrolled in other states' Medicaid Programs. About $14.1 million of this amount pertained to premiums paid to managed care plans and about $14.3 million pertained to fee-for-service payments to Medicaid providers. It is reasonable to conclude that some of these payments would be appropriate. For example, it is possible that some of the enrollees appearing on the PARIS reports moved back and forth between New York and other states during the reporting period and were legitimately covered by New York State payments.

In this regard, Department officials note that the $14.3 million of fee-for service payments pertains to more than 3,000 enrollees and when they reviewed a sample of 245 of these enrollees they found that 49 percent of them were properly covered by New York State's program. However, this would also suggest that 51 percent of the enrollees may not have been properly covered by New York State's program, resulting in inappropriate New York State Medicaid payments. For example, an individual in a state bordering New York could have received services in New York by showing a still active New York State Medicaid card.

Circumstances such as this make it all the more important for the local social service districts and HRA to perform timely investigations of all of the individuals on the PARIS reports. This would allow the districts and HRA to remove ineligible enrollees from the program and stop inappropriate State

Medicaid payments made on behalf of such enrollees. In addition, it is essential that the Department provides adequate direction and oversight for investigations to ensure State and local Medicaid costs are minimized for taxpayers.

The local districts and HRA are expected to investigate the potentially duplicate Medicaid enrollments cited in the quarterly PARIS reports and provide results to the Department. We reviewed the results submitted by all the 57 local social service districts outside of New York City for the period December 2006 through April 2008.

We found that 27 of the districts took, on average, longer than 60 days to complete their investigations, with one district taking on average 161 days to complete its investigations. We believe this is not sufficiently timely to minimize risk of Medicaid overpayments particularly because some of the enrollments noted on the PARIS reports are already four months old when the investigations begin. (The PARIS reports are produced on a quarterly basis.) Similarly, we found indications of untimely investigations at HRA. For example, we followed up on a sample of 17 PARIS enrollees assigned to HRA and noted that investigations for 16 of them did not commence until we asked to review investigation records. These 16 had been inactive for between 4 and 12 months when we made our inquiry.

We also found that HRA's policy was not to investigate fee-for-service individuals identified on the PARIS reports. We believe there is a substantial risk for Medicaid overpayments because, between December 18, 2006 and November 15, 2007, the PARIS reports identify 11,765 cases where New York State Medicaid enrollees are also covered by the Medicaid programs of other states. Under the HRA policy, none of these cases have been investigated to determine whether enrollees should be removed from the State's Medicaid program or the extent to which inappropriate fee-for-service payments may have been made on their behalf. HRA officials responded that they have established their policy because they believe there is less risk with the fee-for-service individuals on the PARIS reports and there is an absence of policy and guidance on these cases from the Department.

To remove an ineligible enrollee, the local district must change the status of enrollment to "close," and must properly update the recipient eligibility end date. We found that local districts and HRA do not always remove ineligible recipients promptly or correctly from the Medicaid program upon the completion of an investigation. For example, HRA eventually concluded that, for 8 of the 17 cases we selected, the enrollees were living in another state and were not eligible for continued Medicaid coverage in New York State. While HRA made these determinations in early April 2008, as of May 27, 2008 HRA had changed the enrollment status to "close" for only one of the enrollees. The remaining seven individuals remained enrolled in New York's Medicaid program and the State was continuing to pay unnecessary monthly managed care premiums on their behalf.

Local social service districts had completed investigations pertaining to about $3 million of the $14.1 million of Medicaid managed care premium payments covered by the PARIS reports. The local districts had determined that the State did, in fact, overpay these premiums because enrollees had moved to another state where they were also covered by Medicaid. However, we determined that about $500,000 of the $3 million resulted because local social service districts inappropriately extended the recipient

eligibility end dates or never changed the original established recipient eligibility end date. Since the eligibility end date is the effective date that Medicaid stops, if this date is inappropriately extended, Medicaid managed care premiums are overpaid. For example, we noted one enrollee's status was closed on December 27, 2005, but their eligibility end date was not changed until September 30, 2006. As a result, an additional nine months of managed care premiums totaling $2,300 were paid for this enrollee.

