A REPORT BY THE NEW YORK STATE OFFICE OF THE STATE COMPTROLLER

Alan G. Hevesi
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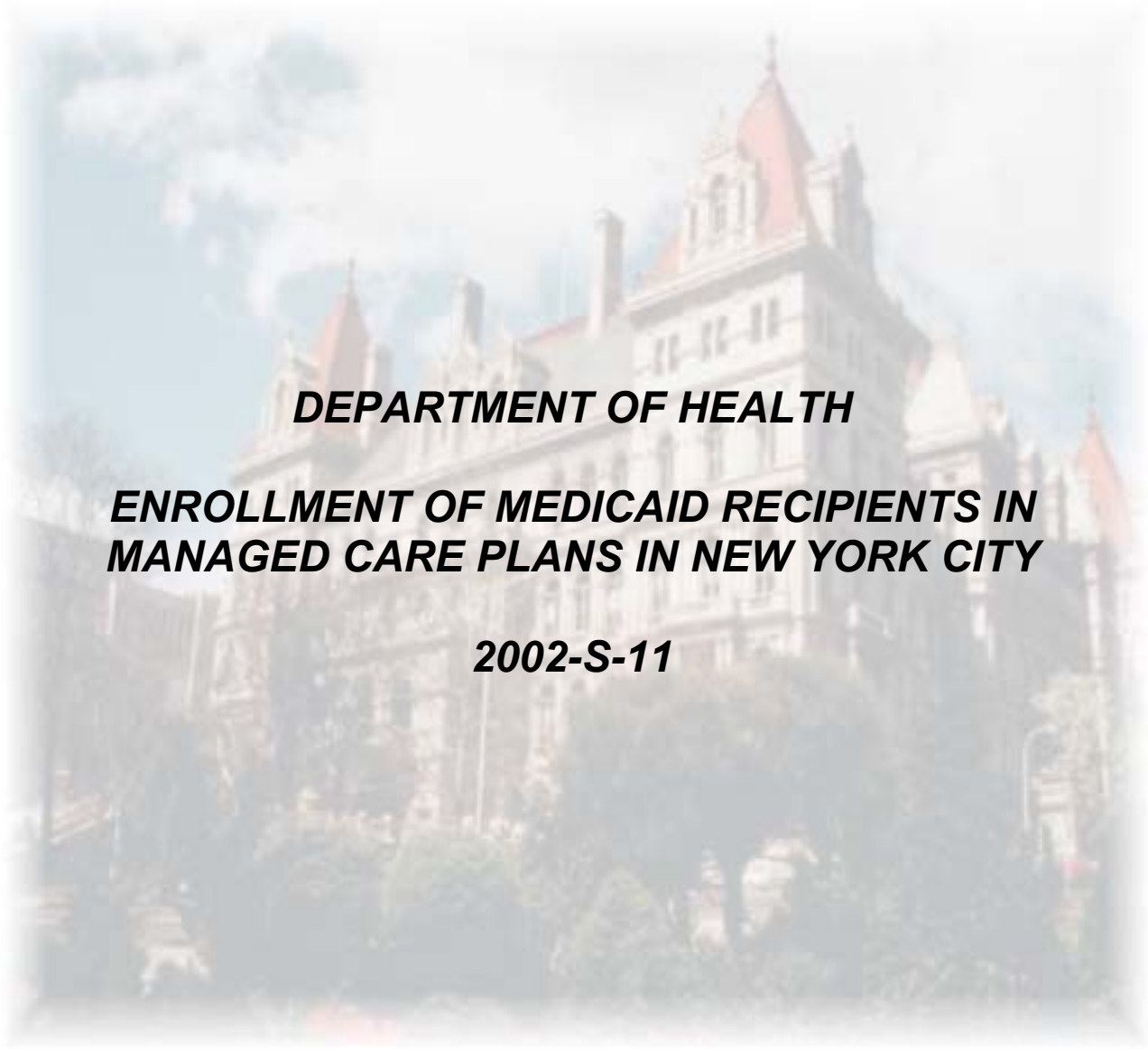

DEPARTMENT OF HEALTH

ENROLLMENT OF MEDICAID RECIPIENTS IN MANAGED CARE PLANS IN NEW YORK CITY

2002-S-11

DIVISION OF STATE SERVICES

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Report 2002-S-11

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Novello:

The following is our report addressing the Department of Health's monitoring of the contract with Maximus, Inc. for services relating to the enrollment of Medicaid recipients in managed care plans in New York City.

