Thomas P. DiNapoli
COMPTROLLER

OFFICE OF THE
NEW YORK STATE COMPTROLLER

DIVISION OF STATE SERVICES

DEPARTMENT OF HEALTH

ELIGIBILITY OF CHILDREN ENROLLED IN CHILD HEALTH PLUS B

Report 2005-S-58

AUDIT OBJECTIVE

Our objective was to determine whether ineligible children were enrolled in Child Health Plus B and if so, the cost of these inappropriate premiums.

AUDIT RESULTS - SUMMARY

We found more than 20,000 enrollees who were ineligible because they were either simultaneously enrolled in Medicaid, were eligible for coverage under the State's public employee health benefits plan, or had other health insurance coverage during the time of their Child Health Plus B enrollment. Department of Health (Department) premiums paid to health insurance plans on behalf of these inappropriate enrollments totaled more than $2.6 million. [Pages 3-6]

We determined Department controls to prevent payment of duplicate premiums on the same children can be improved as we found more than $5,400 in duplicate payments were made. [Page 6]

We found enrollments were not always supported by accurate eligibility documentation. For example, some enrollments contained errors that affected eligibility and/or monthly premiums. [Pages 6-8]

The Child Health Plus B database uses unique business rules for each field to ensure data accuracy. We determined that not all fields met the various rules and the database could be enhanced to ensure validity of the data. [Pages 8-9]

Our audit report contains 12 recommendations to improve controls over Child Health Plus B enrollments. Specifically, we recommend improvements to the Department's enrollment processes and procedures to identify ineligible children enrolled in Child Health Plus B. Department officials generally agreed with our audit findings and have already taken steps to improve processes.

This report, dated April 4, 2007, 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
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, NY 12236

BACKGROUND

Child Health Plus B was created by the State Legislature in 1991 and is administered by the Department. It provides low cost or free health insurance to children under the age of 19 living in New York State. Through Child Health Plus B, children are provided with health care services such as physical exams, immunizations, emergency care, and diagnosis and treatment of illness and injury. As of June 2006, approximately 389,000 children were enrolled in Child Health Plus B. State and Federal spending for Child Health Plus B is about $690 million annually, of which approximately $360 million is State funded.

In administering Child Health Plus B, the Department contracts with 32 health insurance plans (Plans) throughout the State. These Plans are responsible for enrolling children, providing managed care health insurance coverage to them, and annually renewing their eligibility for Child Health Plus B. The Department is responsible for overseeing Plan activities and performance, and ensuring children are appropriately enrolled based on eligibility guidelines. In carrying out this responsibility, the

Department conducts annual audits of all Plans to ensure compliance with applicable eligibility requirements.

AUDIT FINDINGS AND RECOMMENDATIONS

Enrollment in Multiple Health Insurance Programs

Children under the age of 19 living in New York State may enroll in Child Health Plus B if they are not eligible for Medicaid, are not eligible for the State's public employee health benefits plan, and are not covered by any other health insurance plan. Plans that incorrectly determine eligibility for their Child Health Plus B enrollees must reimburse the State for any premiums paid on behalf of such ineligible enrollees. Further, if a child is inappropriately enrolled in both Child Health Plus B and Medicaid, Federal matching funds are no longer available for the child.

During the initial two months of enrollment in Child Health Plus B, a child may be enrolled temporarily on the basis of preliminary information in the enrollment application. During this time, documentation is gathered to support eligibility and to confirm the child is not eligible for or enrolled in other health insurance programs. If during this period it is determined a child should be enrolled in Medicaid, the two-month period may be extended until a final Medicaid approval is made. Generally, Medicaid eligibility determinations may take up to 45 days to complete. Recognizing this time frame, if the Medicaid determination did not commence until late in the initial two month enrollment period or was otherwise extended beyond the 45 days, a child could remain temporarily enrolled in Child Health Plus B for 3.5 months (60 days plus 45 days) or longer. As such, our results include only children who have been confirmed as eligible for Child Health Plus B after all temporary enrollment periods have elapsed.

To determine if ineligible children were enrolled in Child Health Plus B and if inappropriate premium payments were made on behalf of such children, we reviewed six months of enrollment data. During these six months, the Department enrolled more than 630,500 children accounting for about $258 million of premium payments. The following describes our analysis.

- We compared Child Health Plus B enrollment data to the Department's computerized claims payment and information reporting system for Medicaid (eMedNY) to identify children simultaneously enrolled in both Child Health Plus B and Medicaid.

