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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

November 1, 2013

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, NY 12237

Re: Unnecessary Managed Care Payments
for Medicaid Recipients with Medicare
Report 2013-F-15

Dear Dr. Shah:

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, *Unnecessary Managed Care Payments for Medicaid Recipients with Medicare* (Report 2010-S-75).

Background, Scope and Objective

Medicaid is a federal, state and local health insurance program. Medicaid serves low-income and financially needy people and includes the Family Health Plus (FHP) benefit. FHP provides health care to about 400,000 adults with incomes and/or assets slightly above the normal thresholds for Medicaid eligibility. Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). Medicare covers health-related services to people 65 years of age and older, people with disabilities and people with permanent kidney failure.

In some instances, Medicaid pays providers directly under fee for service arrangements. In other instances, Medicaid recipients are enrolled with a managed care organization (MCO), and the MCO charges Medicaid a monthly premium for each enrolled recipient. The MCO then provides or arranges for all health services for the enrolled Medicaid recipients.

Some Medicaid recipients are also enrolled in Medicare. These individuals are known as "dual eligibles." With few exceptions, dual eligible individuals are not eligible for FHP. In addition, dual eligible people should not be enrolled in a Medicaid managed care plan because the costs

of monthly Medicaid managed care premiums usually exceed the costs of Medicare coinsurance and deductibles that Medicaid would otherwise pay when medical services are rendered to these recipients.

The Department contracts with an enrollment broker (Maximus, Inc. [or Maximus]) to provide educational, outreach and enrollment services for the Medicaid managed care program. When appropriate, Maximus must also remove recipients from Medicaid managed care programs as well. The Department contracts with Maximus to provide these services in New York City and several counties. Local districts perform this function in the counties not served by Maximus. Also, Maximus does not perform any enrollment broker functions, including removing recipients from program participation, for FHP.

Our initial report was issued on April 18, 2012. Our objective was to determine whether the Department made premium payments to Medicaid managed care plans for Medicaid recipients who also had Medicare coverage. The audit period included the three years ended May 31, 2010. For this period, we identified about 271,000 unnecessary Medicaid managed care payments (totaling about \$111 million) that were made on behalf of 45,000 Medicare recipients who were ineligible for Medicaid managed care programs. Had Medicaid paid only the deductibles and coinsurance for the recipients in question, the net savings to Medicaid would have been about \$36 million. The unnecessary Medicaid managed care premiums occurred because of delays in posting recipients' Medicare data to eMedNY (Medicaid's automated claims processing and payment system) and because recipients were not removed timely from the managed care plans once their Medicare data was posted to eMedNY.

The objective of our follow-up was to assess the extent of implementation, as of October 15, 2013, of the six recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

Department officials made considerable progress addressing several of the problems identified in our initial report. However, further actions are still needed. Of the six prior audit recommendations, three were implemented, two were not implemented and one is no longer applicable.

Follow-Up Observations

Recommendation 1

Advise Department staff to use the Buy-In Span function to identify the potential Medicare eligibility of Medicaid recipients and prevent improper payments to managed care providers.

Status - Not Applicable

Agency Action - Current Buy-In span data is not sufficiently reliable for identifying a recipient's

Medicare eligibility. As such, Department staff usually cannot use Buy-In span data to prevent improper Medicaid payments to managed care providers.

Recommendation 2

Formally assess the quality and utility of the Medicare eligibility data currently obtained from CMS and determine why it is not sufficient to remove Medicare recipients from Medicaid managed care timely. Take actions to help improve data quality and/or develop alternate means to compensate for data deficiencies.

Status - Implemented

Agency Action - The Department assessed the quality and utility of the Medicare eligibility data obtained from CMS and the reasons why it was insufficient for removing Medicare recipients from Medicaid managed care on a timely basis. Specifically, Department officials stated there are problems with CMS data, including retroactive Medicare enrollment, which results in improper managed care payments that are beyond their control. Officials also stated that CMS does not provide eligibility data timely, causing delays in the disenrollment of Medicare recipients. To address this concern, the Department now receives Medicare eligibility updates from CMS on a weekly basis rather than monthly. Department officials believe this will improve their ability to remove Medicare recipients from Medicaid managed care more timely.

Recommendation 3

Actively monitor the efforts of the localities and the broker to remove Medicaid recipients from managed care programs when they become Medicare eligible. Develop a formal process, including analysis of pertinent eMedNY payment data, to determine if the efforts of the localities and the broker are sufficient.

Status - Not Implemented

Agency Action - The Department planned to begin quarterly monitoring of the localities' and broker's efforts to remove Medicaid recipients from managed care in August 2013. Through such monitoring, the Department could determine if the efforts of the localities and the broker were sufficient. However, as of October 15, 2013 the Department had not begun the planned quarterly monitoring program.

Recommendation 4

Formally consider increasing the Department's direct efforts to remove dual eligible persons from managed care if the efforts of the localities and the broker are deficient.

Status - Implemented

Agency Action - Department officials assessed the adequacy of the efforts by the local districts and the enrollment broker to remove dual eligible persons from managed care. Based on their assessment, the Department took actions to remove dual eligible persons from managed care directly and increase the effectiveness of the enrollment broker's efforts. Specifically, in September 2013, the Department began a monthly WMS "sweep," which removes dual eligible persons from managed care programs in counties not covered by the broker. Also, the Department increased the frequency with which it provides Medicare eligibility information to the enrollment broker from a weekly to a daily basis.

Recommendation 5

Add measureable performance standards to the agreement with the broker regarding the timely removal of Medicare recipients from Medicaid managed care programs.

Status - Not Implemented

Agency Action - According to Department officials, the Department has not added measureable performance standards regarding the timely removal of Medicare recipients from Medicaid managed care to the agreement with the enrollment broker. Officials added, however, that they believe the broker's performance has been satisfactory.

Recommendation 6

Develop and implement procedures to help ensure that Medicaid does not pay managed care premiums for FHP enrollees with Medicare. At a minimum, formally remind local districts to periodically evaluate FHP recipients' eligibility for Medicare coverage.

Status - Implemented

Agency Action - On November 1, 2011, the Department issued a General Information System memo to all local districts and managed care coordinators that addressed methods for identifying and removing dual eligible persons from Medicaid managed care coverage. The memo also instructed local districts to review Medicare eligibility of FHP recipients.

Major contributors to this report were Salvatore D'Amato, David Schaeffer, and Dana Bitterman.

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 of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

A handwritten signature in black ink that reads "Dennis Buckley". The signature is written in a cursive, flowing style with a prominent loop at the end of the last name.

Dennis Buckley
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Ms. Lori Conway, Department of Health
Mr. Thomas Lukacs, Division of the Budget
Mr. James Cox, Office of the Medicaid Inspector General