We performed this audit 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 list major contributors to this report in Appendix A.

August 28, 2003

EXECUTIVE SUMMARY

DEPARTMENT OF HEALTH

ENROLLMENT OF MEDICAID RECIPIENTS IN MANAGED CARE PLANS IN NEW YORK CITY

SCOPE OF AUDIT

The Department of Health (Department) administers New York State's Medicaid program, which provides medical assistance to eligible low-income and disabled individuals. Medicaid recipients may be enrolled in managed care plans, and beginning in 1997, such enrollment became mandatory for most recipients. To facilitate the mandatory enrollment process in New York City, the Department contracted with an enrollment broker, Maximus, Inc. (Maximus). Maximus sends enrollment forms with informational packets to Medicaid recipients and conducts presentations to educate recipients about managed care choices. According to Department records, as of June 30, 2002, about 1.2 million recipients in New York City were eligible for mandatory managed care enrollment.

Our audit addressed the following question about managed care enrollment in New York City for the period April 1, 1998 through June 30, 2002:

- Were the activities of Maximus and its compliance with certain contract requirements effectively monitored by the Department?

AUDIT OBSERVATIONS AND CONCLUSIONS

We found improvements are needed in the Department's oversight of Maximus's enrollment activities and its education and outreach activities.

Certain Medicaid recipients are not eligible for enrollment in managed care plans. We found that existing controls prevented the enrollment of most such recipients. However, the controls did not prevent the enrollment of dual eligible recipients (recipients eligible for both Medicaid and Medicare). Since the medical expenses of dual eligible recipients are generally covered by Medicare, it is usually not cost-effective for them to be enrolled in Medicaid managed care. We determined that, for the four years ended June 30, 2002, 11,202 dual eligible recipients were inappropriately enrolled in Medicaid managed care plans, resulting in the Department unnecessarily paying $46.3 million for managed care insurance coverage. We further determined that, as of June 1, 2002, 2,377 of these

recipients were still enrolled in managed care plans at a cost of more than $790,000 a month. We recommend that controls be established to disenroll these recipients and prevent the enrollment of such recipients in the future. (See pp. 5-7)

Mandatory managed care enrollment is to be achieved in five phases, each of which focuses on a different area of New York City. We examined the progress made in the first two phases and found that enrollment was taking longer than expected. For example, 19 months after a targeted level of enrollment was to have been achieved within an area of New York City, only 85 percent of the targeted level had actually been achieved. We determined that enrollment efforts could be enhanced if the Department performed certain types of analyses and used the results of these analyses to target communities, and recipients in those communities, for educational presentations and follow-up activities.

As part of its efforts to monitor the progress made by Maximus in enrolling eligible recipients, the Department sets interim enrollment goals called targets and compares actual enrollment levels to the targeted levels. We examined this process and determined that the enrollment progress reported by the Department is overstated to some extent, because the Department does not adequately take into account increases in the number of recipients who are eligible for participation in managed care plans. We recommend the Department take certain actions to improve the accuracy of its performance measurement process. (See pp. 7-12)

The informational material sent to recipients and the community presentations made by Maximus are intended to enable recipients to make informed decisions about their choice of a managed care plan. We examined certain aspects of these education and outreach activities and found that improvements are needed in both the performance of the activities by Maximus and the monitoring of the activities by the Department. In particular, surveys assessing the extent to which recipients were satisfied with Maximus generally were not conducted, even though such surveys were required by the contract. We also determined that Maximus did not adequately maintain records or accurately report information relating to community presentations. We recommend the Department more closely monitor the education and outreach activities of Maximus. (See pp. 13-19)

COMMENTS OF OFFICIALS

Department officials generally agreed with our recommendations and indicated actions taken or planned to implement them. A complete copy of the Department's response is included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters of disagreement included in the Department's response.

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INTRODUCTION

Background

The Department of Health (Department) administers New York State's Medicaid program, which provides medical assistance to eligible low-income and disabled individuals. The program is overseen by the federal Centers for Medicare and Medicaid Services (CMS). The program is administered at the local level by 58 local social services districts, which consist of 57 counties and New York City.

