

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE NEW YORK STATE MEDICAID
AGENCY MADE CAPITATION
PAYMENTS TO
MANAGED CARE ORGANIZATIONS
AFTER BENEFICIARIES' DEATHS**

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Office of Inspector General

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Report in Brief

Date: July 2020

Report No. A-04-19-06223



Why OIG Did This Audit

New York pays managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payments). The New York Medicaid Assistance Program (New York Medicaid) is the second largest Medicaid program in the Nation. New York Medicaid provides health coverage to almost 6.2 million of New York's residents. Approximately 80 percent of the New York Medicaid population is enrolled in managed care.

Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly made capitation payments on behalf of deceased beneficiaries. We conducted this audit of New York, which administers New York Medicaid, to determine whether the issue we identified in other States also exists in New York.

Our objective was to determine whether New York made capitation payments on behalf of deceased beneficiaries.

How OIG Did This Audit

Our audit covered 20,824 Medicaid capitation payments, totaling \$28.6 million (\$17.3 million Federal share), made on behalf of beneficiaries whose dates of death preceded the payment dates. We reviewed capitation payments that New York made from July 1, 2014, through December 31, 2018 (audit period). We selected a stratified random sample of 100 capitation payments totaling \$1.3 million (\$825,219 Federal share) for review. Using the results of our sample, we estimated the total value and Federal share of the unallowable capitation payments.

The New York State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths

What OIG Found

New York made capitation payments after beneficiaries' deaths. Based on New York and Social Security Administration data available to us, we could not fully confirm that 2 beneficiaries associated with 4 of the 100 capitation payments were deceased. In addition, New York adjusted 12 capitation payments before our audit. For the remaining 84 payments, New York made unallowable payments totaling \$269,473 (\$143,643 Federal share).

The unallowable payments occurred because New York did not: (1) have system edits to identify errors in the automated process that terminates beneficiaries' eligibility after dates of death were identified; (2) update the eligibility and payment systems with correct dates of death; (3) identify as deceased and disenroll beneficiaries that had a date of death in one of its death data sources; or (4) use additional sources of death information and alternative procedures similar to those that we used in our audit to identify, verify, or determine dates of death.

On the basis of our sample results, we estimated that New York made payments to MCOs on behalf of deceased beneficiaries totaling at least \$23.3 million (\$13.7 million Federal share) during our audit period.

What OIG Recommends and New York Response

We recommend that New York: (1) refund the \$13.7 million to the Federal Government and (2) identify and recover unallowable payments made to MCOs during our audit period on behalf of deceased beneficiaries, which we estimate to be at least \$23.3 million. We also made other procedural and administrative recommendations.

New York did not specifically indicate that it concurred with our findings and recommendations. Regarding our first recommendation, New York said that it has refunded to the Federal Government more than \$10 million of the approximately \$14 million in unallowable payments. For our second recommendation, New York said that it has recovered over \$19 million of the \$23 million of unallowable payments identified.

In addition, New York described actions that it has taken or plans to take to address our remaining recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The New York Department of Health (State agency) pays managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payments). The New York Medicaid Assistance Program (New York Medicaid) is the second largest Medicaid program in the Nation. New York Medicaid provides health coverage to almost 6.2 million of New York's residents. Approximately 80 percent of the New York Medicaid population is enrolled in managed care.

Previous Office of Inspector General (OIG) audits¹ found that State Medicaid agencies had improperly made capitation payments on behalf of deceased beneficiaries. We conducted this audit of the State agency, which administers New York Medicaid, to determine whether the issue we identified in other States also exists in New York.

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of deceased beneficiaries.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income beneficiaries and individuals with disabilities (Title XIX of the Social Security Act (the Act)). 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.

The Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid beneficiaries. States contract with MCOs to make services available to enrolled Medicaid beneficiaries, usually in return for a predetermined periodic payment, known as a capitation payment. States report capitation payments claimed by MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance

¹ See Appendix B for related OIG reports.

percentage (FMAP), which varies depending on the State’s relative per capita income as calculated by a defined formula (42 CFR § 433.10). During our audit period (July 1, 2014, through December 31, 2018), the FMAP in New York ranged from 50 to 88 percent.²

Social Security Administration: Date of Death Information

The Social Security Administration (SSA) maintains death record information obtained from relatives of deceased beneficiaries, funeral directors, financial institutions, and governmental agencies (local, State, and Federal). SSA processes death notifications through its Death Alert, Control, and Update System, which matches the information received from external sources against the Master Beneficiary Record and Supplemental Security Record.³ SSA records the resulting death information in Numident.⁴ SSA then uses information from Numident to create a national record of death information called the Death Master File (SSA Death Master File (or DMF)).^{5, 6} Reported deaths of people who have SSNs are routinely added to the SSA Death Master File. In addition to the SSA Death Master File, the SSA’s State Verification and Exchange System (SVES),⁷ and State Online Query (SOLQ)⁸ are two additional sources that may help States identify a deceased beneficiary.