Department officials noted that prior to December 2006, OTDA was responsible for following up on potentially duplicate public assistance enrollments, including Medicaid. Officials further noted that until December 2006 they received no reports on such enrollments. We conclude that to some extent the weaknesses in the investigative processes are attributable to conditions and practices that predate the Department's takeover of this responsibility. However, the Department now has responsibility for promoting cost containment in the Medicaid program and it should be making every effort to provide guidance and direction to the local social service districts and HRA and it should be continually monitoring their progress.

We recommend that the Department make a commitment to its responsibility for oversight of the PARIS reporting function with a focus on working with local districts to develop standard policies, procedures and time frames for investigations and closing cases. In addition, the Department must monitor local social service district and HRA practices to ensure that they are complying with the policies, procedures and time frames.

Recovering Inappropriate Payments

We examined the Department's process for recovering inappropriate Medicaid payments made by New York State on behalf of individuals no longer residing in the State and enrolled in other states' Medicaid programs. We found significant improvements are needed, as the Department has made no attempt to recover such payments.

The Department receives the quarterly listing of potentially duplicative Medicaid enrollments from OTDA, and forwards the listing to the local social service districts and to HRA. These entities investigate the enrollments and report results to the Department. Nevertheless, the Department does not pursue recovery of inappropriate Medicaid payments that are evidenced by the investigative results.

For example, as previously discussed, about $14.1 million of the potential overpayments for the period April 1, 2004 through May 31, 2008 pertained to cases involving Medicaid managed care premium payments for enrollees. Local social service district investigations confirmed that $3 million of this amount was, in fact, overpayment of premiums for individuals who no longer resided in New York State and had Medicaid coverage in other states. Despite confirmation of overpayment by local social service district investigations, the Department has not sought recovery. Moreover, as of March 31, 2008, HRA had not completed its investigations of the remaining $11.1 million of potential overpayments of Medicaid managed care premiums. If the HRA results are similar to the investigative results of local social service districts, the revenue recovery opportunity will be substantial. This is an opportunity the State can ill afford to miss particularly given the existing fiscal climate.

Department officials do not believe the $14.1 million of premiums are recoverable. According to officials, even if the enrollees did move to another state and enrolled in the Medicaid program of the other state, New York is still responsible for their medical care because the individuals were still officially enrolled with plans. If the individuals had gone back to the plans for medical care while they were still enrolled, the plans would have had to provide the care. Department officials indicated that since the plans could have been at risk of incurring costs for such care, the plans are entitled to the premiums.

We disagree with the Department's position on this matter because it is not consistent with a provision of the State's standard contract with Medicaid managed care plans. According to this contract, the Department can recover premiums paid to plans for enrollees who are later determined to have moved out of the plan's service area when it is determined the plan is not at risk for services. We further note that the $3 million of premiums for individuals confirmed to have moved out of New York State is recoverable, as we determined that these managed care plans did not provide any medical services to the individuals during the periods covered by the premiums. Therefore, the plans were not at risk for payment and recoveries are in order.

The $14.3 million of fee-for-service payments associated with the PARIS reporting is not likely recoverable because it appears to represent payments to providers for services actually rendered to individuals who had remained enrolled in New York's Medicaid program. Providers would have had no ability or responsibility to otherwise know these individuals were covered by another state's program. However, we recommend that the Department further examine the claims to ensure that they do not involve attempts by providers to defraud the Medicaid program through the submission of false claims on behalf of individuals known to have left the State.