Many of New York State's Medicaid recipients are enrolled with managed care organizations (MCOs). The Department pays a monthly premium payment to MCOs for each enrolled recipient. In return, the MCOs must ensure that each enrollee has a primary care provider and adequate access to a full continuum of 24-hour health care of acceptable quality.

Initially, Medicaid recipients in New York State were enrolled in managed care plans on a voluntary basis. However, beginning in 1997, such enrollment became mandatory for most recipients. The recipients not subject to mandatory enrollment are either excluded from enrollment (these recipients should not be enrolled in managed care plans) or exempt from enrollment (these recipients may choose to participate in managed care, but participation is not required). Recipients may be excluded or exempt for various reasons.

To facilitate mandatory managed care enrollment in New York City, the Department contracted with an enrollment broker, Maximus, Inc. (Maximus). Maximus is expected to contact New York City Medicaid recipients who are not enrolled in managed care, educate the recipients about the nature of managed care and available managed care choices, and enroll eligible recipients in managed care plans. According to Department records, as of June 30, 2002, about 1.2 million recipients in New York City were eligible for enrollment in managed care plans.

Generally, Maximus sends an informational packet to targeted recipients and holds educational presentations in the recipients' communities. Each informational packet contains an enrollment

form, which must be completed and signed by the recipient. The recipient may return the completed enrollment form by mail or complete the form with the assistance of a Maximus representative at one of the educational presentations in the community. Since a recipient cannot be enrolled in a managed care plan until a signed and completed enrollment form is received, Maximus may have to follow up on recipients who do not submit their forms.

The targeted recipients are to be enrolled through a gradual, five-phase outreach and enrollment process. In phase 1, which was implemented in August 1999, outreach efforts were initiated in Staten Island, certain parts of Brooklyn, and certain parts of Manhattan. In phase 2, which was implemented in April 2001, outreach efforts continued in these locations and were initiated in certain parts of Bronx and Queens. In phase 3, which was implemented in November 2001, and in phases 4 and 5, which were implemented in September 2002, outreach efforts continued in the prior locations and were initiated in the remaining parts of New York City.

Two New York City agencies help the Department administer the contract with Maximus: the New York City Human Resources Administration (HRA) and the New York City Department of Health and Mental Hygiene (DOHMH). The roles and responsibilities of the three agencies are described in a Memorandum of Understanding that was signed in 1998. According to this agreement, the Department is responsible for Maximus's overall compliance with contract requirements, HRA is responsible for monitoring the day-to-day education and outreach activities, and DOHMH helps in the planning and development of education and outreach activities.

The contract with Maximus originally covered the period April 1, 1998 through June 30, 2000. In July 2000, the Department extended the contract through June 30, 2002. The original contract called for Maximus to be paid a total of $23.6 million. The extension added $40.8 million, bringing the total payments to be made under the contract to $64.4 million. In the Fall of 2001, the Department solicited competitive proposals for a new managed care enrollment broker contract for New York City. At the conclusion of this process, a new contract was awarded to Maximus. This contract covers the period July 1, 2002 through June 30, 2004, and calls for Maximus to be paid a total of $59.7 million.

Audit Scope, Objective and Methodology

We audited the Department's oversight of Maximus. We also audited the compliance of the Department and Maximus with certain requirements contained in the original contract and contact extension. Our audit covered the period April 1, 1998 through June 30, 2002. The objective of our performance audit was to determine whether the Department was effectively monitoring the activities of Maximus.

To accomplish our objective, we interviewed officials from the Department, Maximus, HRA and DOHMH, and reviewed the policies and procedures of these four entities. We also reviewed the original contract, contract extension and associated documents, and examined selected records maintained by the Department and Maximus. In our examination of records relating to the enrollment of targeted Medicaid recipients, we analyzed the extent to which the targeted recipients were enrolled within each New York City zip code. We also used a linear regression model to analyze enrollment information in relation to certain demographic census data. In our use of this model and our performance of these analyses, we were assisted by research associates from the State University of New York at Albany. We also obtained information from CMS relating to the Medicare eligibility of certain Medicaid recipients, and used computer-assisted audit techniques to determine whether these recipients had inappropriately been enrolled in Medicaid managed care plans.

