

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEW YORK MADE UNALLOWABLE  
PAYMENTS TOTALING MORE THAN  
\$9 MILLION TO THE SAME MANAGED  
CARE ORGANIZATION FOR  
BENEFICIARIES ASSIGNED MORE THAN  
ONE MEDICAID  
IDENTIFICATION NUMBER**

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Deputy Inspector General  
for Audit Services

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A-02-20-01007

# *Office of Inspector General*

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## Report in Brief

Date: May 2021

Report No. A-02-20-01007

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



### Why OIG Did This Audit

A recent OIG audit found that New York made more than \$10 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. Using computer matching and other data analysis techniques, we determined that Medicaid payments to the *same* MCO were at risk for similar noncompliance with Medicaid requirements.

Our objective was to determine whether New York claimed Federal Medicaid reimbursement for managed care payments made to the same MCO on behalf of beneficiaries who were assigned more than one Medicaid ID number.

### How OIG Did This Audit

Our audit covered Medicaid managed care payments totaling \$25.5 million (Federal share) for 13,784 beneficiary-matches that New York made to the same MCO for the same month during the period January 2015 through September 2019. We reviewed a stratified random sample of 105 of these beneficiary-matches. 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 gender) was identical for more than one Medicaid ID number.

## New York Made Unallowable Payments Totaling More Than \$9 Million to the Same Managed Care Organization for Beneficiaries Assigned More Than One Medicaid Identification Number

### What OIG Found

New York improperly claimed Federal Medicaid reimbursement for Medicaid beneficiaries who were assigned more than one Medicaid ID number. Specifically, for 100 of the 105 beneficiary-matches in our sample, New York made managed care payments to the same MCO for the same beneficiary for the same month under different Medicaid ID numbers.

The assignment of more than one Medicaid ID number and resulting improper payments occurred because (1) New York's procedures for identifying whether an individual applying for Medicaid 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) local district and Marketplace staff did not use all available resources to ensure that qualified applicants were not issued more than one Medicaid ID number. We note that, in 2019 and 2020, New York took steps to improve its processes for identifying beneficiaries assigned more than one Medicaid ID number.

On the basis of our sample results, we estimated that New York claimed at least \$10.6 million in Federal Medicaid reimbursement for managed care payments made to the same MCO on behalf of beneficiaries assigned more than one Medicaid ID number. We reduced our recommended financial disallowance to reflect payments New York refunded after our fieldwork.

### What OIG Recommends and New York's Comments

We made a series of recommendations to New York, including that it refund \$9,325,338 to the Federal Government and identify and recover improper managed care payments made to the same MCO on behalf of beneficiaries with more than one Medicaid ID number prior to and after our audit period.

New York did not indicate concurrence or nonconcurrence with our recommendations; however, it described steps that it has taken or plans to take to address them. New York also stated that it refunded more than \$1 million for payments made on behalf of beneficiaries assigned more than one Medicaid ID number. We verified that New York refunded more than \$1 million in recoveries after completion of our fieldwork for payments in our sampling frame and revised our report accordingly.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

A recent Office of Inspector General (OIG) audit found that the New York State Department of Health (State agency) made more than \$10 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.<sup>1</sup> Using computer matching and other data analysis techniques, we determined that Medicaid payments to the *same* MCO were at risk for similar noncompliance with Medicaid requirements.

### OBJECTIVE

The objective of our audit was to determine whether the State agency claimed Federal Medicaid reimbursement for managed care payments made to the same MCO on behalf of beneficiaries who were assigned more than one Medicaid ID number.

### 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 (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.

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<sup>1</sup> *New York Made Unallowable Payments Totaling More Than \$10 Million for Managed Care Beneficiaries Assigned Multiple Medicaid Identification Numbers* ([A-02-18-01020](#)) February 20, 2020.

## **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 should review a WMS-generated report on potential beneficiary-matches.<sup>2</sup> 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 the information of current Medicaid beneficiaries to determine whether the applicant already exists in the Marketplace’s system (i.e., has a Medicaid ID number). If the Marketplace’s system does not find a Medicaid ID number assigned to the applicant, the applicant’s information is run against demographic information in the WMS. If there is no match in the WMS on the applicant’s Social Security number (SSN) and at least one other factor (i.e., date of birth, gender, first and last names), a new Medicaid ID number will be assigned to the applicant. Manual reviews of potential beneficiary-matches (i.e., matches on factors other than SSN) were not performed by Marketplace staff during our audit period.