- We compared Child Health Plus B enrollment data to the New York State Health Insurance Plan's (NYSHIP) enrollment data on non-New York City government employees and their dependents to identify children with access to the State's public employee health benefits plan.

- We compared eMedNY's historical data of third party insurance coverage to the portion of Child Health Plus B enrollees who were previous recipients of Medicaid. Our objective was to identify Child Health Plus B enrollees who potentially had third party insurance coverage.

The results of our analyses are summarized in the following table on page 4 and show that there were potentially 20,809 ineligible enrollees for whom $2.6 million of premiums had been incorrectly paid.

Reason for Ineligibility	Ineligible Enrollees	CHP B Net Premium Paid
CHP B Enrollees in Medicaid	18,575	$2,359,573
CHP B Enrollees with Access to NYSHIP	1,989	249,886
CHP B Enrollees with Third Party Health Insurance Coverage	245	34,557
Totals	20,809*	$2,644,016

* This total could represent up to six multiple enrollments of the same child.

Child Health Plus B Enrollees in Medicaid

According to Department officials, the Medicaid file (eMedNY) includes approximately 4,500 children who they claim are not enrolled in Medicaid, but are coded in the system as "Family Planning". Nevertheless, Department officials stated that if a Medicaid payment was incorrectly made on behalf of these children, Child Health Plus B is considered primary coverage and all recoupments should be made from Medicaid. Based on this statement, we analyzed some of the 4,500 children to determine if Medicaid payments were made. Specifically we analyzed Medicaid fee-for-service payments and identified 372 children for whom nearly $76,000 in Medicaid payments were made to health care providers for medical services rendered during the month of dual enrollment.

For the remaining approximate 14,000, Department officials explained that the overlapping coverage could have occurred if local Department social services offices were not timely in determining Medicaid eligibility or in entering Medicaid determinations into the Welfare Management System (the Central registry for all data about recipients who receive some form of public assistance in the State).

Department officials told us that in January 2005, they changed their processes so Plans could no longer enroll a child in Child Health Plus B until the Department conducted its nightly computer match against Medicaid data to determine if a child was also enrolled in Medicaid (called a prospective review). Previously, Plans could enroll children without the benefit of this up-front matching (called a retrospective review), often resulting in at least one month or more of enrollment in both Child Heath Plus B and Medicaid. While the prospective review is an improvement, overlaps in enrollments can still occur due to timing issues.

Department officials stated it is not uncommon to find no matches for several months, only to have a three-month overlap identified in one night. There are indications that these timing problems are particularly severe. We found approximately 20 percent of the 18,575 enrollees had been enrolled in Medicaid six months or longer prior to their Child Health Plus B enrollment. For these cases, we believe the Department had sufficient time to be notified of the child's Medicaid enrollment. For example, we determined one child had been enrolled in Medicaid from August 2002 to May 2006, yet was also fully enrolled in Child Health Plus B from September 2005 to November 2005. This occurred eight months after the Department's conversion to the new prospective review.

We also found Plans were not consistently applying the rules regarding temporary enrollment. For instance, at the three Plans we visited, we determined children are only temporarily enrolled in both Child Health Plus B and Medicaid for a period of up to 60,

90, or 120 days, respectively. As stated previously, the temporary enrollment period is to last up to 60 days or to the date a final Medicaid approval is made. Therefore, if the Medicaid approval takes longer than 60, 90 or 120 days, the child could be disenrolled from Child Health Plus B, even though the child remains eligible for Child Health Plus B until a final Medicaid eligibility determination is made.

We also determined more than 300 of the 18,575 enrollees were insured by the same Plan during the dual Child Health Plus B and Medicaid coverage. In these situations, the Department should recoup Child Health Plus B premiums for all previous months of dual enrollment since these Plans received multiple premiums for the same individual.

In addition to the 18,575 children identified above as being enrolled in both Child Health Plus B and Medicaid, we used additional computer assisted audit techniques to identify 2,914 other enrollees who also appear to be simultaneously enrolled in both programs (equivalent net premium payment amount of approximately $359,400). This analysis was based on similarity of data, such as first and last names (i.e., John Smith versus John Smith, Jr.). We believe these occurrences warrant further investigation by the Department and recommend the Department do analyses, based on similarity of information, in the future.

Other Enrollee Matches

Regarding the 1,989 NYSHIP matches and 245 third party insurance matches, Department officials indicate they will refer these results to the appropriate parties to determine whether enrollees need to be disenrolled from Child Health Plus B.