² Under the Patient Protection and Affordable Care Act’s (ACA’s) Medicaid expansion, payments for “newly eligible” individuals were reimbursed at a 100-percent FMAP during calendar years (CYs) 2014 through 2016.

³ SSA, *Programs Operations Manual System*, GN 02602.060 (May 13, 2011). The Master Beneficiary Record is an electronic record of all beneficiaries as defined in Title II of the Act (*Federal Old-Age, Survivors, and Disability Insurance Benefits*). The Supplemental Security Record is an electronic record of all beneficiaries as defined in Title XVI of the Act (*Supplemental Security Income for the Aged, Blind, and Disabled*).

⁴ Numident contains personally identifiable information for each individual issued a Social Security Number (SSN). Examples of data elements on a Numident record include name, date of birth, parents’ names, and date of death.

⁵ SSA, *Programs Operations Manual System*, GN 02602.060.B.1 (May 13, 2011).

⁶ SSA maintains death data—including names, SSNs, dates of birth, and States of death—in the SSA Death Master File for approximately 98 million deceased individuals. The more comprehensive file, referred to as the “full DMF,” is available to certain eligible entities and includes State-reported death data. A subset of the SSA Death Master File, called the “public DMF,” is available to the public and does not include State-reported death data.

⁷ The SVES is a batch query system that provides States and some Federal agencies with a standardized method of SSN verification. SVES allows States to request information from other SSA exchange systems external to SVES (e.g., Beneficiary and Earnings Data Exchange, State Data Exchange) via the SVES request.

⁸ The SOLQ is an online SVES that allows States real-time access to SSA’s SSN verification service and retrieval of Title II and Title XVI data. It enables personnel from State social services and other State benefit programs to rapidly obtain information they need to determine whether individuals are eligible for programs.

Federal and State Requirements

A capitation payment is a “payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment” (42 CFR § 438.2).

The State agency MCO contracts provide that both the MCO and the State agency may initiate a beneficiary’s disenrollment upon death of the beneficiary. Disenrollment is effective the first day of the month after death.⁹ Additionally, the contracts allow the State agency to recover capitation payments for the entire applicable month from the MCO in instances in which a member should have been disenrolled in a prior month (MCO Contract, section 3.6, “[State agency] Right to Recover Premiums”).

New York’s Medicaid Program

In New York, the State agency is responsible for administering New York Medicaid. New York Medicaid provides health insurance coverage to low-income individuals, such as pregnant women, children, parents or caretaker relatives of dependent children, adults aged 65 or older, individuals with disabilities, and adults aged 19 or older who have not yet reached age 65 and whose family’s income is at or below 138 percent of the Federal Poverty level.

Managed Care Organization Contracts

During our audit period, the State agency made capitation payments totaling approximately \$9.7 billion and had 38 MCO contracts with 22 MCOs to make Medicaid services available to eligible New York Medicaid beneficiaries in exchange for a fixed per-member, per-month capitation payment.

Eligibility Systems

To determine eligibility, the State agency relies on two eligibility systems: the New York State of Health (Marketplace) and the Welfare Management System (WMS).¹⁰

⁹ MCO Contracts, Attachment H, “Section 5 Disenrollment.”

¹⁰ The New York State Department of Family Assistance (DFA) is the New York agency that administers a variety of public assistance and social programs. Because DFA recipients may be Medicaid eligible, DFA provides eligibility information to the State agency via WMS.

The Marketplace

The Marketplace is designed to help people obtain health insurance coverage, including determining whether beneficiaries are Medicaid eligible. The eligibility status of Marketplace beneficiaries is verified using a synchronous SSA process.¹¹ Additionally, since January 1, 2016, the Marketplace has used the SSA's Periodic Verification Composite (PVC)¹² service for all consumers who are eligible for any Marketplace program. These eligibility verification processes are performed when a beneficiary submits a Medicaid application for: (1) an initial eligibility determination, (2) a redetermination, or (3) a renewal of services.

The Welfare Management System

In New York, the WMS is used to determine eligibility for public assistance, which may include Medicaid.

If a marketplace or a public assistance beneficiary is deemed Medicaid eligible, the beneficiary's information is transmitted from the eligibility system to the State agency's electronic Medicaid New York System (payment system), which maintains all the Medicaid eligibility and Managed Care enrollment information, including dates of death. The payment system is also used to process and adjust capitation payments as required by the State agency's policies and procedures and the MCO contracts.

New York: Date of Death Information

Date of Death information is electronically transmitted to the eligibility systems through scheduled electronic exchanges and data matches with various State and Federal databases,¹³ which include the SSA Death Master File. When a beneficiary is reported as deceased to the Marketplace or the WMS through the electronic exchanges, the beneficiary's case file is closed systemically (ending eligibility and future capitation payments), a date of death reason code is

¹¹ The synchronous SSA process verifies eligibility simultaneously between the New York State of Health and the SSA.

