Alan G. Hevesi
COMPTROLLER

OFFICE OF THE
NEW YORK STATE COMPTROLLER

DIVISION OF STATE SERVICES

DEPARTMENT OF HEALTH

OVERSIGHT OF THE FAMILY HEALTH PLUS PROGRAM

Report 2004-S-17

AUDIT OBJECTIVE

Our objective was to determine whether overpayments were made for medical services provided to individuals enrolled in New York State's Family Health Plus Program.

AUDIT RESULTS – SUMMARY

The Family Health Plus Program (Program) provides health insurance to low-income individuals with no other health insurance who are not eligible for Medicaid. The Program is overseen by the Department of Health (Department) and administered by local social services districts. Program recipients must enroll in local managed care organizations (plans). The plans provide recipients with access to covered health services and pay the service providers. The Department pays the plans a monthly premium for each Program recipient enrolled in the plans by the local districts.

We found that certain actions need to be taken by the Department to improve coordination among the local districts and provide the districts with more reliable information for their determinations of applicants' Program eligibility. We identified a number of instances in which duplicate monthly premiums were paid because recipients were enrolled in two different plans in two different local districts. We also found indications that many ineligible individuals may have been enrolled in the Program.

We further determined that closer Department oversight is needed over certain local district actions. The districts sometimes incorrectly change the expiration date for a recipient's Program coverage; as a result, Medicaid payments are inappropriately made for services that should be reimbursed by a Program managed care plan.

We identified an estimated $1.9 million in overpayments during our 30-month testing period, and found indications that a significant portion of another $32.5 million in monthly premiums and another $1.5 million in fee-for-service payments may also have been overpaid, as follows:

- An estimated $1.6 million in monthly premiums was overpaid because recipients were enrolled in two different plans at the same time. [Pages 4 - 6]
- A significant portion of $32.5 million in monthly premiums may have been overpaid because individuals already covered by Medicare or private health insurance, and thus ineligible for the Program, may have been enrolled in the Program. [Pages 6 - 9]
- About $322,000 was overpaid and a significant portion of another $1.5 million in fee-for-service payments may also have been overpaid because the local districts incorrectly changed the expiration date for recipients' Program coverage. [Pages 9 - 12]

Our report contains 10 recommendations for improving Department oversight and enhancing the automated information system containing Program data. Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them.

This report, dated September 15, 2005, 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
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BACKGROUND

The Family Health Plus Program (Program) provides health insurance to individuals who could not otherwise afford it. To qualify for the Program, an applicant must be between the ages of 19 and 64 and have limited income but not be eligible for Medicaid due to income or resources. Individuals who have their own health insurance, whether it is private health insurance or Medicare, are not eligible for the Program. Individuals with private health insurance may apply for the Program, but must cancel that coverage if they are accepted.

Program recipients must enroll in a managed care organization (plan). The plan is responsible for ensuring Program recipients have access to all covered health services and for paying the actual service providers. The New York State Department of Health (Department) pays each plan a monthly premium for each Program recipient covered by the plan. Generally, the monthly premium is the only payment made by the Department on behalf of a Program recipient.

The Program has an initial six-month guarantee period. If a recipient's circumstances change during the first six months of coverage, the recipient continues to receive coverage, even if the change renders the person ineligible for the Program. Thereafter, the recipient is recertified after every twelve months of continuous coverage. If a change in the recipient's circumstances after the initial six-month guarantee period renders the person ineligible for the Program, the person's coverage by the Program should be cancelled.

Applicants' eligibility for the Program is determined by their local social services district (local district). Outside of New York City (City), each individual county is considered a separate local district. The five boroughs of the City are a single local district, under the New York City Human Resources Administration. The local districts are to assess a recipient's eligibility upon application for the Program and are to review that eligibility at least every 12 months or when the recipient's circumstances change.

The Department is responsible for overseeing the Program, paying the monthly premiums, and ensuring compliance with the State's policies and procedures. For example, the Department monitors the local districts' enrollment activities and provides technical assistance to the local districts and the participating plans.

The Welfare Management System (WMS) is the central registry for all data about public assistance recipients in the State. When a person is first approved for public assistance in the State, local district staff are to register that person on WMS and issue the person a recipient identification number (ID). If the person is subsequently approved for another public assistance program, the person generally should not be issued another ID, because each public assistance recipient should have only one recipient ID on WMS. Thus, a Program enrollee who also receives food stamps should have only one recipient ID.