### *Additional Resources for Identifying Beneficiaries With More Than One Medicaid ID Number*

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, the State agency issued guidance in 2013 that encouraged local district and Marketplace staff to use other available resources to identify and prevent the issuance of more than one Medicaid ID number to the same individual. These resources include a search function in the State agency’s Web-based system for claiming Medicaid reimbursement that allows users to

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<sup>2</sup> This report is created by matching applicants’ information (i.e., name, date of birth, Social Security number, and gender) to that of all existing Medicaid ID numbers in WMS and the Marketplace data repository.

enter criteria to determine if an individual has a Medicaid ID number.<sup>3</sup> Additionally, the State agency developed a query in its WMS to identify individuals who had been assigned a Medicaid ID number by one local district and then relocated to another local district.<sup>4</sup>

## **HOW WE CONDUCTED THIS AUDIT**

We limited our audit to Medicaid managed care payments the State agency made to the same MCO for the same beneficiary under different Medicaid ID numbers for the same month. Specifically, we identified 13,784 beneficiary-matches with payments totaling \$46,754,251 (\$25,494,259 Federal share) that the State agency claimed for the period January 1, 2015, through September 1, 2019. We reviewed a stratified random sample of 105 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 gender) 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. Generally, States must refund the Federal share of Medicaid overpayments to CMS.<sup>5</sup> Overpayments are amounts paid in excess of allowable amounts and would include unallowable capitation payments made on behalf of the same beneficiary for the same coverage of services.

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<sup>3</sup> Based on the search criteria entered, users can retrieve information such as Medicaid ID numbers, SSNs, and prior Medicaid billing information.

<sup>4</sup> Local district and Marketplace staff can query an individual's SSN or can query an individual's name if the individual does not have or has not produced an SSN.

<sup>5</sup> 42 CFR § 433.312.



For 100 of the 105 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.<sup>6</sup> Specifically:

- For 58 beneficiary-matches, the associated case files indicated that both the Marketplace and a local district assigned Medicaid ID numbers to the same beneficiary.
- For 19 beneficiary-matches, the associated case files indicated that the Marketplace assigned more than 1 Medicaid ID number to the same beneficiary.
- For 19 beneficiary-matches, the associated case files indicated that the same local district assigned more than 1 Medicaid ID number to the same beneficiary.
- For four beneficiary-matches, the associated case files indicated that different local districts assigned more than one Medicaid ID number to the same beneficiary.<sup>7</sup>

The assignment of more than one Medicaid ID number 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 more than one Medicaid ID number. We note that, in August 2019 and May 2020, the State agency took steps to improve its processes for identifying beneficiaries assigned more than one Medicaid ID number. In our prior audit, we commended the State agency on these efforts, which included implementing changes to the Marketplace, issuing guidance to local districts, and implementing an internal quality improvement process to monitor local districts' handling of more than one Medicaid ID number. Since most of these improvements were made after our audit period, we could not determine the effectiveness of these improvements on preventing the issuance of more than one Medicaid ID number identified in this report.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$10,637,932 in Federal Medicaid reimbursement for managed care payments made to the

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<sup>6</sup> The remaining beneficiary-matches consisted of (1) three beneficiary-matches for which a parent's SSN was mistakenly used on their newborn baby's application, (2) one beneficiary-match involving twins for whom the local district entered the same SSN for each twin during the enrollment process, and (3) one beneficiary-match in which the applicant provided the wrong SSN during the application process.

<sup>7</sup> This occurred when the beneficiary moved from one New York 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.

same MCO on behalf of beneficiaries assigned more than one Medicaid ID number.<sup>8</sup> We reduced our recommended financial disallowance by \$1,312,594, to \$9,325,338, to reflect payments in our sampling frame that the State agency refunded to the Federal Government after the end of our fieldwork.

## RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund \$9,325,338 to the Federal Government;
- identify and recover improper managed care payments made to the same MCO on behalf of beneficiaries with more than one Medicaid ID number prior to and after our audit period, and repay the Federal share of the amounts recovered; and
- ensure that improvements made to its processes for determining whether an individual applying for Medicaid has already been assigned a Medicaid ID number are effective by verifying that:
  - system queries are adequate to identify all individuals with existing Medicaid ID numbers and
  - local district and Marketplace staff are following guidance on identifying individuals with Medicaid ID numbers and using all available resources to identify and prevent the issuance of more than one Medicaid ID number 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; however, it described steps that it has taken or plans to take to address them. Specifically, the State agency stated that it refunded more than \$1 million to the Federal Government for payments made on behalf of beneficiaries assigned more than one Medicaid ID number. In addition, it stated that its Office of Medicaid Inspector General (OMIG) conducts audits to identify similar payments. The State agency also described actions it has taken to improve its identification of beneficiaries assigned multiple Medicaid ID numbers. The State agency's comments are included in their entirety as Appendix D.