This report is our second of two audit reports relating to the Department's contract with Maximus. The first report (Report 2001-R-2) was issued in June 2002, and addressed the appropriateness of the contract payments made to Maximus and certain related financial operations.

We conducted our audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform our audit to adequately assess those operations that are within our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing

procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities for audit. This approach focuses our audit efforts on those operations that we have identified through a preliminary survey as having the greatest probability of needing improvement. Consequently, by design, we use our finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Department Officials to Audit

We provided draft copies this report to Department officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters of disagreement included in the Department's response.

In addition to the matters discussed in this report, we have also reported separately to Department officials about a number of other audit issues. While these are matters of lesser significance, the Department should implement our recommendations related to these issues to help maintain the integrity of Maximus's proprietary computer system, MAXSTAR.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health 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.

ENROLLMENT ACTIVITIES

We examined the progress made by Maximus in enrolling Medicaid recipients in managed care plans. We determined that more than 11,000 recipients were inappropriately enrolled in such plans. Since these recipients were excluded from participation in managed care plans, they should not have been enrolled in the plans. As a result of these inappropriate enrollments, the Department paid $46.3 million for managed care insurance coverage that was not needed. We also determined that the enrollment process was taking longer than expected, and the achievement of enrollment goals was not accurately measured by the Department. We recommend that certain controls be improved to prevent the enrollment of excluded recipients. We also recommend certain actions that could be taken by the Department to increase managed care enrollment and improve the accuracy of its performance measurement process.

Inappropriate Enrollments

Certain Medicaid recipients should not be enrolled in Medicaid managed care plans. The Department and Maximus have established controls that are intended to prevent the enrollment of such recipients. Through the State's automated Welfare Management System (WMS) and Electronic Medicaid Eligibility Verification System (EMEVS), the Department provides Maximus with information identifying recipients who should be excluded from managed care enrollment. Maximus then transfers this information to its own computer system (MAXSTAR), which is used in the enrollment process. In this way, recipients who should not be enrolled are identified before they can be enrolled.

We evaluated the effectiveness of these controls. We found the controls are usually effective, as they prevent the enrollment of most recipients who should not be enrolled. However, the controls are not always effective, because they do not always prevent the enrollment of certain excluded recipients: recipients who are eligible for both Medicare and Medicaid (known as dual eligible recipients).

Dual eligible recipients have primary health insurance coverage through Medicare; consequently, most of their eligible medical expenses are paid by Medicare. In some instances, Medicaid may be liable for a relatively small deductible or co-insurance payment for these recipients. In other instances (e.g., when a dual eligible recipient is enrolled in a Medicare managed care plan), Medicaid is not liable for any of the recipient's medical expenses. For these reasons, it usually is not cost-effective for dual eligible recipients to be enrolled in Medicaid managed care plans, and accordingly, it is the Department's policy that most dual eligible recipients be excluded from such enrollment. (Some dual eligible recipients, such as those in mental health programs, may be enrolled in Medicaid managed care plans, because a process has been developed for adjusting their monthly Medicaid managed care payments to account for their Medicare coverage).

While it is the Department's policy that dual eligible recipients usually be excluded from enrolling in Medicaid managed care, the Department did not always identify such recipients for Maximus through WMS and EMEVS. Also, some recipients do not become eligible for Medicare until after they are enrolled in managed care. As a result, Maximus was unable to exclude the recipients from managed care. Department officials told us that, in response to this problem, Maximus developed an automated process to disenroll dual eligible recipients. However, the process was not always accurate, as some of the recipients who were disenrolled should not have been disenrolled. Consequently, in May 2000, the Department instructed Maximus to disable the disenrollment process. Thus, dual eligible recipients continued to be enrolled.

To determine how many dual eligible recipients were inappropriately enrolled in managed care plans by Maximus, we obtained a list of dual eligible recipients from CMS. We then compared the names on this list to the names of the recipients who were enrolled in managed care plans by Maximus during the four years ended June 30, 2002. After making adjustments for the dual eligible enrollments that were allowable (such as individuals in mental health programs), we determined that a total of 11,202 recipients should not be enrolled in managed care. We also determined that, as a result of these enrollments, the Department made $46.3 million in monthly managed care premium payments that could have been avoided. We further determined that, as of June 1, 2002, 2,377 of these dual eligible

recipients were still actively enrolled in managed care plans, and the Department was paying more than $790,000 a month in premium payments for their enrollment. If these ineligible recipients were removed from managed care, the State would save over $9 million annually.