When a new Program enrollee is registered on WMS, it automatically verifies the income claimed by the individual against external databases, such as those maintained by the Social Security Administration and the State Department of Taxation and Finance. The Department uses its automated Medicaid Management Information System (MMIS) to make Program payments, and MMIS uses information from WMS and from claims submitted by plans to calculate the monthly premiums to be paid to each plan.

For the 11 months ended November 30, 2004, almost 508,000 recipients were enrolled in the Program and about $542.3 million was paid by the Department for the health insurance coverage provided through the Program.

AUDIT FINDINGS AND RECOMMENDATIONS

Duplicate Payments for Program Enrollment

Due to changes in their circumstances, Program recipients sometimes become eligible for Medicaid and Medicaid recipients sometimes become eligible for the Program. For example, a Program recipient who began earning less income might become eligible for Medicaid, and a Medicaid recipient who began earning more income might become eligible for the Program. In such instances, the recipient should be enrolled in the new program and disenrolled from the old program. If the recipient is not disenrolled from the old program at the same time that he or she is enrolled in the new program, the Department could pay duplicate monthly enrollment premiums on behalf of the recipient: one for the recipient's enrollment in the Family Health Plus Program and another for the recipient's enrollment in a Medicaid managed care program.

Similarly, Program recipients sometimes move from one local district to another local district. When this happens, the recipient will usually have to be enrolled in a different managed care plan, because each plan serves a different geographic area. In such instances, the recipient should be disenrolled from the old plan at the same time that he or she is enrolled in the new plan. Otherwise, the Department will pay duplicate monthly enrollment premiums on behalf of the recipient.

To determine whether any duplicate enrollment premiums were paid by the Department during our 30-month testing period (October 1, 2001 through April 1, 2004), we used computer-assisted audit techniques to analyze certain WMS and MMIS data for the period (the WMS data we examined was recorded on the MMIS, which regularly incorporates data from WMS). Specifically, we analyzed the recipient names, social security numbers, dates of birth and recipient IDs recorded on the system and identified all the recipients who appeared to have more than one recipient ID. We then reviewed Program and Medicaid expenditure information for the period to determine whether any duplicate enrollment premiums were paid for these recipients under their different recipient IDs.

We found that duplicate monthly enrollment premiums were paid for a total of 1,322 individuals during this period. Each of these individuals had two recipient IDs and, as a result of these duplicate IDs, in at least one month, two monthly enrollment premiums were paid by the Department on behalf of these individuals. Some of the individuals were enrolled in a Medicaid plan at the same time that they were enrolled in a Program plan, while others were enrolled in two different Program plans at the same time.

The duplicate enrollment premiums paid on behalf of these 1,322 recipients during our 30-month testing period totaled $3,718,721. Because the monthly premium amount varies by local district (different amounts are charged by different plans), the amount to be recovered by the Department is not simply half of the total amount. Rather, each pair of duplicate payments has to be reviewed to determine which managed care plan should have been paid and which plan should not have been paid because the recipient no

longer belonged in that plan. Using the lower monthly premium payment in each pair of duplicate payments, we conservatively estimate that at least $1,581,148 in premium payments should not have been made and therefore should be recovered. We recommend the Department review these duplicate premium payments and recover from the managed care plans all the payments that should not have been made.

These inappropriate payments were made because, contrary to Department procedures, some recipients were assigned more than one recipient ID at the same time and thus were able to be enrolled in more than one managed care plan at the same time. We identified a number of reasons why some recipients are assigned more than one ID.

First, WMS consists of two application subsystems: "Upstate," which contains data about public assistance recipients living outside New York City, and "New York City," which contains data about recipients living in the City. Each subsystem uses a different numbering sequence for recipient IDs. Consequently, whenever a recipient moves from New York City to a local district outside the City (or vice versa), the new local district must assign a new ID number to the recipient. If the recipient's old ID number was deactivated at the same time that the new ID number was assigned, there would be no problem. However, the old ID number cannot be deactivated by the new local district; it must be deactivated by the old local district and this is not always done.

Second, recipients may be assigned a new ID when they move from one upstate local district to another, and when they move from one New York City borough to another. In such circumstances, recipients should not be assigned a new ID. Rather, their existing ID should continue to be used by their new local district (or new borough). However, we found that the new local district (or new borough) may not be aware of a recipient's existing ID, and as a result, may assign the recipient a new ID. Since the recipient's old ID would not be deactivated by the old local district unless the old district was instructed to do so by the new district or the Department, the recipient would have two IDs on WMS at the same time.