¹² PVC allows users to verify SSNs against SSA records. This verification process helps authenticate the identity of beneficiaries and may provide a death indicator.

¹³ The State agency uses three automated sources of data to obtain date of death information. The first source is the State Data Exchange, which is a batch data exchange that SSA created to provide Title XVI data to the States for use in determining entitlement and eligibility for federally funded benefit programs such as Medicare and Medicaid, subsidized housing, the Supplemental Nutrition Assistance Program, and Temporary Assistance to Needy Families, as well as other federally funded, State-administered benefit programs. The second automated source is the Resource File Integration, known as BENDEX Automated Death Match, which is a batch data exchange that provides Title II and earnings data. BENDEX provides the death data that the State agency obtains from WMS. The third automated source is New York's Vital Statistics death match file. In addition, the State verifies nonautomated death notifications from family members, obituaries, and others.

added to the beneficiary file, and the date of death is transmitted to the payment system. If a Medicaid beneficiary was reported as deceased but a date of death is not available or is not on file, the day the beneficiary is reported as deceased is used to end Medicaid coverage. In addition, when the PVC service identifies beneficiaries as deceased, the State agency sends letters requesting that the beneficiaries contact the Marketplace within 10 days for their Medicaid eligibility to continue. If the beneficiaries do not respond within 15 days of the date the notice is sent (5 additional days are added to allow for mail delivery), their managed care enrollment will end on the date of death stated in the PVC or at the beginning of their current eligibility periods if the PVC does not contain their dates of death.

In addition, the State agency takes steps to identify unallowable payments. For example, the Office of the Medicaid Inspector General (OMIG) performs audits and investigations using data mining and analysis to identify potential overpayments. If overpayments are identified, OMIG recovers the overpayments.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 20,824 Medicaid capitation payments, totaling \$28,606,883 (\$17,300,461 Federal share), made on behalf of beneficiaries whose dates of death preceded the payment dates. We reviewed capitation payments that the State agency made from July 1, 2014, through December 31, 2018 (audit period).¹⁴ We selected a stratified random sample of 100 capitation payments totaling \$1,341,814 (\$825,219 Federal share) for review. Using our sample results, we estimated the total value and Federal share of the unallowable capitation payments.

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 C contains the details of our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal and State requirements.

FINDINGS

The State agency made unallowable capitation payments after beneficiaries' deaths. Based on State agency and SSA data available to us, we could not fully confirm that 2 beneficiaries associated with 4 of the 100 capitation payments were deceased.¹⁵ In addition, the State

¹⁴ The audit period encompassed the most current data available at the time we initiated our review.

¹⁵ Although we initially determined that these two beneficiaries were deceased, during our audit, the agency provided documentation showing that the two beneficiaries were alive. As a result, we deemed the four sampled items related to the two beneficiaries to be correct.

agency adjusted 12 capitation payments before our audit. For the remaining 84 capitation payments, the State agency made unallowable payments totaling \$269,473 (\$143,643 Federal share) as follows:

- for 56 payments, the State agency did not have system edits to identify errors in the automated process that terminates beneficiaries' eligibility after dates of death were identified or did not update the eligibility and payment systems with correct dates of death;
- for 22 payments, the State agency did not identify the beneficiaries as deceased and disenroll them even though it had a date of death in one of its death data sources; and
- for 6 payments, the State agency did not use additional sources of death information and alternative procedures similar to those that we used in our audit to identify, verify, or determine the dates of death for these beneficiaries.

On the basis of our sample results, we estimated that the State agency made payments to MCOs on behalf of deceased beneficiaries totaling at least \$23,325,502 (\$13,696,760 Federal share) during our audit period.

THE STATE AGENCY MADE UNALLOWABLE PAYMENTS TO MEDICAID MANAGED CARE ORGANIZATIONS

The State agency did not always stop making capitation payments to MCOs after a beneficiary's death, despite its efforts to identify and recover any unallowable payments as allowed by its contracts with the MCOs. Of the 100 capitation payments in our sample, the State agency made 84 unallowable payments totaling \$269,473 (\$143,643 Federal share).

The State Agency Made Unallowable Payments on Behalf of Beneficiaries Whose Dates of Death Were Available in New York's Eligibility and Payment Systems

Of the 84 unallowable payments in our sample, 56 (67 percent of the 84) made on behalf of deceased beneficiaries were associated with beneficiaries who had dates of death in the State agency's eligibility and payment systems. Nevertheless, the State agency made unallowable payments totaling \$201,490 (\$105,247 Federal share) on behalf of these deceased beneficiaries:

- For 54 of the 56 sampled payments, the State agency eligibility and payment systems had a correct date of death for the beneficiaries associated with these payments. The State agency's eligibility systems regularly interfaced with State and Federal data exchanges that identified dates of death, and the State agency had internal controls to help identify deceased beneficiaries. When death information is properly identified and processed, the eligibility system uses that information to automatically terminate the

beneficiary's eligibility, remove him or her from the Managed Care program using a date of death reason code, and interface with the payment system, which stops capitation payments from being made and initiates the recovery process for capitation payments made after the beneficiary's date of death. The unallowable payments occurred because the State agency did not process death information and did not dis-enroll the deceased beneficiaries because it did not have system edits to terminate beneficiaries' eligibility after dates of death were identified. As a result, the State agency made unallowable payments totaling \$200,443 (\$104,332 Federal share) on behalf of these beneficiaries.

