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June 15, 2007

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

Re: Report 2007-F-5

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 (Department), to implement the recommendations contained in our audit report, *Department of Health: Oversight of the Family Health Plus Program* (Report 2004-S-17).

Background, Scope and Objective

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 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.

Our initial audit report, which was issued on February 7, 2006, addressed the overpayments made for medical services provided to individuals enrolled in New York State's Family Health Plus Program. 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 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 changed the expiration date for a recipient's Program. As a result, Medicaid payments are inappropriately made for services that should be reimbursed by a Program managed care plan. 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 11 recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

We found Department officials have made some progress in correcting some of the problems we identified. However, additional improvements are needed. Of the 11 prior audit recommendations, 1 recommendation was implemented, 4 recommendations have been partially implemented, 5 recommendations have not been implemented, and 1 recommendation is no longer applicable.

Follow-up Observations

Recommendation 1

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

Status - Implemented

Agency Action - The Department and the Office of Medicaid Inspector General (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 our audit report 2004-S-48, *Multiple Medicaid Payments for Managed Care Recipients*. 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 2

Develop an exception report for the local districts that includes data from both WMS subsystems and identifies all the 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.

Status - Not Implemented

Agency Action - Department officials informed us that due to the incompatibility of New York City and upstate WMS subsystems, an exception report was not developed detailing all recipients statewide who appear to have more than one recipient ID.

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.

Status - Not Implemented

Agency Action - The Department officials agree with our recommendation. However, the officials informed us they are presently precluded from taking action pending the outcome of litigation on a related matter. In the meantime, the Department has continued to use "*Duplicate CIN*" reports that were in use at the time of our initial audit.

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.

Status - Partially Implemented

Agency Action - The Department began investigating the 97 sampled recipients in March 2007. Department officials informed us that they will decide whether to review the 10,690 remaining recipients based on the results of the sample review.

Recommendation 5

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

Status - Partially Implemented

Agency Action - In March 2007, the Department requested a system edit to prevent applicants in New York City from enrolling in the Program if they have other health insurance coverage such as Medicaid, Medicaid Managed Care or Medicare. In addition, the Department provides periodic third party insurance training to the local social services districts. As in our initial audit, upstate county and local social services district officials still only have access to a third party roster which they may use to verify if any Program recipients have other coverage.

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.

Status - Partially Implemented

Agency Action - Department officials state that the Report of Dually Eligible Recipients Enrolled in Mainstream Managed Care is widely used in the local social service districts. However, the Department does not monitor the districts to ensure that they are taking steps to minimize dual enrollments.

Recommendation 7

(This recommendation was deleted from the initial audit report.)

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.

Status - Not Implemented

Agency Action - The Department did not review or recover the inappropriate payments that resulted from retroactive disenrollments. According to Department officials, their priority, instead, has been the formation of the Department, OMIG and MFCU work group to identify and recover payments related to duplicate recipient IDs. (See Recommendation 1)

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 payments that are determined to be inappropriate.

Status - Not Implemented

Agency Action - The Department did not investigate the potentially inappropriate payments for the 823 recipients who were retroactively disenrolled. According to Department officials, their priority, instead, has been the formation of the Department, OMIG and MFCU work group to identify and recover payments related to duplicate recipient IDs. (See Recommendation 1)

Recommendation 10

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

Status - Partially Implemented

Agency Action - The Department has sent various communications to the local social services districts containing instructions, codes, reasons and examples for completion of the Notification of Retro Disenrollment forms. In addition, the Department has scheduled refresher courses for the local districts on retroactive disenrollments. However, the Department does not have a formal process to monitor retroactive disenrollments to ensure they are appropriate or to ensure corrective action is taken where needed.

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 local districts to help them identify monthly Program premiums that need to be recovered.

Status - Not Implemented

Agency Action - The Department did not develop a report that summarizes retroactive disenrollments by local social services district. As in our initial audit, Department staff informed us they still occasionally review a report of retroactive disenrollments sorted by a reason code instead of by local social services district. However, this report format would not necessarily meet the needs of the local social services districts.

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

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this process.

Very truly yours,

Sheila A. Emminger
Audit Manager

cc: Lisa Ng, Division of Budget
Tom Howe, Department of Health
Steve Sossei, OSC Audit Director