In addition to the 245 children identified above as having had other third party insurance coverage while enrolled in Child Health Plus B, we identified an additional 1,032 enrollees who also appear to have had other third party insurance (equivalent net premium payment amount of approximately $131,700). Since, information maintained on eMedNY regarding third party coverage is not always up-to-date, we cannot conclusively determine, at this time, whether these additional instances are multiple enrollments. Accordingly, these occurrences warrant further investigation by the Department.

Department officials do not require comparisons of Child Health Plus B enrollments to other insurance data except Medicaid. However, we identified other databases and additional sources, such as New York City health benefits programs, which would allow for additional verifications of access to other health insurance. Department officials indicated they will pursue obtaining access to other databases.

Recommendations

1. Investigate all enrollees we identified as ineligible and recoup all related overpayments.

2. Investigate enrollments we identified as potentially ineligible based on similar enrollment information and those who appear to have had other third party insurance and recoup all overpayments.

3. Improve processes currently used to identify multiple enrollments in Child Health Plus B and other health insurance programs. Consider performing analyses based on the similarity of names and other identifying information, improving coordination with the Medicaid program to increase the effectiveness of the prospective review process, identifying occurrences in which enrollees are dually enrolled by the same Plan, and gaining access to other databases.

4. Determine whether the Plans are complying with temporary enrollment procedures. If not, take the necessary steps to foster compliance.

Duplicate Enrollments Within Child Health Plus B

The Department pays Plans one monthly premium for each child enrolled in Child Health Plus B. According to program guidelines, enrollee data such as plan enrollee identifier and enrollee social security number should be unique among enrollees within Plans. However, we found instances where enrollee data was not unique and duplicate payments were made for the same child.

We found 88 duplicate enrollees (44 matching sets), based on exact matches of plan enrollee identifier, gender, social security number, first and last name, household home and mailing address, and date of birth. Duplicate Child Health Plus B premiums paid on behalf of these enrollees totaled $5,444 for the six months we reviewed. The Department has taken steps to recover duplicate payments and has made improvements to help preclude future overpayments.

We used additional computer assisted audit techniques to identify more than 12,000 records, suspected as being duplicates based upon similarity of data. For instance, criteria we used to identify and test potential duplicate records included analyses of enrollments that had (1) similar first name, last name, home address, and home city, and (2) exact date of birth, home zip code, and home phone number. As discussed in the next section of this report, our onsite testing of Plan records confirmed some of these records suspected as being duplicated were indeed duplicate enrollments.

We determined the Department's tests for duplicate enrollments are based upon exact matches of data, as opposed to matches based also on similarity of records, leaving open the possibility of enrollments to be duplicated with slightly altered data. If a child is erroneously enrolled multiple times, Plans could receive multiple monthly premiums on the same child. Based on our findings, the Department's current checks for duplicate enrollments should be reviewed to ensure controls are working properly to prevent these types of errors.

Recommendations

5. Recoup overpayments on duplicate enrollees.

6. Review and enhance controls for identification of duplicate enrollments.

Enrollment Verification

According to Child Health Plus B rules and regulations, eligible children must be under the age of 19 and reside in New York State. Documentation must be provided to prove age and residency. Documentation is also required to verify income and to make a determination as to what premium the family should pay toward the cost of the program.

We reviewed records from 3 of the 32 Plans in the State. From these three, we judgmentally selected 130 enrollment files for onsite testing of documentation supporting eligibility. We reviewed file documentation for appropriateness of age, residency, income and premium calculations, Child Health Plus B versus Medicaid eligibility, and enrollment in and access to other health insurance plans. Of the 130 files, we found 16 files had errors (13 percent) that affected eligibility and premium contribution amounts.

- 5 enrollments were invalid because enrollees were eligible for NYSHIP,
- 3 enrollments were duplicate enrollments,
- 1 enrollment was invalid because the enrollee was eligible for Medicaid,
- 1 enrollment was invalid based on an erroneous birth certificate,
- 1 enrollment was invalid because the enrollee was terminated by the Plan, yet the enrollee still remained in Child Health Plus B,
- 1 enrollment was missing an application, and
- 4 enrollments had files with incorrect family premium contribution amounts.

We observed other enrollment verification deficiencies such as incomplete applications and incorrect addresses, social security numbers, date of birth, and family size. Although these deficiencies did not affect eligibility for those in our sample, such deficiencies can affect eligibility.