The local districts can perform a verification procedure to determine whether new applicants already have a recipient ID on WMS. In this procedure, a local district can enter an applicant's name, social security number and date of birth onto WMS, and inquire whether the individual already has a recipient ID. WMS responds to the inquiry by producing a listing of all possible matches (i.e., all the recipients already recorded on WMS with the same or a similar name, social security number and/or date of birth as the applicant) ranked in order of likelihood.

While this listing can identify applicants who already have recipient IDs, there are two important limitations on the effectiveness of this verification procedure. First, the listing is limited to the data within the WMS subsystem of the local district making the inquiry. As a result, a listing requested by an upstate county would not include any possible matches from the data on the New York City subsystem (and vice versa). Second, the listing can contain several pages of possible matches, especially when the applicant has a common last name, and consequently can be very cumbersome to use. For this reason, local districts do not always use the verification procedure, and instead rely on the applicants to provide information that would indicate they already have a recipient ID.

While the possible matches identified in the verification procedure are limited to one WMS subsystem, this limitation can be overcome. A local district can use a manual process to identify possible matches in the other WMS subsystem. However, local district officials indicated that, in their opinion, this manual process is cumbersome and time-consuming, and for this reason, it is not always used. They stated that they would use the manual process when there was a clear indication that it was likely to identify a definite match, but they would not use the process for every new applicant.

We note that, because local district staff are intent on meeting application processing timeframes established by the Department, they are reluctant to use verification procedures that will jeopardize their ability to meet these timeframes. A local district has 45 days (30 days in the case of pregnant women) to process an application. Otherwise, the county is liable for the cost of certain medical expenses incurred by the individual, starting with the 45th day (or 30th day in the case of pregnant women) after the date of the application.

We conclude the local districts need help from the Department if they are to ensure that each recipient has only one recipient ID on WMS. In particular, the Department needs to develop an exception report for the local districts that includes data from both WMS subsystems and identifies all recipients statewide who appear to have more than one recipient ID. To increase the likelihood that the exception report will be used on a regular basis by the local districts, the Department should actively follow up with districts that do not appear to be making regular use of the report. We also recommend that the Department develop a process for identifying recipients who have moved from one local district to another, and take action to ensure that such recipients have only one recipient ID.

Recommendations

1. Review the $3.7 million in duplicate premium payments that we identified, and recover from the managed care plans all the payments that should not have been made.

2. Develop an exception report for the local districts that includes data from both WMS subsystems and identifies all recipients statewide who appear to have more than one recipient ID. Actively follow up with districts that do not appear to be making regular use of the exception report.

3. Develop a process for identifying recipients who have moved from one local district to another, and take action to ensure that such recipients have only one recipient ID.

Ineligible Enrollees

Individuals covered by Medicare or private health insurance are not eligible for the Program. To determine whether any such individuals were enrolled in the Program during our 30-month testing period (October 1, 2001 through April 1, 2004), we used computer-assisted audit techniques to analyze certain WMS and MMIS data (the WMS data was incorporated in MMIS). We found indications that as many as 10,827 such individuals may have been enrolled in the Program at some point during this period.

According to WMS health insurance coverage information, these 10,827 Program recipients

were covered by either Medicare or private health insurance before they were enrolled in the Program. Thus, if this insurance information was correct, the recipients may not have been eligible for enrollment in the Program. However, it is possible that the insurance information was not correct for some of the recipients. It is also possible that some of the recipients with pre-existing insurance coverage were eligible for the Program, because their pre-existing coverage was terminated before they were enrolled in the Program.

To determine to what extent individuals in this group were appropriately or inappropriately enrolled in the Program, we selected a sample of 137 of the 10,827 Program recipients for further review. We judgmentally selected our sample from four local districts: Erie County, Greene County, Monroe County and New York City. We chose these four local districts because their Program caseloads ranged from large (New York City) to medium (Erie and Monroe Counties) to small (Greene County).

Within each of the four local districts, we judgmentally selected a certain portion of the recipients with pre-existing Medicare coverage and a certain portion of the recipients with pre-existing private health insurance coverage. Our selection of the particular recipients in each portion was random. In total, our sample consisted of 74 Program recipients with pre-existing Medicare coverage and 63 Program recipients with pre-existing private health insurance coverage.

For each of these 137 Program recipients, we reviewed the case file maintained by the local district and information about the recipient in MMIS. The purpose of our review was to determine whether there was evidence in the case file that the recipient's pre-existing insurance coverage either (a) was terminated before the recipient enrolled in the Program or (b) never actually existed and was inaccurately recorded.

