

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

December 5, 2013

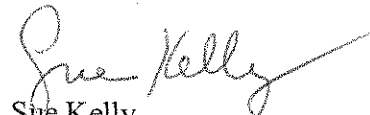
Dennis Buckley, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236

Dear Mr. Buckley:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Report 2013-F-15 on Department actions relative to the recommendations contained in earlier OSC Report 2010-S-75 entitled, "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare."

Thank you for the opportunity to comment.

Sincerely,



Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Jason A. Helgersen
James C. Cox
Michael Nazarko
Diane Christensen
Lori Conway
Robert Loftus
Joan Kewley
Ronald Farrell
Brian Kiernan
Elizabeth Misa
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**Department of Health
Comments on the
Office of the State Comptroller's
Follow Up Audit Report 2013-F-15 Entitled
"Unnecessary Managed Care Payments for
Medicaid Recipients with Medicare"**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-up Report 2013-F-15 entitled, "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare" (2010-S-75).

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.

Response #1:

As the OSC has deemed this recommendation not applicable, no further action is required by the Department.

Recommendation #2:

Formally assess the quality and utility of the Medicare eligibility data currently obtained from the Center for Medicare and Medicaid Services (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 #5:

Add measurable 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 measurable 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.

Response #5:

The Department does not agree with this recommendation. The Broker's contract has adequate performance standards and specifying this activity is unnecessary.

Recommendation #6:

Develop and implement procedures to help ensure that Medicaid does not pay managed care premiums for Family Health Plus (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.

Response #6:

The Department confirms our agreement with this report.