The Plans we visited do not use automated programs to aid in enrollment verification functions such as calculations of income, the determination of eligibility for either Child Health Plus B or Medicaid, and family premium contribution amounts. If automation was used, errors in these enrollment processes may decrease. The Plans do have quality controls to review enrollment representative's work. However, making automation programs available would further reduce the risk of errors.

The Department sends Plans data on enrollees who appear to be enrolled in Medicaid. However, the Department does not send Plans reports of enrollees who appear to have access to State health benefits or third party insurance, or who appear to be duplicate enrollments based on similarity of enrollment information. In addition, the Department does not check for or include this information as part of their annual audits of Plans.

The Department conducts annual audits of all Plans, which are referred to as first stage audits. Tests of records in first stage audits are based on random samples of 50 records. Identified disallowances are recouped on the 50 records tested. If a first stage audit results in a fatal error (errors of Plan compliance, including eligibility) rate greater than ten percent, a second stage audit is scheduled and tests of 200 randomly selected records are conducted. If the resulting fatal error rate of the second stage audit is greater than five percent, disallowances are projected to the entire population. Department officials stated special reviews of Plans are occasionally conducted, either as part of the annual audits or separate from the audit process, to allow the Department to select specific records for review. In certain instances, these special reviews are added to examine the validity of social security numbers that appear to be inaccurate based on the Social Security Administration's rules and regulations.

We believe the Department's review process would be enhanced if all annual reviews included tests of records suspected as being inappropriate based on risk analysis, such as tests of enrollees who appear to have access to other health insurance or appear to have duplicate enrollments based on similarity of records. Department officials indicated they will explore incorporating this recommendation. Department officials indicated they will also consider modifying their policy on second stage audits to project disallowances when fatal error rates are greater than three percent (as opposed to five percent), resulting in future higher recoveries.

Recommendations

7. Follow up on the 16 files we identified and recoup all overpayments made to ineligible enrollees.

8. Take steps to improve the application process including, but not limited to, creating electronic worksheets to aid in calculations of income, program determination, and family premium contribution amounts.

9. Provide Plans with reports of enrollees who appear to have access to State health benefits, have third party insurance, and who appear to be duplicate enrollments based on similarity of enrollment information.

10. Revise the methodology used to select records for testing during the annual eligibility audits of Plans to include additional tests based on risk analysis to test for such things as access to or enrollment in other health insurance and duplicate enrollments based on similarity of records.

Accuracy of the Department's Database

Child Health Plus B data resides on the Department's Knowledge Information Data System. The database contains 47 fields. There are unique business rules for each field to help ensure data integrity. For instance, Plan Identifier represents a Plan's contract number with the State and should be a valid number from the Department's list of contract numbers; an enrollee Birth Date requires that the child must be less than 19 years of age as of the last day of the previous month of enrollment.

We tested the accuracy of the data contained in 20 of 47 fields (43 percent) using computer assisted audit tools to see if they met the unique business rules for new enrollments after implementation of the Knowledge Information Data System in March 2004. We selected these 20 fields judgmentally based upon our analysis of the significance of the field. We found 10 fields met the business rule while the remaining 10 fields did not. For instance, Household Family Identifier is a unique code that is assigned to each member of a family and cannot be used for anyone outside of the family. However, we found instances in which Plans used Household Family Identifiers for individuals who did not appear to be members of that family.

We believe the edit checks built within the Knowledge Information Data System are not strong enough to prevent these types of data entry errors. Consequently, there is a risk some data is not valid. Department officials indicated they will review the database for improvement opportunities.

Another field we tested was the enrollee Social Security Number field. Using Veris Social Security Number validation software,

we determined 145,100 social security numbers (approximately 7 percent) were invalid, including some that belonged to deceased persons. According to Department officials, the Department does not always follow its business rules for the social security number field because this information is not required for a child's eligibility into the program.

However, social security numbers are used by the Department and Plans to ensure program eligibility, by matching them to external databases, among other verifications. Checks should be strong for this field to encourage Plans to enter accurate social security numbers.

Department officials indicated they plan to revise the business rules relating to social security numbers and will require Plans to follow up on the cases in which social security numbers were identified as belonging to deceased persons, and will obtain access to social security number verification software to use as a standard part of their annual eligibility audits.

Recommendations

11. Strengthen controls over the Knowledge Information Data System to ensure the data is accurate.

12. Include tests of social security numbers that appear invalid during all audits and report back to Plans on the results and the need to ensure valid and accurate social security numbers.