Recommendations

1. Commit to ensuring effective oversight of the PARIS reporting function.

2. Work with local social service districts and HRA to develop standard policies, procedures and time frames for completing investigations of enrollees identified on PARIS reports. Also work with local social service districts and HRA to timely and correctly remove ineligible enrollees from the program when investigations result in closed cases.

3. Provide guidance and direction to HRA concerning investigation of fee-for-service cases represented on PARIS reporting.

4. Examine the fee-for-service payments pertaining to PARIS reporting to ensure that these cases do not involve fraud.

5. Identify the premiums that were paid to plans during periods of dual enrollment and recover these premiums, unless the plans can show that they provided medical services to the individuals during the period covered by premiums.

AUDIT SCOPE AND METHODOLOGY

We audited the Department's efforts to ensure local social service districts and HRA adequately investigated instances where New York State Medicaid program enrollees were also enrolled in another states' Medicaid program. We also audited whether the Department recovered inappropriate New York State Medicaid payments made on behalf of ineligible enrollees who no longer

resided in the State and had enrolled in another state's Medicaid program. Our audit covered the period April 1, 2004 through May 31, 2008.

To accomplish our audit objectives, we interviewed Department and local district officials, reviewed applicable sections of Federal and State laws and regulations, and examined the Department's relevant policies and procedures. We also extracted paid Medicaid claim information for certain recipients listed on PARIS reports, and reviewed certain medical information (managed care plan encounter information) for some of these recipients.

We visited seven judgmentally selected local districts (the counties of Albany, Erie, Monroe, Nassau, Saratoga, Suffolk, and New York City) to review records relating to their investigations of a random sample of 137 recipients listed on PARIS reports. We selected the districts for geographical diversity and because their investigations were not timely.

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

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.

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.

REPORTING REQUIREMENTS

We provided a draft copy of this report to Department officials for their review and comment. Department officials generally agreed with our recommendations and indicated actions planned to implement the recommendations. We considered their comments in preparing this report. A complete copy of the Department's response is included as Appendix A. Appendix B contains a State Comptroller's comment which addresses matters contained in the Department's response.

Within 90 days of the 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 what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to the report include Steve Sossei, Andrea Inman, Amanda Strait, Lucas McCullough, Tracy Samuel, and Dana Newhouse.

APPENDIX A - AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

January 22, 2009

Mr. Steven E. Sossei, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2008-S-4 on "Inappropriate Payments for Medicaid Recipients Residing and Enrolled in Other States."

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Executive Deputy Commissioner

Enclosure

cc: Stephen Abbott
Deborah Bachrach
Homer Charbonneau
Ron Farrell
Gail Kerker
Robert W. Reed
James Sheehan

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2008-S-4 on
"Inappropriate Payments for Medicaid Recipients Residing and Enrolled in Other States"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2008-S-4 on "Inappropriate Payments for Medicaid Recipients Residing and Enrolled in Other States."

Recommendation #1:

Commit to ensuring effective oversight of the PARIS reporting function.

Response #1:

The Department commits to enhancing its oversight of the PARIS reporting function.

Recommendation #2:

Work with local social services districts and HRA to develop standard policies, procedures and timeframes for completing investigations of enrollees identified on PARIS reports. Also work with local social service districts and HRA to timely and correctly remove ineligible enrollees from the program when investigations result in closed cases.

Response #2:

The Department agrees and will work more closely with the local social services districts including HRA to develop standardized policies, procedures and timeframes for completing investigations of enrollees identified on PARIS reports. The Department recognized the value of the PARIS data and implemented the requirement for local districts to perform follow-up investigations even though they are not a Federal requirement. It would like to point out that not all states perform such follow-up and that the various states that do follow-up utilize different timeframes for completing investigations, ranging from within 90 days to within one year. Currently, the Department is developing an automated process to close certain cases appearing on the PARIS match. It is also exploring appropriate timeframes for local districts to conduct their investigations, which the Department believes should afford adequate time to investigate the match while minimizing the risk of overpayment.