In response to our audit findings, Department officials stated that they re-examined the disenrollment process developed by Maximus and have found an alternative approach that should be effective. The officials also stated that, in September 2002, they instructed Maximus to implement an automated control that would prevent the mandatory managed care enrollment of recipients aged 64 or older (eligibility for Medicare generally begins at age 65). We note that 1,438 of the 2,377 dual eligible recipients (60 percent) who were inappropriately enrolled in managed care plans as of June 1, 2002 were aged 65 or older.

We agree that automated controls should be developed that would disenroll the dual eligible recipients who are currently inappropriately enrolled in managed care plans, and prevent the enrollment of such recipients in the future. We note the Department should identify such recipients for Maximus before the recipients are targeted for mandatory managed care enrollment. We further note that, in a prior audit report (Report 96-S-67 *Controls Over Certain Medicaid Payments to Managed Care Providers*), which was issued in April 1997, we alerted Department officials to the control weaknesses that allowed the inappropriate enrollment of dual eligible recipients and recommended that they correct these weaknesses. However, the control weaknesses were not addressed.

We also note that controls would be further strengthened if the form used by Maximus in the enrollment process were revised to enable recipients to disclose Medicare or other third-party insurance coverage.

Enrollment of Targeted Recipients

If the Department's program of mandatory managed care enrollment is successful in New York City, enrollment of eligible recipients (i.e., recipients who are not excluded or exempt) will be maximized. Enrollment is to be achieved in five phases, each of which focuses on a different area of New York City. We examined the actions taken in phase 1 (covering Staten Island, Southern Brooklyn and Southern Manhattan) and

phase 2 (covering Northern Bronx and Northeast/Central Queens), which together account for about 40 percent of the recipients in New York City who are eligible for enrollment in managed care.

The Department estimated that, as of June 30, 2002, a total of 1,215,606 Medicaid recipients in New York City were eligible for enrollment in a managed care plan, and 487,221 of these recipients lived in the areas covered by phase 1 and phase 2. As part of its efforts to monitor the progress made by Maximus in enrolling eligible recipients, the Department sets interim enrollment goals called targets, which are a certain percentage of the eligible population. Thus, at any point in time, the actual enrollment is compared against the targeted enrollment. As of June 30, 2002, the targeted enrollment for the areas covered by phase 1 and phase 2 was 86 percent of the eligible population of 487,221 recipients, or 419,010 recipients (257,318 recipients in the areas covered by phase 1, and 161,692 recipients in the areas covered by phase 2).

Phase 1 was initiated on August 9, 1999, and phase 2 was initiated on April 25, 2001. According to Department officials, it was expected that up to 15 months would be needed for the targeted enrollment to be reached in each phase. We examined the progress made by Maximus in achieving the targeted enrollment as of June 30, 2002. At this point in time, phase 1 had been in progress for about 34 months, and phase 2 had been in progress for about 14 months.

We found that, even though phase 1 had been in operation for far longer than 15 months, Maximus had yet to achieve the targeted enrollment for this phase, as according to Department records, only 217,936 recipients were enrolled in the areas covered by phase 1 (85 percent of the targeted enrollment of 257,318). We also found that, even though phase 2 had been in operation for nearly 15 months, Maximus was far short of achieving the enrollment goal for this phase, as only 119,003 recipients were enrolled in the areas covered by phase 2 (74 percent of the targeted enrollment of 161,692). Thus, the total enrollment in the areas covered by these two phases (336,939 recipients) was only about 80 percent of the targeted level (419,010 recipients).

Department officials told us that they took action in November 2001 to expedite the enrollment process. They stated that they

analyzed the non-enrolled Medicaid recipients in the areas covered by phase 1 and determined that a greater number of recipients could be selected for outreach efforts if certain changes were made in the process used by Maximus to identify such recipients. The officials stated that they instructed Maximus to make these changes, and as a result, information packets (with enrollment forms) began to be sent to a larger number of recipients. The officials stated their belief that enrollment was accelerated after these changes. They note that, in December 2002, after the changes had been in place for about one year, the enrollment in the areas covered by phase 1 reached the targeted level and the enrollment in the areas covered by phase 2 reached 96 percent of the targeted level.