- For 2 of the 56 sampled payments, the eligibility and payment systems had the incorrect date of death. The State agency ended Medicaid coverage on the date it received the notification of death. The State agency's Monthly Auto-Close Procedure states that if a beneficiary is reported as deceased but a date of death is not available or is not on file, the day the beneficiary is reported as deceased is used to end Medicaid coverage. However, as it states in the MCO contracts, disenrollment is effective the first day of the month after the beneficiary date of death, and the State agency can recover capitation payments from the MCO when a member should have been disenrolled in a prior month. For example, for one of the two beneficiaries related to these sampled payments, the State agency used the date the beneficiary was reported as deceased (August 2, 2018) as the date to end Medicaid coverage because the actual date of death was not on file. However, the SSA Death Master File had the beneficiary's date of death as May 4, 2018, or 3 months before the date the State agency identified the beneficiary as deceased. Because the State agency did not update the eligibility and payment systems with the correct date of death, it did not end the beneficiary's enrollment the month after the beneficiary's date of death (June 2018) and made payments for June, July and August when it should not have. As a result, the State agency made unallowable payments totaling \$1,047 (\$915 Federal share) on behalf of these beneficiaries.

The State Agency Made Unallowable Payments on Behalf of Beneficiaries Whose Dates of Death Were Not Available in the Eligibility System but Were Available in One or More of New York's Death Data Sources

Of the 84 unallowable payments in our sample, 22 (26 percent of the 84) made on behalf of deceased beneficiaries were associated with beneficiaries whose dates of death were not available in the eligibility systems but were available in various State agency death data sources. Nevertheless, the State agency made unallowable payments totaling \$61,453 (\$33,801 Federal share) on behalf of these deceased beneficiaries:

- For 13 of the 22 sampled payments, the State agency had the dates of death for the beneficiaries associated with these payments but did not disenroll the beneficiaries. The State agency has an automated procedure in place that compares the eligibility files from WMS with the weekly files containing dates of death from BENDEX. Once BENDEX

updates the date of death in WMS, WMS then updates the date of death in the payment system. If a beneficiary is identified as deceased, the system automatically disenrolls the deceased beneficiary. The unallowable payments occurred because the automated interface between WMS, BENDEX, and the payment system failed to update the dates of death. Without an updated enrollment, the payment system continued to make payments on behalf of enrolled beneficiaries who were deceased. As a result, the State agency made unallowable payments totaling \$34,015 (\$18,358 Federal share) on behalf of these beneficiaries.

- For 9 out of the 22 sampled payments, the SOLQ had the date of death for the beneficiaries associated with those payments. The State agency has access to the SOLQ, which provides information the State agency needs to determine whether individuals are eligible for Medicaid, including the date of death. However, the State agency does not have an automated process to compare SOLQ date of death to the eligibility system. Because the SOLQ contains the date of death, performing this match after the State agency has identified a beneficiary as deceased, but whose date of death was not available in the eligibility system or other sources of death data, will help reduce overpayments made after beneficiaries' deaths. The unallowable payments occurred because the State agency did not perform a manual beneficiary match between its eligibility system and the SOLQ. As a result, the State agency made unallowable payments totaling \$27,438 (\$15,443 Federal share) on behalf of these beneficiaries.

The State Agency Made Unallowable Payments on Behalf of Beneficiaries Whose Dates of Death Were Not Available in New York's Eligibility System or Death Data Sources

Of the 84 unallowable payments in our sample, 6 (7 percent of the 84) were made on behalf of deceased beneficiaries for which the State agency had no dates of death in the eligibility systems or its death data sources. These unallowable payments occurred because the State agency did not use additional sources of death information or alternative procedures similar to those that we used in our audit to identify, verify, or determine dates of death.¹⁶ As a result, the State agency made unallowable payments totaling \$6,530 (\$4,595 Federal share) on behalf of these beneficiaries.

ESTIMATE OF UNALLOWABLE CAPITATION PAYMENTS

On the basis of our sample results, we estimated that the State agency made unallowable payments to MCOs totaling at least \$23,325,502 (\$13,696,760 Federal share) during our audit period.

¹⁶ For these six sampled items, we identified the beneficiaries' dates of death using the SSA Death Master File and verified and determined the beneficiaries' dates of death using obituaries and Accurint.