AUDIT SCOPE AND METHODOLOGY

We conducted our performance audit in accordance with generally accepted government auditing standards. We audited the Department's administration of the Child Health Plus B program for the period April 1, 2004 through August 15, 2006. To accomplish our objectives, we met with Department and Plan officials to confirm and enhance our understanding of the Child Health Plus B program, requirements, and enrollment controls. We reviewed program policies and procedures, Department audits, and Plan contracts. We used computer assisted audit tools to review the appropriateness of Child Health Plus B enrollment data for six months that were judgmentally selected based on months that showed higher spikes in enrollment: June 2004, December 2004, January 2005, September 2005, October 2005, and November 2005. Some audit testing included use of eMedNY and New York State Health Insurance Plan data to verify the appropriateness of enrollee eligibility. For our onsite testing of Plan enrollment files and documentation supporting eligibility, we used the exception results of our computer analyses to judgmentally select (1) a sample of three insurance plans and (2) 130 enrollment files out of a population of approximately 173,000 files. We selected 40 enrollment files per Plan, with the exception of one Plan for which we increased the sample to 50 after identifying there was a higher risk of duplicate records for that Plan.

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 who 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 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.

REPORTING REQUIREMENTS

We provided a draft copy of this report to Department officials for their review and comment. We considered their comments in preparing this report. A copy of the Department's response is included as Appendix A. Appendix B contains State Comptroller comments which address certain matters included in the Department's response.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include William Challice, David R. Hancox, Sheila Emminger, Albert Kee, Edward Durocher, Andrea Inman, Shakesha Coleman, David Reilly, Justin Scribner, and Sue Gold.

APPENDIX A - AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

January 10, 2007

William P. Challice
Audit Director
Division of State Services
State Audit Bureau
123 William Street – 21st floor
New York, New York 10038

Dear Mr. Challice:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report on "Eligibility of Children Enrolled in Child Health Plus B" (2005-S-58).

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Ms. Arnold
Mr. Bielefeldt
Mr. Griffin
Mr. Howe
Mr. Reed
Ms. Stackman

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2005-S-58 on
"Eligibility of Children Enrolled
in Child Health Plus B"

The following is the Department of Health's response to the Office of the State Comptroller's (OSC) Draft Audit Report 2005-S-58, on "Eligibility of Children Enrolled in Child Health Plus B."

Recommendation #1:

Investigate all enrollees we identified as ineligible and recoup all related overpayments.

Response #1:

OSC found potential overpayments of one (1%) of total premium payments made by the Child Health Plus B (CHPlus B) Program during the six sampled months of the audit period. The enrollees identified throughout the report are not counts of children, but counts of member months. For example, a child enrolled during the entire six month audit period would count six times in the findings.

The Department concurs with some of these findings and disagrees with others. Many of the Medicaid duplicates had been previously identified and the premiums recouped as an ongoing part of administering the CHPlus B program.

The family planning expansion program is a special limited benefit waiver program that is not considered for Medicaid eligibility, and therefore does not make a child ineligible for CHPlus B (SCHIP). The family planning expansion waiver states, "If the State provides SCHIP enrollees' coverage of family planning services, the State must only seek reimbursement through the SCHIP program."

The obligation is on the family planning expansion program to repay the federal government when a child is found enrolled in both CHPlus B and the family planning expansion program. Moreover, children enrolled in the family planning expansion program cannot be enrolled in a Medicaid managed care product through that program; thus, there are no duplicate premium payments to plans. All of the children identified by OSC are appropriately enrolled in CHPlus B and eligible for coverage.

The Department will investigate the other enrollees identified as potentially ineligible and, if found ineligible, recoup related overpayments.

* See State Comptroller's Comments, p. 18

Recommendation #2:

Investigate enrollments we identified as potentially ineligible based on similar enrollment information and those who appear to have had other third party insurance and recoup all overpayments.

Response #2:

Similar to the above, the Department will investigate potentially ineligible enrollments and recoup confirmed overpayments.

Recommendation #3:

Improve processes currently used to identify multiple enrollments in Child Health Plus B and other health insurance programs. Consider performing analyses based on the similarity of names and other identifying information, improving coordination with the Medicaid program to increase the effectiveness of the prospective review process, identifying occurrences in which enrollees are dually enrolled by the same Plan, and gaining access to other databases.

Response #3:

The Department will refine its matching criteria to compare similarity of names and other identifying information to improve the program's ability to find duplicate enrollments. We are testing several methods to determine which approach increases the ability to identify duplicates while not producing excessive false positives that need to be individually assessed.

Recommendation #4:

Determine whether the Plans are complying with temporary enrollment procedures. If not, take the necessary steps to foster compliance.