For 25 of the 137 recipients (18 percent), we found evidence that their pre-existing health insurance coverage was terminated before they were enrolled in the Program (in 15 instances, Medicare coverage was terminated, and in 10 instances, private coverage was terminated). We therefore conclude that these 25 recipients were appropriately enrolled in the Program by the four local districts in our sample.

For 15 of the 137 recipients (11 percent), we found the recipient's enrollment in the Program was terminated by the local district due to existing Medicare (nine recipients) or private (six recipients) health insurance coverage. While the local districts were correct to terminate these recipients' Program coverage, we question why recipients with pre-existing insurance coverage were enrolled in the Program in the first place. This pre-existing coverage was recorded on WMS, and thus should have been known to the local districts. In addition, information in some of these recipients' case files indicated that they either were covered by Medicare or might be covered by Medicare.

Specifically, some of the recipients received Social Security disability benefits, and such recipients are supposed to receive a letter from the Social Security Administration that indicates both the amount of the monthly benefit payment and the amount of any deduction that is made for Medicare. Even though this letter would confirm the status of a recipient's Medicare eligibility, a copy of the letter was not always maintained in the case files of the Program recipients receiving

Social Security disability benefits. Moreover, in some instances, the letter was present in the case file and showed a deduction for Medicare, but the recipient was still enrolled in the Program.

We note that such enrollment errors cannot be corrected for at least six months, due to the Program's initial six-month guarantee period. Thus, even if a recipient's pre-existing coverage is identified by the local district shortly after enrollment, monthly enrollment premiums for the recipient must continue to be paid for at least six months. A total of $20,628 in monthly premiums was paid for the 15 inappropriately enrolled recipients in our sample.

For the remaining 97 recipients in our sample (71 percent), there was no evidence in the case file that the recipients' pre-existing insurance coverage was either terminated or inaccurately recorded. Thus, in the absence of any evidence to the contrary, we must conclude it is likely that some, and perhaps many, of these 97 recipients still had Medicare or private health insurance coverage and were therefore not eligible for enrollment in the Program. According to the WMS data, 50 of these Program recipients had Medicare coverage and 47 of the recipients had private health insurance coverage. During our 30-month testing period, a total of $262,877 in monthly premiums was paid for these 97 recipients' enrollment in the Program. We recommend the Department determine whether these 97 recipients were in fact covered by Medicare or private health insurance, and therefore should not have been enrolled in the Program by the local districts. We also recommend the Department follow up on the other 10,690 Program recipients who were identified as having pre-existing Medicare or private health insurance coverage, but were not included in our audit sample. During our 30-month testing period, a total of $32.3 million in monthly enrollment premiums was paid on behalf of these recipients. While it is likely that some portion of these premiums was paid on behalf of recipients who were eligible for the Program, it is also likely that a significant portion was paid on behalf of recipients who were ineligible. We note that, while 18 percent of the Program recipients in our sample were eligible for the Program, the remaining 82 percent may have had other insurance coverage and thus may have been ineligible.

The Department relies on local districts to determine eligibility. Local district officials told us that they do not always rely on WMS data because it is known to be inaccurate. Rather, they rely on the insurance coverage information provided by the recipients. We also note that, to a large extent, the local districts themselves may be responsible for inaccuracies in the data. For example, the insurance coverage information on WMS needed to be updated for 25 of the 137 Program recipients in our sample to reflect the fact that their pre-existing Medicare or private health insurance coverage was terminated before they were enrolled in the Program. However, in none of the 25 instances was this information updated by the local districts. In fact, no such updates were made by the local districts for any of the 137 recipients in our sample. We recommend that the Department work with the local district staff to improve the accuracy and reliability of insurance coverage data in WMS.

We further note that WMS insurance coverage data could potentially be very useful to the local districts. For example, the districts can generate a report from WMS, called the *Report of Dually Eligible Recipients Enrolled in Mainstream Managed Care,* that lists all recipients who are both

covered by Medicare and enrolled in the Program. Such recipients should be disenrolled from the Program. However, we found no indication the four local districts we visited were using this report on a regular basis. Similarly, we found no indication the Department was following up on the report to determine whether Medicare recipients were being disenrolled from the Program as required.

We recommend the Department encourage local districts to use this report, monitor the extent to which Medicare recipients listed in the report are disenrolled from the Program, and follow up with any local districts not disenrolling such recipients.