RECOMMENDATIONS

We recommend that the New York Department of Health:

- refund \$13,696,760 Federal share to the Federal Government;
- identify and recover unallowable payments made to MCOs during our audit period on behalf of deceased beneficiaries, which we estimated to be at least \$23,325,502;
- identify and recover capitation payments made on behalf of deceased beneficiaries before and after our audit period, and repay the Federal share of amounts recovered;
- create system edits to help identify overpayments and failures in the automated interfaces between the eligibility, payment, and death data; and
- use additional sources of date of death consistently to help reduce unallowable payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not specifically indicate that it concurred with our recommendations, but it provided information about actions it has taken to address them. Regarding our first recommendation, the State agency said that it has refunded to the Federal Government more than \$10 million of the approximately \$14 million in unallowable payments. For our second recommendation, the State agency said that it has recovered over \$19 million of the \$23 million of unallowable payments identified.

In addition, the State agency described actions that it has taken or plans to take to address our remaining recommendations. According to the State agency, discussions between the State agency and its payment system vendor have yielded the potential development of an edit to the eligibility system to identify capitation payments paid incorrectly after the date of death and to void such payments automatically. Also, the State agency said that it established a workgroup dedicated to remediating date of death data discrepancies and other system defects by May 31, 2020. Recoupment opportunities identified by this workgroup will be planned and pursued, as applicable.

Furthermore, the State agency said that it would be implementing the following procedures to reduce unallowable payments:

- a process to review patient status codes that are assigned to all paid claims and

- a new monthly procedure to identify beneficiaries whose coverage has ended because the SSA synchronous service or PVC service identified them as deceased without a date of death.

The State agency also said that it would review current processes for adding dates of death to eligibility files with the goal of identifying all areas used for identification and documentation and implementing edits where possible to reduce incorrect payments.

The State agency said that it would continue to perform audits to identify and recover inappropriate payments made to MCOs on behalf of deceased beneficiaries.

Finally, the State agency provided additional clarifying comments, which we reviewed but determined no additional changes to the report were necessary. State agency comments are included in their entirety as Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 20,824 Medicaid capitation payments to MCOs totaling \$28,606,883¹⁷ (\$17,300,461 Federal share) made on behalf of beneficiaries whose dates of death preceded the payment dates. We reviewed capitation payments that the State agency made from July 1, 2014, through December 31, 2018. We selected a stratified random sample of 100 capitation payments totaling \$1,341,814 (\$825,219 Federal share) for review.

We did not review the overall internal control structure of the State agency or its Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our audit to determining whether MCOs in New York received capitation payments on behalf of beneficiaries whose dates of death preceded the payment dates.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the State agency. Although we performed a completeness test, we do not attest to the completeness of the file.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance;
- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments after a beneficiary's death;
- reviewed the State agency contracts with the MCOs during the period of our audit;
- obtained from the State agency a file of capitation payments made to MCOs on behalf of Medicaid beneficiaries in New York for the audit period (the State agency file);
- matched the State agency file to the SSA Death Master File and identified 3,482,992 capitation payments totaling \$9,668,150,849 that the State agency made to MCOs from July 1, 2014, through December 31, 2018, on behalf of Medicaid beneficiaries who were deceased;

¹⁷ These capitation payments made on behalf of beneficiaries whose dates of death preceded the payment dates amounted to less than 0.5 percent of approximately \$9.7 billion in capitation payments that the State agency made to MCOs during our audit period.

- eliminated 3,462,168 capitation payments totaling \$9,639,543,966¹⁸ because of various factors (see Appendix C);
- created a sampling frame from the capitation payment data of 20,824 capitation payments totaling \$28,606,883 (\$17,300,461 Federal share) that the State agency made to MCOs on behalf of beneficiaries whose dates of death preceded the payment dates;
- selected for review a stratified random sample of 100 capitation payments on behalf of deceased beneficiaries totaling \$1,341,814 (\$825,219 Federal share);
- obtained documentation for each sample capitation payment to support:
 - the beneficiaries' first and last names, SSNs, dates of birth (which we verified using the SSA Death Master File), and member identification numbers;
 - whether the eligibility systems identified the beneficiaries' dates of death;
 - that a capitation payment occurred for the service month (and verified the accuracy of the paid amount);
 - that a capitation payment was not a Stop-Loss payment;¹⁹ and
 - any adjustments to the sample capitation payment;
- compared the dates of death in the eligibility system and in the SSA Death Master File for 100 sample items;
- used Accurint,²⁰ obituaries, death certificates, or encounter data to verify the accuracy of the SSA Death Master File;

¹⁸ We netted all capitation payments made to one MCO on behalf of a single beneficiary during a transaction month because, for some beneficiaries, the State agency made more than one capitation payment to an MCO for a transaction month. The resulting file consisted of 20,824 net capitation payments totaling \$28,606,883 from which we drew our sample.