We commend the Department for its efforts to increase enrollment. However, the progress reported by the Department is overstated to some extent, because the Department does not adequately take into account increases in the number of recipients who are eligible for participation in managed care plans. In the performance data reported by the Department for December 2002, the number of recipients enrolled as of December 2002 is compared to the number who were eligible as of January 2002, not the number who were eligible as of December 2002. Since the number eligible as of December 2002 was larger than the number eligible as of January 2002, the enrollment rates reported by the Department for December 2002 are overstated (we did not calculate the magnitude of the overstatement, since the period in question was outside our audit scope). We note that, while the Department updates actual enrollment data monthly, it does not update the number of eligible recipients at the same time. Rather, this number is updated only once or twice a year. If the target were adjusted each month to account for increases (or decreases) in the number of eligible recipients, the resulting measurements would be more accurate.

We also note that the accuracy of the performance information reported by the Department is undermined by its reliance on an estimate for the number of recipients eligible for participation in managed care plans. We believe the actual number of eligible recipients could be determined from information already maintained by the Department. We note that we were able to make this determination, as in the previous section of this report, when we identified the number of inappropriate dual

eligible recipients who were enrolled in managed care plans during the four years ended June 30, 2002.

We therefore recommend that the Department improve the accuracy of its performance information by determining the actual number of recipients eligible for participation in managed care plans, and adjusting enrollment targets monthly to account for increases or decreases in the number of eligible recipients.

Enhancement of Enrollment Efforts

The Department's efforts to improve the enrollment process in November 2001 focused on the selection of recipients for outreach. While this aspect of the process is important, equally important are the outreach activities that follow the mailing of the information packet to the selected recipients. These activities include the educational presentations in the recipients' communities and follow-up efforts to obtain completed enrollment forms. As is discussed later in this report, we identified a number of opportunities for improvement in the performance and monitoring of educational presentations. In addition, we determined that enrollment efforts could be enhanced if the Department performed certain types of analyses on a regular basis and used the results of these analyses to target certain communities, and certain recipients in those communities, for educational presentations and follow-up activities.

Specifically, we analyzed the extent to which the targeted recipients in the areas covered by phase 1 and phase 2 were enrolled in managed care plans within each zip code in those areas. We performed this analysis on the enrollment data maintained by the Department as of June 30, 2002. We found that, while the level of enrollment is fairly consistent in most of the zip code precincts (i.e., between 60 and 90 percent of the targeted population), it is significantly lower in a few of the precincts. If the Department performed this type of analysis, it could identify these low-enrollment communities and target them for additional educational presentations and other follow-up activities.

For example, while at least 60 percent of the targeted population was enrolled in managed care plans in most (48 of 61) of the zip code precincts covered by phase 1, less than 40 percent was enrolled in four of the precincts, including one

precinct in which less than 20 percent was enrolled. We believe this type of analysis could be especially helpful in phases 3, 4 and 5, as follow-up activities could be targeted to the areas where they are most needed.

Once an area has been analyzed by zip code, and certain communities within the larger area have been targeted for follow-up, further analysis can be performed to target individuals within the targeted communities. For example, with the assistance of research associates from the State University of New York at Albany, we used a linear regression model to analyze the geographic enrollment information in relation to certain demographic census data. The purpose of our analysis was to identify demographic factors associated with increases or decreases in managed care enrollment.

We identified a number of such factors. For example, we determined that each one-percent increase in the number of female-headed households with children in a zip code precinct leads to a 1.06 percent increase in the percent of the targeted population enrolled in managed care in that precinct. This information indicates that outreach and education activities are effective for such households. Similarly, we determined that each one-percent increase in the number of recipients in a zip code precinct without a high school diploma leads to a 0.41 percent increase in the percent of the targeted population enrolled in managed care in that precinct. This information indicates that enrollments could be increased if outreach and education activities were better geared to the needs of recipients without a high school diploma.

Recommendations

1. Develop and implement automated controls that will disenroll all dual eligible recipients who are excluded from managed care participation.

2. Identify for Maximus the dual eligible recipients who are excluded from enrollment in managed care plans, monitor the enrollments to determine whether any of these recipients are enrolled, and take corrective action if inappropriate enrollments are made.

3. Revise the managed care enrollment form used by Maximus to enable recipients to disclose Medicare or other third-party insurance coverage.