Recommendations

4. Determine whether the 97 recipients in our sample and the 10,690 recipients not in our sample were covered by Medicare or private health insurance during our 30-month testing period in order to determine the extent to which ineligible recipients are enrolled in the Program.

5. Work with the local district staff to improve the accuracy and reliability of insurance coverage data in WMS.

6. Encourage the local districts to use the *Report of Dually Eligible Recipients Enrolled in Mainstream Managed Care* to identify recipients who should be disenrolled from the Program, monitor local district performance in disenrolling such recipients, and follow up with any districts that do not disenroll such recipients. Work with any local districts that repeatedly enroll ineligible recipients and determine what actions can be taken to reduce or prevent such enrollments.

7. Recommendation deleted.

Overlapping Program and Medicaid Coverage

The monthly enrollment premium paid on behalf of Program recipients is generally intended to cover all the Program services provided to the recipient that month. In certain specified circumstances, an additional fee-for-service payment may be made directly to a medical provider for services provided to the recipient, but in most cases, the enrollment premium should be the only Program payment that is made for the recipient.

If a recipient loses Program eligibility and becomes eligible for Medicaid instead, the recipient's Medicaid coverage should not begin until Program coverage has expired, and Program coverage generally does not expire until the end of the month in which the Program's managed care plan is notified by the local district about the need for the recipient to be disenrolled from the Program. Program coverage extends to the end of the month because, according to the contract between the local districts and managed care plans, the plans are entitled to the entire monthly premium for any month in which coverage is provided to a recipient.

For example, if a local district determines that a recipient is no longer eligible for the Program but is eligible for Medicaid instead, and notifies the managed care plan on January 10 about the need for the recipient to be disenrolled from the Program, the recipient continues to be covered by the Program through January 31. If the recipient actually became eligible for Medicaid sometime before January, it usually does not matter: in most cases, Program coverage does not expire until the end of the month in which the

managed care plan is *notified* about the change in the recipient's status.

There are certain circumstances in which a recipient's Program coverage may be terminated retroactively (i.e., so that the termination is effective prior to the month in which the managed care plan is notified). For example, if a Program recipient was admitted to a nursing home in November, Program coverage would expire (and Medicaid coverage would begin) at the end of November, even if the managed care plan was not notified about the recipient's change in status until January 10. In such circumstances, all the enrollment premiums paid subsequent to the recipient's change in status should be recovered from the managed care plan. In this example, the recipient's enrollment premiums for December and January should be recovered from the managed care plan. Recoveries of this kind should be made by the local districts.

Thus, for each month a recipient is enrolled in the Program, the Department should generally make only one medical payment on behalf of the recipient (the Program premium). If a recipient is retroactively disenrolled from the Program, more than one payment may initially be made in the same month (i.e., Medicaid payments may be made in the same month as a premium), but in such instances, the overlapping premiums (i.e., the premiums paid after the date of the retroactive disenrollment) should be recovered from the managed care plan.

To determine whether multiple monthly medical payments were inappropriately made for Program recipients, and not recovered, during our 30-month testing period of October 1, 2001 through April 1, 2004, we used computer-assisted audit techniques to analyze certain MMIS data for the period.

We found indications that inappropriate payments may have been made for as many as 883 Program recipients, as at least one potentially inappropriate Medicaid or Program fee-for-service payment was made for these recipients in a month covered by an enrollment premium. The potentially inappropriate fee-for-service payments totaled $2,212,307, while the concurrent Program enrollment premiums totaled $351,058. The fee-for-service payments were made for services that were to be included, without exception, in the Program's managed care coverage. Thus, unless the recipient was no longer enrolled in the Program at the time of the fee-for-service payment, there was no apparent reason for the fee-for-service payment to be made. If the recipient was no longer enrolled in the Program at the time of the fee-for-service payment, the concurrent enrollment premium should be recovered.

To determine to what extent these overlapping payments were inappropriate and should be recovered, and to what extent monthly premiums had already been recovered for retroactive disenrollments, we judgmentally selected 60 of the 883 recipients for further review. We selected the 60 recipients from three of the four local districts we visited (the fourth district, Greene County, had no recipients with overlapping payments). Forty of the recipients were selected because they had the highest number of potentially inappropriate fee-for-service payments in the three districts (as many as seven payments per recipient). The other 20 recipients were selected because they accounted for all of the recipients with overlapping fee-for-service and monthly premium payments in one of the districts (Erie County).