¹⁹ Stop-Loss is a risk protection payment that the State agency makes, in addition to the monthly capitation payment, to help limit an MCO's liability. The State agency pays medical expenses incurred by the MCOs when an MCO exceeds a certain threshold amount. For example, an MCO may have a Stop-Loss plan with a threshold of \$100,000 per beneficiary per calendar year. Under this plan, the State agency would reimburse the MCO 80 percent of medical expenses that the MCO pays in excess of \$100,000 and up to \$250,000. For amounts in excess of \$250,000, the State agency would reimburse the MCO 100 percent.

²⁰ Accurint is a LexisNexis data depository that contains more than 20 billion records from more than 10,000 data sources. Accurint's primary source for dates of death is the SSA Death Master File. Accurint also contains death information from obituaries and State death records.

- estimated the value of identified unallowable payments made after a beneficiary's death by using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software;
- determined the Federal share of the unallowable payments made after a beneficiary's death by:
 - obtaining the annual FMAP rates from the Federal Register,
 - matching the FMAP rates to the sample capitation payments using the date the payment was paid,
 - calculating the Federal payment by multiplying the payments by the applicable FMAP rate, and
 - estimating the value of unallowable payments identified in our sample by using the OIG/OAS statistical software program; and
- discussed the results of our audit with State agency officials.

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 B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths</i>	<u>A-05-17-00048</u>	2/14/20
<i>The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-05-19-00007</u>	1/29/20
<i>The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-05-17-00049</u>	10/3/19
<i>Illinois Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-18-00026</u>	8/20/19
<i>Georgia Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Death</i>	<u>A-04-15-06183</u>	8/9/19
<i>California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-04-18-06220</u>	5/7/19
<i>Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-17-00008</u>	10/4/18
<i>Wisconsin Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-17-00006</u>	9/27/18
<i>Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-04-15-06190</u>	12/22/17
<i>Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-06-16-05004</u>	11/14/17
<i>Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-04-15-06182</u>	11/30/16

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

From a database of 3,482,992 capitation payments (totaling \$9,668,150,849) extracted from the State agency Capitation Payment Management and eligibility systems, we removed 3,462,168 capitation payments, totaling \$9,639,543,966, to refine our sampling frame (Table 1).

Table 1: Capitation Payments Removed From the Sampling Frame

Number of Payments in Frame	Value	Reason for Removal
3,210,512	\$9,219,528,194	Service was before the date of death or FMAP = 0
128,047	420,015,101	Data match was unreliable based on date of birth
123,609	671	Payment was less than \$50
3,462,168	\$9,639,543,966	Total Removed

This refinement left 20,824 capitation payments totaling \$28,606,883 in our sampling frame. We netted all capitation payments made to one MCO on behalf of a single beneficiary during a transaction month because, for some beneficiaries, the State agency made more than one capitation payment to an MCO for a transaction month. The resulting file consisted of 20,824 net capitation payments.

SAMPLE UNIT

The sample unit was a capitation payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We divided the sampling frame into five strata, as shown in Table 2.

Table 2: Categories of Sampling Frame

Payment Range	Number of Payments in Frame	Value	Sample Size
≥\$55.99* and <\$802.42	12,489	\$5,908,079	20
≥\$802.42 and <\$2,044.35	5,044	6,281,582	20
≥2,044.35 and <\$4,802.12	2,041	6,199,039	20
≥\$4,802.12 and <\$17,713.40	1,202	7,351,869	20
≥17,713.40 and ≤\$253,968.67	48	2,866,312	20
Total	20,824	\$28,606,883[†]	100

* Our sampling frame includes capitation payments \$50 and above. However, our first stratum starts at \$55.99 because there were no payments between \$50 and \$55.98.

[†] The amount does not sum to the column total because of rounding.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software Random Number Generator.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the capitation payments within each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. To be conservative, we recommend recovery of unallowable 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 total of unallowable payments 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Number of Payments in Frame	Value*	Sample Size	Value of Sample*	Number of Unallowable Payments	Value of Unallowable Payments*
1	12,489	\$5,908,080	20	\$10,267	20	\$10,291
2	5,044	6,281,583	20	24,584	20	24,841
3	2,041	6,199,041	20	53,256	17	48,455
4	1,202	7,351,869	20	119,438	19	115,778
5	48	2,866,312	20	1,134,270	8	70,107
Total	20,824	\$28,606,883	100	\$1,341,814	84	\$269,473

* Stratum amounts do not sum to the column totals because of rounding.

Table 4: Federal Share Amounts

Stratum	Number of Payments in Frame	Value*	Sample Size	Value of Sample	Number of Unallowable Payments	Value of Unallowable Payments
1	12,489	\$5,908,080	20	\$7,926	20	\$7,946
2	5,044	6,281,583	20	12,292	20	12,421
3	2,041	6,199,041	20	32,408	17	30,008
4	1,202	7,351,869	20	59,719	19	57,889
5	48	2,866,312	20	712,874	8	35,379
Total	20,824	\$28,606,883	100	\$825,219	84	\$143,643

* The stratum amount does not sum to the column total because of rounding.