Response #4:

We have examined the temporary enrollment practices at the three plans visited by OSC. All three are in compliance with the Department's rules on temporary enrollment.

Recommendation #5:

Recoup overpayments on duplicate enrollees.

Response #5:

The Department has already recouped overpayments on the 13 confirmed duplicate children identified in the audit report. We will investigate the additional 12,000 member months identified in the report based on an analysis of similar data. To the extent we find confirmed duplicates, we will recoup overpayments.

Recommendation #6:

Review and enhance controls for identification of duplicate enrollments.

Response #6:

As discussed in Response #3, the Department has taken steps to enhance the identification of duplicate enrollments using similarity of names and other identifying information.

Recommendation #7:

Follow up on the 16 files we identified and recoup all overpayments made to ineligible enrollees.

Response #7:

The Department has followed up on all 16 files identified and recouped the overpayments made to ineligible enrollees.

Recommendation #8:

Take steps to improve the application process including, but not limited to, creating electronic worksheets to aid in calculations of income, program determination, and family premium contribution amounts.

Response #8:

The Department will explore ways to improve the accuracy of the application process at the health plans. This may include making available an electronic worksheet to aid in calculations of income, program determination, and family premium contribution amounts or other strategies to minimize data entry or calculation errors.

Recommendation #9:

Provide Plans with reports of enrollees who appear to have access to State health benefits, have third party insurance, and who appear to be duplicate enrollments based on similarity of enrollment information.

Response #9:

The Department has been working with the Department of Civil Service to obtain access to the New York State Health Insurance Plan database to match against CHPlus B applicants prior to enrollment. We will also provide Plans with reports of enrollees who appear to be duplicates based on similarity of enrollment information.

Recommendation #10:

Revise the methodology used to select records for testing during the annual eligibility audits of Plans to include additional tests based on risk analysis to test for such things as access to or enrollment in other health insurance and duplicate enrollments based on similarity of records.

Response #10:

The Department will add cases to our annual random audit sample based on risk analysis.

Recommendation #11:

Strengthen controls over the Knowledge Information Data System to ensure the data is accurate.

Response #11:

The Department has adequate controls to ensure the accuracy of data in KIDS. The Department continues to reiterate that the missing data elements identified by OSC as errors are not errors. They reflect the migration from an old data system to a new data system as well as a problem duplicating the records for OSC. The latter problem was rectified and should have resulted in those errors being removed.

* Comment 3

The Department added new data elements when KIDS was developed. These new elements were only required for new applications after the implementation of KIDS. For children enrolled prior to March 1, 2004, the plans were not required to go back to the original application for the new elements. They were only required to migrate data available on their system to the new KIDS system.

The Department corrected the three confirmed errors. These affected a very small number of cases.

Recommendation #12:

Include tests of social security numbers that appear invalid during all audits and report back to Plans on the results and the need to ensure valid and accurate social security numbers.

* See State Comptroller's Comments, p. 18

Response #12:

The Department has modified the business rule for how plans complete the social security number (SSN) field when a valid SSN is not available. This will enable the Department to separate those numbers reported as valid SSNs from missing numbers and eliminate the problem of some "dummy" numbers matching SSNs or appearing as invalid numbers. All entries that do not conform to the new business rules will be rejected.

In addition, the Department will validate all SSNs submitted as valid and reject suspect SSNs if certain criteria are not met. Suspect SSNs will be reviewed with the health plans and corrected as necessary.

APPENDIX B - STATE COMPTROLLER'S COMMENTS ON AUDITEE RESPONSE

1. As indicated in our footnote to the table on page 4, we acknowledge that an illegible enrollee could represent up to six multiple enrollments of the same child.

2. We acknowledge that the approximate 4,500 children who are coded on the Medicaid eMedNY file as Family Planning does not make a child ineligible for Child Health Plus B. In addition, we understand that children enrolled in the Family Planning program cannot be enrolled in Medicaid managed care programs; thus there should be no duplicate premium payments to the plans. However, our analysis shows that $76,000 in Medicaid fee-for-service payments were made on behalf of 372 of these children. As such, we maintain Department officials need to investigate these circumstances that led to this duplication and recoup the related overpayments. We also modified our report to reflect Department comments about managed care premiums.

3. We did remove those errors that related to the Department's duplication of records. Further, the data errors we reported upon relate only to children who were enrolled in Child Health Plus B after March 1, 2004. The new data elements would be applicable for these enrollments and, as such, we maintain the Department needs to strengthen controls to ensure the data is accurate.