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OFFICE OF THE STATE COMPTROLLER

June 15, 2007

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 2007-F-6

Dear Dr. Daines:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health, to implement the recommendations contained in our audit report, *Department of Health - Multiple Medicaid Payments for Managed Care Recipients* (Report 2004-S-48).

Background, Scope and Objective

The Department of Health (Department) administers the State's Medicaid program, which provides medical assistance to needy individuals. These individuals receive medical care from providers, such as hospitals and clinics. Medicaid pays providers by one of two methods: the fee-for-service method, in which a provider is paid for each Medicaid-eligible service, and the capitation method, in which a managed care plan (Plan) is paid a monthly fee based on each individual's demographics (age, gender, Medicaid eligibility). The Department provides oversight and establishes guidelines for the local social services districts regarding Medicaid eligibility. However, the local social services districts are responsible for determining whether an individual meets Medicaid eligibility requirements.

The Welfare Management System (WMS) is the central registry for all data about recipients who receive some form of public assistance in the State. There are two separate systems, one for the upstate counties and another for New York City. When a person is first approved for assistance, such as Medicaid, local social services district staff enroll that person on WMS and issue a recipient identification number (ID). Medicaid uses the ID as one of the important fields to determine the appropriateness of Medicaid payments made under fee-for-service and managed care programs. If the person is subsequently approved for another assistance program, the person should only be assigned one active ID.

Our initial audit report, which was issued on February 7, 2006, addressed the effectiveness of the Department's controls over payments for individuals enrolled in Medicaid Plans. Our audit covered the period July 1, 2000 through June 30, 2004. Our audit found the Department made multiple payments on behalf of Medicaid Plan recipients who were erroneously assigned more than one ID. The objective of our follow-up, which was conducted in accordance with generally accepted government auditing standards, was to assess, as of May 2, 2007, the extent of implementation of the three recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

We determined Department Officials implemented the three recommendations included in our initial report.

Follow-up Observations

Recommendation 1

Department management needs to ensure that the work group established to address the issue of multiple IDs identifies and addresses all possible scenarios where duplication can occur. Once these scenarios are identified, management needs to take action to minimize the potential for duplication.

Status - Implemented

Agency Action - As recommended, the work group consisting of Department and Office of Medicaid Inspector General (OMIG) staff identified scenarios where duplicate IDs can occur. For example, the Department runs electronic queries of all Medicaid systems to identify multiple IDs. The queries match recipient enrollment data, within the same Plan, between different Plans and between fee-for-service and the Plans. These queries are based on exact matches of last name, first few characters of the first name, gender, and date of birth of the enrolled recipients. After resolution of the duplicates identified in these queries, a secondary query is planned to identify a wider net of potential duplicates based on partial matches (i.e., first name or date of birth, etc. may closely but not exactly match). The Department also runs an annual query to identify multiple IDs that may not have been detected by previous queries. The Department also sends correspondence to the local social services district commissioners to educate them in the proper policies and procedures for preventing and closing out duplicate IDs; and for recovering erroneously paid managed care premiums. For example, the Department sends a monthly report of duplicate IDs to the local social services district commissioners and a letter requesting the duplicates be closed. Additionally, the Department supplies the local social services districts with standard forms and reports to document the close-out of duplicate IDs. The Department officials also use a monthly trend report to monitor local social services district progress in resolving duplicate IDs, and monitor the timeliness of the case closing to ensure the local social services districts are following through.

Recommendation 2

Recover the $212,000 in overpayments that was paid for the 221 recipients in our samples where multiple payments were made on behalf of the same individual.

Status - Implemented

Agency Action - The Department and OMIG have coordinated efforts with the NYS Attorney General's Medicaid Fraud Control Unit (MFCU) to recover overpayments. Although the workgroup did not specifically identify the recoveries related to our initial audit, their recovery effort updated and expanded beyond our sample to include additional overpayments due to duplicate identification numbers. The recovery effort also included duplicate payments identified in our initial audit and in audit report 2004-S-17, *Oversight of the Family Health Plus Program*. In addition, the recovery effort included duplicate payments from all Medicaid plans incurred after our initial audit period. Since November 2006, the Department has initiated duplicate payments audits at 34 plans including Program providers. Although the audits are still in process, the Department has identified $35,896,803 in potential cost recoveries at the 34 plans. According to Department officials MFCU has recovered about $6.6 million as of May 2, 2007.

Recommendation 3

Determine the extent to which multiple payments were made for the 57,985 recipients not included in our sample and recover any identified overpayments.

Status - Implemented

Agency Action - As discussed in the Agency Action for Recommendation 2, the Department, OMIG and MFCU have initiated audits and recoveries at 34 plans.

Major contributors to this report were Ronald Pisani, Laura Brown, Holly Thornton and Rebecca Tuczynski.

We thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Sheila A. Emminger
Audit Manager

cc: Lisa Ng, DOB
Tom Howe, DOH
Steve Sossei, OSC Audit Director