A total of $698,826 in overlapping payments ($661,537 in fee-for-service payments and $37,289 in monthly premiums) was made on

behalf of the 60 recipients during our 30-month testing period. From our review of the recipients' case files and the MMIS, we estimate that $334,894 of this $698,826 (48 percent) should be recovered, as follows:

- $322,508 in fee-for-service payments should not have been made, because the services were covered by a Program managed care plan and thus should have been paid for by the plan, and

- $12,386 in monthly Program premiums should be recovered, because the recipients had been retroactively disenrolled from the Program after being admitted to a nursing home ($11,177) or other institution ($1,209) for treatment, but the local districts had not recovered the premiums paid after the date of retroactive disenrollment.

We also determined that an additional $7,011 in fee-for-service payments may be recoverable. We were unable to make a conclusive determination because, in some cases, we could not identify the medical service that was provided, and in other cases, we could not determine whether the service limitation imposed by the Program had been reached (e.g., if more than one routine eye examination was provided within a 24-month period, the managed care plan was not responsible for the cost of the additional eye examinations). We were able to determine that the remaining $332,018 in fee-for-service payments were appropriate, and the remaining $24,903 in monthly Program premiums were either appropriate or had already been recovered by the local districts.

We recommend the Department recover the $334,894 in inappropriate payments and determine whether the $7,011 in questionable payments are in fact recoverable. We also recommend the Department investigate the remaining $1,864,539 in potentially inappropriate payments for the 823 recipients not included in our sample, and recover all as yet unrecovered payments that are determined to be inappropriate.

We identified a number of reasons why inappropriate fee-for-service payments are made for Program recipients, and why local districts do not always recover Program premiums for retroactive disenrollments. First, recipients who lose their Program eligibility and become eligible for Medicaid may have unpaid medical bills that should be paid by their former Program managed care plan. However, we found that local district staff do not always check to see if such unpaid bills should be paid by the former managed care plan. Instead, if local district staff determine that the recipient would have been eligible for Medicaid at the time of the unpaid service, they retroactively disenroll the recipient from the Program to enable the recipient to be covered by Medicaid on the service date. As a result of this retroactive disenrollment, the inappropriate Medicaid fee-for-service payment is not prevented by the Department's automated claims processing controls, which are designed to prevent inappropriate fee-for-service payments on behalf of Program recipients.

Local district staff use this inappropriate retroactive disenrollment process because, when recipients have unpaid medical bills, the staff focus on getting the bills paid. However, according to the Program contract between the local districts and managed care plans, retroactive disenrollments may only be used in the four following circumstances:

- if the recipient dies,

- if the recipient moves out of the plan's service area,
- if the recipient has been placed in prison, or
- if the recipient is admitted to a nursing home or other institution for treatment.

We recommend the Department remind the local districts of this contract requirement, monitor retroactive disenrollments to determine whether they are appropriate, and take corrective action when necessary. Our prior audit report (Report 2001-S-44, *Medicaid Overpayments Relating to Managed Care*, released in February 2003) contained a similar recommendation, because we found that a number of Medicaid overpayments had been made as a result of inappropriate retroactive disenrollments from Medicaid managed care plans.

We note that retroactive disenrollments are not highlighted by WMS for follow-up. If WMS routinely generated a report summarizing all retroactive disenrollments by local district, the Department could use the report to facilitate its monitoring efforts. Such a report could also help the local districts ensure that Program enrollment premiums were properly recovered for retroactive disenrollments. We found that the officials responsible for making such recoveries in the local districts we visited were not aware of the disenrollments. As a result, they were not initiating the recoveries.

Recommendations

8. Recover the $334,894 in inappropriate payments that were made on behalf of the 60 recipients in our sample, and determine whether the $7,011 in questionable payments are also recoverable.

9. Investigate the $1,864,539 in potentially inappropriate payments that were made on behalf of the 823 recipients not included in our sample, and recover all unrecovered payments that are determined to be inappropriate.

10. Remind the local districts of the circumstances in which retroactive disenrollments may properly be made, monitor such disenrollments to determine whether they are appropriate, and take corrective action when necessary.

11. Develop a routine WMS report that summarizes retroactive disenrollments by local district. Use the report to monitor local district disenrollment practices, and provide the report to the local districts to help them identify monthly Program premiums that need to be recovered.

AUDIT SCOPE AND METHODOLOGY

We audited the Department's oversight of the Program for the period October 1, 2001 through August 31, 2004. We examined applicable sections of the Social Services Law and Department policies and procedures; reviewed the model contract which specifies the terms and conditions for a plan's participation in the Program; interviewed personnel at the Department and four local districts (Erie County, Greene County, Monroe County and New York City); and analyzed information on monthly premiums and other payments made on behalf of Program recipients.