**Table 5: Estimated Value of Unallowable Payments
(Limits Calculated for a 90-Percent Confidence Interval)**

	Total Amount	Federal Share
Point estimate	\$24,762,692	\$14,720,940
Lower limit	23,325,502	13,696,760
Upper limit	26,199,882	15,745,120

APPENDIX E: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

In the Medicaid managed care program, providers are defined as "any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services" (42 CFR § 400.203).

A capitation payment is "a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

STATE REQUIREMENTS

State Agency Contract With Managed Care Organizations

The contractual agreements that were current during our audit period between the State agencies and the MCOs allowed adjustments to previously paid rates when capitation payments had been made for beneficiaries who were determined not to have been eligible. The managed care contracts provide that both the State agency and MCO may initiate a beneficiary's disenrollment upon death of the beneficiary. Disenrollment is effective the first day of the month after death. Additionally, the contracts allow the State agency to recover capitation payments from the MCO in instances in which a member should have been disenrolled in a prior month (section 3.6, "[State agency] Right to Recover Premiums").

APPENDIX F: 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

May 29, 2020

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street SW, Suite 3T41
Atlanta, GA 30303

Ref. No: A-04-19-06223

Dear Ms. Pilcher:

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-04-19-06223 entitled, "The New York State Medicaid Agency Made Capitation Payments To Managed Care Organization After Beneficiaries' Deaths."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Geza Hrazdina
Dan Duffy
Erin Ives
Timothy Brown
Amber Rowan
Brian Kiernan
Jeffrey Hammond
Jill Montag
Michael Spitz
James DeMatteo
James Cataldo
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-04-19-06223 entitled,
“The New York State Medicaid Agency Made Capitation Payments To
Managed Care Organizations After Beneficiaries’ Deaths”

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-04-19-06223 entitled, “The New York State Medicaid Agency Made Capitation Payments To Managed Care Organizations After Beneficiaries’ Deaths.”

General Comments:

Since the focus of this audit was capitation payments made to managed care organizations (MCOs) on behalf of deceased consumers, strategic steps were taken by the auditors to mine the data to specifically target payments made to MCOs for consumers with dates of death that preceded the payment dates. Therefore, it is unsurprising that more payments than not needed recovery from the MCOs. However, for context, it is important to emphasize that the extrapolated amount of \$23.3 million calculated by OIG based on the sample findings equals less than one quarter of a percent of the initial \$9.7 billion payment universe before OIG removed payments unlikely to result in federal overpayments.

Recognizing the importance of minimizing such overpayments regardless of the low error percentage, the Department continuously monitors the system to identify deceased consumers and has robust procedures to identify and recover payments made after a consumer’s death. For example, as of the date the Department received OIG’s draft audit report for review, it had already recovered at least 57 percent of the sample overpayments identified by OIG.

Other Comments and Clarifications

New York’s Medicaid Program section (pages 3 and 4):

- *The eligibility status of Marketplace beneficiaries is verified using a synchronous SSA Process¹¹. Additionally, since January 1, 2016, the Marketplace has used the SSA’s Periodic Verification Composite (PVC)¹² service for all consumers who are eligible for any Marketplace program. These eligibility verification processes are performed when a beneficiary submits a Medicaid application for: (1) an initial eligibility determination, (2) a redetermination, or (3) a renewal of services.*

In addition to verifying a consumer’s social security number and citizenship status, the NY State of Health (NYSOH) uses the Social Security Administration’s (SSA) synchronous service to determine a consumer’s living status at initial determination and at all redeterminations including renewal. The synchronous service verifies a consumer’s living status but it does not return a date of death. NYSOH sends a file to SSA’s Periodic Verification Composite (PVC) service on a monthly basis to confirm a consumer’s living status. This service returns a date of death if one is available.

New York's Medicaid Program section (page 4):

- *In New York, the WMS is used to determine eligibility for public assistance, which may include Medicaid.*

The Welfare Management System (WMS) contains eligibility information for consumers who have been determined eligible for Medicaid by the Local Departments of Social Services (LDSS). Consumers may be eligible for Medicaid even if they are not eligible for Public Assistance.

- *If a marketplace or a public assistance beneficiary is deemed Medicaid eligible, the beneficiary's information is transmitted from the eligibility system to the State agency's electronic Medicaid New York System (payment system), which maintains all the Medicaid eligibility and Managed Care enrollment information, including dates of death. The payment system is also used to process and adjust capitation payments as required by the State agency's policies and procedures and the MCO contracts.*

The Department's Medicaid payment system is named eMedNY.