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<sup>8</sup> 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.

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid. We verified that the State agency refunded \$1,312,594 in recoveries made by OMIG after completion of our fieldwork for Federal Medicaid payments in our sampling frame and revised our report accordingly. We commend the State agency on its continuing efforts to identify beneficiaries assigned multiple Medicaid ID numbers and to recover the improper payments made on behalf of these beneficiaries.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered Medicaid managed care payments the State agency made to the same MCO for the same service month for 13,784 beneficiary-matches totaling \$46,754,251 (\$25,494,259 Federal share) during the period January 1, 2015, through September 1, 2019.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS)<sup>9</sup> 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 determined that the State agency's control activities, information and communication, and monitoring were significant to our audit objective. We assessed the design, implementation, and operating effectiveness of the State agency's internal controls related to payments made to MCOs on behalf of beneficiaries with more than one Medicaid ID number. We also met with State agency, Marketplace, and local district officials to gain an understanding of the procedures in place for assigning Medicaid ID numbers to eligible beneficiaries and ensuring that 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 16 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 more than one Medicaid ID number;
- identified a sampling frame of 13,784 beneficiary-matches with managed care payments totaling \$46,754,251 (\$25,494,259 Federal share);

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<sup>9</sup> The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

- reconciled the Medicaid managed care payment data reported on the State agency's CMS-64 for selected quarters during our audit period with the managed care claim data obtained from the MMIS;
- selected a stratified random sample of 105 beneficiary-matches from our sampling frame;
- obtained and reviewed case record documentation from the Marketplace and local district(s) for each sample item to determine whether a beneficiary was issued more than one Medicaid ID number;
- reviewed encounter data to determine which managed care payment was unallowable;<sup>10</sup>
- estimated the unallowable Federal Medicaid reimbursement in the sampling frame of 13,784 beneficiary-matches; and
- discussed our results with State agency officials.

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.

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<sup>10</sup> Encounter data are the primary records of medical services provided to beneficiaries enrolled in managed care. We did not review encounter data when documentation maintained by the Marketplace or the local district(s) 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

### SAMPLING FRAME

The sampling frame consisted of an Access database containing 13,784 beneficiary-matches with managed care payments for the same service month totaling \$46,754,251 (\$25,494,259 Federal share) made to the same MCO for the period January 1, 2015, through September 1, 2019. A beneficiary-match occurred when more than one Medicaid ID was associated with the same SSN or when select beneficiary information (first four characters of the first name, entire last name, date of birth and gender) was the same for more than one Medicaid ID. 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 Medicaid managed care payments made on behalf of beneficiaries who were assigned more than one Medicaid ID number as shown below in Table 1:

**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 ≤ \$1,810.47	\$11,403,357	\$6,139,154	8,273	25
2	Match by SSN and related information > \$1,810.47 and ≤ \$5,056.48	17,208,770	9,191,293	3,281	25
3	Match by SSN and related information > \$5,056.48 and ≤ \$54,892.01	10,839,833	6,449,984	734	24
4	Match by SSN and related information > \$54,892.01	1,579,079	806,015	6	6
5	No SSN match, but match by select information	5,723,213	2,907,813	1,490	25
<b>Totals</b>		<b>\$46,754,251*</b>	<b>\$25,494,259</b>	<b>13,784</b>	<b>105</b>

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

### SAMPLE SIZE

We selected a sample of 105 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 for strata 1 through 3 and 5. After generating random numbers for these strata, we selected the corresponding frame items. We selected all six beneficiary-matches in stratum 4.

## **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**

<b>Stratum</b>	<b>Beneficiary-Matches in Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Beneficiary-Matches with Overpayments</b>	<b>Value of Overpayments in the Sample (Federal Share)</b>
1	8,273	\$6,139,154	25	\$21,412	25	\$11,131
2	3,281	9,191,293	25	77,030	25	34,153
3	734	6,449,984	24	217,949	20	89,748
4	6	806,015	6	806,015	5	201,087
5	1,490	2,907,813	25	33,046	25	18,554
<b>Total</b>	<b>13,784</b>	<b>\$25,494,259</b>	<b>105</b>	<b>\$1,155,452</b>	<b>100</b>	<b>\$354,674<sup>‡</sup></b>

<sup>‡</sup> The individual strata values do not add up to the total amount due to rounding.

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

Point estimate	\$12,217,574
Lower limit	10,637,932
Upper limit	13,797,216



## APPENDIX D: STATE AGENCY COMMENTS



**ANDREW M. CUOMO**  
Governor

**Department  
of Health**

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

**LISA J. PINO, M.A., J.D.**  
Executive Deputy Commissioner

Date: April 2, 2021

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

Ref. No: A-02-20-01007

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-02-20-01007 entitled, "New York Made Unallowable Payments Totaling More Than \$10 Million to the Same Managed Care Organization for Beneficiaries Assigned More Than One Medicaid Identification Number."