We selected three judgmental samples of Program recipients from the recipients recorded on MMIS for our 30-month testing period (October 1, 2001 through April 1, 2004). Details about our sampling methodologies are provided in the *Audit*

Findings and Recommendations section of this report. For each sample, we reviewed information in MMIS and compared that with information from the case files maintained by the local districts. The information in MMIS included WMS data, which is regularly incorporated into MMIS.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess Department operations within our audit scope. Further, these standards require that we understand the Department's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records, and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

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, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

AUTHORITY

The audit was performed in accordance with the State Comptroller's authority under Article V, Section 1 of the State Constitution, and Article II, Section 8 of the State Finance Law.

REPORTING REQUIREMENTS

We provided a draft copy on the matters contained in this report to Department officials for their review and comment. Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them. A complete copy of the Department's response is included as Appendix A. Appendix A also contains a State Comptroller's Note, which addresses a matter of disagreement included in the Department's response.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising of the steps that were taken to implement the recommendations it contained, and/or the reasons certain recommendations were not implemented.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include David R. Hancox, Kenneth Shulman, Ed Durocher, Carol O'Connor, Jennifer Paperman, Erika Akers, Amanda Strait, Holly Winters, and Marticia Madory.

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

Dennis P. Whalen
Executive Deputy Commissioner

June 17, 2005

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

Dear Mr. Hancox:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2004-S-17) entitled "Oversight Of The Family Health Plus Program."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

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

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2004-S-17 Entitled
"Oversight Of The Family Health Plus Program"

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2004-S-17) entitled "Oversight Of The Family Health Plus Program."

Recommendation #1:

Review the $3.7 million in duplicate premium payments that we identified, and recover from the managed care plans all the payments that should not have been made.

Response #1:

The Department issued a Dear Commissioner Letter (DCL) which advises local departments of social services (LDSSs) of the steps they must take to ensure appropriate handling of multiple client identification numbers (CINs) identified by the State, regarding managed care plans involving the same recipient. The DCL explains the steps to unduplicate multiple CINs for a recipient; ensure enrollment in the appropriate managed care plan for the surviving CIN; and, identify any appropriate amounts for recovery from managed care plans. Recovery of premiums paid to managed care plans will only be made in cases where both duplicate CINs are enrolled in the same plan. When duplicate CINs are enrolled in different plans or in a plan and fee-for-service Medicaid, no recovery will be made, as the plan was at risk for the provision of services to that person under the duplicate CIN.

Recommendation #2:

Develop an exception report for the local districts that includes data from both WMS subsystems and identifies all recipients statewide who appear to have more than one recipient ID. Actively follow up with districts that do not appear to be making regular use of the exception report.

Response #2:

Development of an exception report that includes data from both upstate districts and New York City is a very complex task, because it is not an issue of separate Welfare Management System (WMS) subsystems, but of entirely separate databases. However, one of the principal requirements of the future redesign of WMS is that there be one WMS for Upstate and New York City. In the meantime, a systemic solution is being pursued for the unduplication of multiple CINs within New York City.

The CIN unduplication process developed by a project team for upstate districts is now operational. Since July 2004, a monthly report has been sent to any district with a recipient with multiple CINs, accompanied by a letter advising the district to initiate the duplicate CIN resolution process. The Office of Medicaid Management (OMM) is working on an Administrative Directive regarding this process.

Recommendation #3:

Develop a process for identifying recipients who have moved from one local district to another, and take action to ensure that such recipients have only one recipient ID.

Response #3:

The duplicate CIN resolution process referenced above identifies recipients who have CINs in more that one upstate district.

Recommendation #4:

Determine whether the 97 recipients in our sample and the 10,690 recipients not in our sample were covered by Medicare or private health insurance during our 30-month testing period in order to determine the extent to which ineligible recipients are enrolled in the Program.

Response #4:

OMM will request that the local districts of the 97 recipients in the sample conduct reviews of these cases and advise us of their findings. After evaluating the results, we will determine if reviews of the additional 10,690 recipients identified by the audit would be cost-effective.

In 2002, an edit was put in WMS on the Prepaid Capitalization Plan (PCP) subsystem that prevents enrollment for an individual who is known to the WMS system to have Medicare coverage.

In 2003, the Department began providing local districts with a monthly report of anyone enrolled in Medicaid Managed Care (MMC) or Family Health Plus (FHPlus) who is in receipt of Medicare. The benefit package code is indicated on the report so local districts are able to distinguish Medicare recipients in receipt of either MMC or FHPlus.