- *In addition, when the PVC service identifies beneficiaries as deceased, the State agency sends letters requesting that the beneficiaries contact the Marketplace within 10 days for their Medicaid eligibility to continue. If the beneficiaries do not respond within 15 days of the date the notice is sent (5 additional days are added to allow for mail delivery), their managed care enrollment will end on the date of death stated in the PVC or at the beginning of their current eligibility periods if the PVC does not contain their dates of death.*

If the PVC service does not return a date of death, the consumer's Medicaid coverage is ended on the date NYSOH receives the PVC data return indicating the consumer is deceased.

FINDINGS section (page 5):

- *Based on the State agency and SSA data we had, we could not confirm that 2 beneficiaries associated with 4 of the 100 capitation payments were deceased.*

OIG was unable to confirm that the two consumers discussed above were deceased because they are alive. Not only do the WMS and SSA electronic data sources indicate that they are both alive, encounter data verifies that they each continued to receive services through the audit period. This corroborating information was shared with OIG during its audit fieldwork phase.

Recommendation #1:

Refund \$13,696,760 Federal share to the Federal Government.

Response #1:

The State has refunded more than \$10 million to date to the Federal Government. The Office of the Medicaid Inspector General (OMIG) is currently performing additional audits that overlap the OIG audit scope and will continue its reviews in this area.

Recommendation #2:

Identify and recover unallowable payments made to MCOs during our audit period on behalf of deceased beneficiaries, which we estimated to be at least \$23,325,502.

Response #2:

OMIG regularly performs audits to identify and recover inappropriate payments made to MCOs on behalf of deceased beneficiaries. For the OIG audit scope period, OMIG has recovered more than \$19 million of inappropriate payments. OMIG will continue performing these audits and recovering any inappropriate payments.

Recommendation #3:

Identify and recover capitation payments made on behalf of deceased beneficiaries before and after our audit period, and repay the Federal share of amounts recovered.

Response #3:

OMIG will continue performing audits to review and recover inappropriate payments made to MCOs on behalf of deceased beneficiaries.

Recommendation #4:

Create system edits to help identify overpayments and failures in the automated interfaces between the eligibility, payment, and death data.

Response #4:

The Department reviewed the 84 claims identified in the audit and identified that a number of these claims (in addition to the 12 already noted as resolved in the audit) have already been resolved, with the capitation overpayments being recovered and their associated federal shares identified for reimbursement.

The eligibility system in eMedNY is tied to the posting date for a date of death, which reflects the date the death was entered in the eligibility system by the LDSS. An individual's Medicaid eligibility ends once a date of death is verified and posted. A review of all claims included in the audit indicates posting dates after the actual date of death, ranging from one to several months.

Discussions between the Department and the Department's eMedNY vendor yielded the potential development of an edit to the eligibility system in eMedNY to identify capitation claims paid incorrectly after the date of death and void these claims automatically. A joint meeting with all systems involved in this process is being scheduled to review the current process and develop any required system edits.

Specific to the Marketplace, the Department has established a workgroup dedicated to remediating Date of Death (DoD) data discrepancies transmitted from NYSOH to eMedNY, and efforts to resend 834 transactions to correct these data inconsistencies are in process. The workgroup is additionally tasked with remediating any system defects contributing towards the data discrepancies; remediation is tentatively scheduled in the next three NYSOH releases and will be fully corrected no later than 5/31/2020. Gaps in requirements, which have also contributed to the data discrepancies, have been logged into the Change Management process as change requests

and have been tentatively scheduled for releases later in 2020 as well as early 2021. Recoupment opportunities identified by this workgroup will also be planned and pursued, as applicable.

Recommendation #5:

Use additional sources of date of death consistently to help reduce unallowable payments.

Response #5:

In addition to its electronic data sources, the Department uses the following additional sources of death information and alternative procedures to identify a consumer's date of death and initiate recoupments, if needed:

- WMS consumers verified as deceased are automatically closed during the Department's monthly automated matching process. Any individuals who are not able to be systematically closed during this process are reviewed on a monthly basis and are manually closed once Department staff are able to confirm the consumer's date of death via alternate sources, including obituaries; and
- The Department also receives living status information, including the date of death, from the consumer's health plan, surviving spouse or other relatives.

Additionally, the Department will be implementing the following procedures:

- A process to review patient status codes which are assigned to all paid claims. This will enable the Department to identify consumers whose status was deceased at the conclusion of the service so the appropriate steps can be made to verify the consumers date of death, ensure coverage is ended timely and recoup overpayments, if any; and
- The Department will be implementing a new monthly procedure to identify NYSOH consumers whose coverage has ended due to being identified as deceased without a date of death returned by the SSA synchronous service or PVC service. The Department will manually research the date of death for these consumers and update eMedNY accordingly. Any overpayments made after the date of death will be recouped.

The Department will review current processes for adding dates of death to eligibility files with the goal of identifying all areas utilized for identification and documentation and implementing edits where possible to reduce incorrect payments.