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan  
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen  
Frank Walsh  
Brett Friedman  
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Daniel Duffy  
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Jill Montag  
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James Cataldo  
Robert Schmidt  
Lori Conway  
OHIP Audit SM

**New York State Department of Health  
Comments on the Department of Health and Human Services  
Office of Inspector General Draft Audit Report A-02-20-01007  
entitled, "New York Made Unallowable Payments Totaling More Than  
\$10 Million to the Same Managed Care Organization for Beneficiaries  
Assigned More Than One Medicaid Identification Number"**

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The following are the responses from New York State Department of Health (Department) to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-20-01007 entitled, "New York Made Unallowable Payments Totaling More Than \$10 Million to the Same Managed Care Organization for Beneficiaries Assigned More Than One Medicaid Identification Number."

**Recommendation #1:**

Refund \$10,637,932 to the Federal Government.

**Response #1:**

The State has refunded more than \$1 million to date to the Federal Government. The Office of the Medicaid Inspector General (OMIG) has finalized additional audits in this area, with monies identified to be refunded to the Federal Government in the upcoming CMS-64 reporting period. OMIG is currently performing audits that overlap the OIG audit scope and will continue its reviews in this area.

**Recommendation #2:**

Identify and recover improper managed care payments made to the same MCO on behalf of beneficiaries with more than one Medicaid ID number prior to and after our audit period, and repay the Federal share of the amounts recovered.

**Response #2:**

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

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

In addition, as of the October 2015 amended Managed Care Model Contract, the Mainstream Managed Care Organizations (MCOs) are required to review and identify cases of multiple CINs on a quarterly basis and report them to the LDSS/NYSOH. These cases are then reported to OMIG and included in OMIG audits if the MCO does not void the duplicate capitation payment.

Prior to the OIG audit scope period, OMIG finalized audits totaling more than \$22 million for the period 2012-2014.

**Recommendation #3:**

Ensure that improvements made to its processes for determining whether an individual applying for Medicaid has already been assigned a Medicaid ID number are effective by verifying that:

- system queries are adequate to identify all individuals with existing Medicaid ID numbers and
- local district and Marketplace staff are following guidance on identifying individuals with Medicaid ID numbers and using all available resources to identify and prevent the issuance of more than one Medicaid ID number to the same individual.

**Response #3:**

The Department has undertaken the following system change requests (CRs) to improve the identification of potential duplicate CINs and HX Identifications (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 addressed issues that contributed to issuing multiple HX IDs and cleaned up the multiple HX IDs that already existed within the system;
- *CR 1909 - Modify CIN Scoring and the other one is Close Gaps in CIN Clearance:* Deployed in June 2020, this CR modified 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 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:* Deployment schedule is to be determined.

The Department explored the feasibility of incorporating additional edits to the system queries in the Welfare Management System (WMS). While it did not identify any additional edits that would strengthen the current queries, the Department took significant steps to increase its oversight of WMS-only duplicate CIN resolution.

The Department informed LDSS of prior duplicate CIN audit findings and reiterated the need to follow WMS CIN correction and consolidation procedures in July 2019, which was two months prior to the end of the audit period.

As indicated by OIG in the report, since August 2019, the Department has expanded its internal duplicate CIN procedures to research, correct and terminate duplicate Medicaid coverage timely

and to support recoupment efforts when duplicate payments are made to health plans. The Department also implemented a quality improvement process to monitor the timeliness, accuracy, and efficiency of CIN correction and consolidation by LDSS.

To enhance the Department's centralized oversight, the Department developed a new database to identify and monitor duplicate CINs active on Upstate and Downstate WMS. This new database is maintained in addition to the existing duplicate CIN database used to identify and monitor duplicate CINs that are active on NYSOH and WMS. The Department uses this new database to generate reports and track the efficiency of LDSS duplicate CIN resolution and consolidation activity. The Department will provide quarterly data reports to LDSS and monitor their correction of enrollee demographic data, termination of duplicate coverage and CIN consolidation.

The Department also released a General Information System (GIS) message to the LDSS in November 2020. In addition to reminding LDSS of the WMS CIN correction and consolidation procedures, the GIS provided detailed policy guidance outlining the Department's enhanced oversight procedures.

Additionally, the Department developed and disseminated guidance to the appropriate Marketplace staff after deploying enhanced NYSOH functionality in June 2020, which required manual intervention in some instances to resolve duplicate CINs prior to the consumer being determined eligible for Medicaid.