In Fall 2005, an additional edit on WMS will give workers a warning when someone has third party health iInsurance (TPHI) and FHPlus coverage being input. This will alert staff to verify whether or not the individual's TPHI is still in effect.

Recommendation #5:

Work with the local district staff to improve the accuracy and reliability of insurance coverage data in WMS.

Recommendation #6:

Encourage the local districts to use the *Report of Dually Eligible Recipients Enrolled in Mainstream Managed Care* to identify recipients who should be disenrolled from the Program, monitor local district performance in disenrolling such recipients, and follow up with any districts that do not disenroll such recipients. Work with any local districts that

repeatedly enroll ineligible recipients and determine what actions can be taken to reduce or prevent such enrollments.

Response #5 and #6:

As noted in earlier responses, OMM is working with local districts to upgrade the timeliness and accuracy of third party data. In addition, the Department's contractor, the Public Consulting Group, processes matches against numerous national insurance carriers. FHPlus is included in this match. At this time, only commercial insurance information is included in the electronic update process with eMedNY. The Department will look at the feasibility of including FHPlus in this update process or preparing a separate report that will alert the LDSS to reexamine FHPlus case eligibility.

For Medicare, the Report of Dually Eligible Recipients Enrolled in Mainstream Managed Care also includes individuals in receipt of FHPlus. When districts receive these reports, they must determine if FHPlus case closing is appropriate and evaluate the individual for Medicaid eligibility.

In addition, the indicator now available through eMedNY Phase II informs staff that there is third party information on the third party file. Staff readily know if there is third party insurance on the file and can investigate before opening a case.

Recommendation #7:

Develop a WMS report that identifies Program recipients with pre-existing private health insurance. Encourage and monitor local district use of this report, and follow up with any local districts not disenrolling recipients with private health insurance.

Response #7:

OMM believes that sufficient reporting already exists and will continue to monitor local district use of the available tools and resources.

* Note

Recommendation #8:

Recover the $334,894 in inappropriate payments that were made on behalf of the 60 recipients in our sample, and determine whether the $7,011 in questionable payments are also recoverable.

Response #8:

Capitation payments related to retroactive disenrollment are not always recoverable since the health plan is at risk. The Department will review the OSC claims identified in this finding to determine the appropriateness of the payments.

* State Comptroller's Note: Certain matters and the associated recommendation presented in the draft audit report were deleted in this final report based on the Department's response.

Recommendation #9:

Investigate the $1,864,539 in potentially inappropriate payments that were made on behalf of the 823 recipients not included in our sample, and recover all unrecovered payments that are determined to be inappropriate.

Response #9:

The audit report states that OSC has not determined which of these claims are recoverable and asks DOH staff to identify, through audits, those that are inappropriate. The Department will defer in determining the next steps in reviewing these claims until a determination of similar disallowances identified in Recommendation #8 are validated.

Recommendation #10:

Remind the local districts of the circumstances in which retroactive disenrollments may properly be made, monitor such disenrollments to determine whether they are appropriate, and take corrective action when necessary.

Recommendation #11:

Develop a routine WMS report that summarizes retroactive disenrollments by local district. Use the report to monitor local district disenrollment practices, and provide the report to the local districts to help them identify monthly Program premiums that need to be recovered.

Response #10 and #11:

As noted in a prior response, if an individual who has been enrolled in FHPlus is retroactively determined to have been Medicaid eligible, or eligible due to local district error or delay, we are liable for fee-for-service payment for any medical expense not covered by FHPlus. When FHPlus was implemented, local districts were trained to pay such claims off-line, rather than overwriting the FHPlus coverage with Medicaid coverage. The report's findings suggest that local districts do not always follow this procedure, nor do they always verify that the services for which fee-for-service payments are made would have been included in the FHPlus benefit package. OMM will continue to work with local districts to reinforce their understanding of this issue.

In the Fall of 2004, the Office of Managed Care (OMC) held regional meetings around the State. All local districts, including New York City (and all managed care plans), were trained on disenrollment policies. Emphasis was placed on the proper use of retroactive disenrollments and under what circumstances managed care organizations are required to void premiums. A report was developed, using the Datamart, of PCP payments without PCP enrollment that shows cases where a PCP payment was made and the health plan may potentially owe a repayment. The PCP subsystem, and in turn the managed care disenrollment roster, now has a disenrollment code which indicates that a voided premium is necessary. This code was implemented in November of 2004.