The Department has issued instructions requiring local districts to close ineligible cases appearing on the PARIS match in a timely manner. Certain individuals in Medicaid are entitled to 12 months of continuous coverage and/or to six months of guaranteed coverage in a managed care plan. Some districts did not understand that moving out of the State is an acceptable reason to end these guarantees in coverage and therefore did not close these cases in a timely manner. Although the Department has previously

provided clarification on this issue, it will instruct districts, through a formal process, of the policies and procedures to be followed for the PARIS match.

Recommendation #3:

Provide guidance and direction to HRA concerning investigation of fee-for-service cases represented on PARIS reporting.

Response #3:

The Department agrees and will provide guidance and direction to HRA concerning investigation of fee-for-services cases represented on the PARIS reporting.

Recommendation #4:

Examine the fee-for-service payments pertaining to PARIS reporting to ensure that these cases do not involve fraud.

Response #4:

The report notes that the Department performed a review of 245 enrollees included in the audit sample, finding that 49 percent were properly covered by New York State Medicaid and that the other 51 percent may or may not have been properly covered as the eligibility of these individuals could not be immediately deduced. However, the report does not consider that 68 percent of the claims associated with the 245 enrollees are for the individuals properly covered by New York State Medicaid and the 32 percent remainder are for the individuals for whom the Department could not resolve eligibility. Depending on the number of these individuals who in fact were properly covered, the percentage of claims associated with ineligible individuals could be significantly lower than 32 percent. Additionally, the report does not distinguish the ages of enrollees. This is important because, if an enrollee is under the age of 18, he or she has no responsibility to notify Medicaid of an out-of-state move; rather, that is the duty of his or her custodial parent or guardian. Other reasons may exist for a child to use a New York State Medicaid card for services with an out-of-state provider (e.g., visiting an out-of-state relative during summer vacation, staying with a non-custodial parent for court-mandated visits, etc.). The existence of Medicaid enrollees under the age of 18 could further reduce the percentage of ineligible individuals by a significant number.

* Comment

Recommendation #5:

Identify the premiums that were paid to plans during periods of dual enrollment and recover these premiums, unless the plans can show that they provided medical services to the individuals during the period covered by premiums.

Response #5:

The recovery of premiums from plans is governed by the contract, which states in Section 3.6, "The parties acknowledge and accept that the SDOH has a right to recover premiums paid to the Contractor for MMC Enrollees listed on the monthly Roster who

* See State Comptroller's Comment, Page 14

are later determined for the entire applicable payment month, to have been in an institution; to have been incarcerated; to have moved out of the Contractor's service area subject to any time remaining in the MMC Enrollee's Guaranteed Eligibility period; or to have died. SDOH has a right to recover premiums for FHPlus Enrollees listed on the Roster who are determined to have been incarcerated; to have moved out of the Contractor's service area; or to have died. In any event, the State may only recover premiums paid for MMC and/or FHPlus Enrollees listed on a Roster if it is determined by the SDOH that the Contractor was not at risk for provision of Benefit Package services for any portion of the payment period. Notwithstanding the foregoing, the SDOH always has the right to recover duplicate MMC or FHPlus premiums paid for persons enrolled under more than one Client Identification Number (CIN) in the Contractor's MMC or FHPlus product whether or not the Contractor has made payments to providers."

In response to the specific recommendation, the Department agrees to recover premiums from plans in accordance with the contract provisions set forth above.

APPENDIX B - STATE COMPTROLLER'S COMMENT ON AUDITEE RESPONSE

The Department states our report does not distinguish the ages of enrollees and provides reasons why an individual under the age of eighteen could use a New York State eligibility card with an out-of-state provider, such as visiting an out-of-state relative or staying with a non-custodial parent. While we recognize an individual's right to seek services in another state in certain instances such as while visiting that state, our audit addressed individuals who have established Medicaid eligibility in two or more states at the same time. The age of an individual should not matter in such circumstances.