4. Improve the accuracy of the Department's measurement of the progress made by Maximus in achieving managed care enrollment goals by (a) determining the actual number of recipients eligible for participation in managed care plans and (b) adjusting enrollment targets monthly to account for increases or decreases in the number of eligible recipients.

5. Analyze by zip code the extent to which targeted recipients are enrolled in managed care plans and use the results of this analysis to target particular communities for educational presentations and follow-up activities. Supplement the zip code analysis with analyses that relate geographic enrollment information to demographic data to determine whether follow-up activities can be further targeted within each community.

OUTREACH ACTIVITIES

The recipients targeted for enrollment in managed care plans cannot be enrolled in a plan until a signed and completed enrollment form is received from the recipients. Maximus is expected to send enrollment forms with informational packets to the targeted recipients, and conduct presentations that educate the recipients about managed care procedures and choices. The informational packets and presentations are intended to enable the recipients to make informed decisions about their participation in a managed care plan.

We examined certain aspects of the outreach activities performed by Maximus. We also examined the Department's monitoring of these activities. We found that improvements were needed in both the performance of outreach activities and the Department's monitoring of the activities. In particular, surveys assessing the extent to which recipients were satisfied with the performance of Maximus generally were not conducted, even though such surveys were explicitly required by the terms of the contract. We also determined that information relating to the community presentations was not adequately maintained by Maximus and was not accurately reported to HRA. We recommend the Department more closely monitor the outreach activities of Maximus.

Assessing Recipient Satisfaction

Maximus was required by the original contract to assess recipients' satisfaction with managed care outreach and enrollment activities, and to make such assessments on a quarterly basis. When the original contract was extended in July 2000, this requirement was modified and Maximus was specifically required to assess recipients' satisfaction with the presentations made in the community. In the new contract that began in July 2002, Maximus continues to be required to make assessments of recipients' satisfaction with community presentations.

We examined whether the assessment requirements contained in the original contract and contract extension were met by

Maximus. We found that, generally, they were not met, as Maximus assessed recipient satisfaction during only 2 of the 51 months covered by the original contract and contract extension. As a result, the Department was less able to evaluate the effectiveness of Maximus's outreach activities and less able to identify changes that could improve the effectiveness of these activities.

Department officials indicated that, during the term of the original contract (April 1, 1998 through June 30, 2000), there was less need than originally anticipated for Maximus to assess recipients' satisfaction. This was because the Department conducted its own surveys of newly enrolled recipients, as required by CMS in May 1999, and conducted a series of focus groups that allowed recipients to comment on the managed care program, including their interaction with Maximus. Consequently, the Department told Maximus it did not have to perform surveys to assess recipient satisfaction.

We question whether the intent of the requirement in the original contract was fulfilled by the Department's survey and series of focus groups. First, the Department's survey of newly enrolled recipients was not initiated until October 1999. As a result, recipients were not surveyed at all during the first 18 months of the contract, even though the contract required that they be surveyed every three months. Second, while the Department's survey contained an extensive set of questions and was administered monthly to newly enrolled recipients between October 1999 and August 2001, only four of the questions addressed the enrollment process and none of these four questions explicitly addressed recipients' overall satisfaction with Maximus, as the contract required. Third, the Department provided no documentation indicating that any of the focus groups did in fact address recipients' satisfaction with the activities performed by Maximus.

Maximus did address the assessment requirement in the contract extension, as it initiated a pilot consumer satisfaction survey addressing the content and effectiveness of its community information meetings. Maximus administered this survey between February 26 and April 18 of 2001, at which time it notified the Department that the survey was on hold until the Department provided further direction on whether the survey should be continued. However, the Department did not provide any direction to Maximus until 14 months later in June 2002,

when it instructed Maximus to restart the survey. At this point, the contract extension was about to expire and the new contract was set to begin.

Department officials stated that they did not instruct Maximus to continue the survey because they wanted to ensure that Maximus could direct its available resources toward higher priority areas. Department officials also indicated that, since HRA does extensive, in-person monitoring of the community presentations, there was some basis for making assessments about the effectiveness of the presentations. We acknowledge that HRA's monitoring provides the Department with an informed opinion on the quality of the presentations. However, the opinions of HRA's staff are not necessarily the same as the opinions of the recipients who are to be enrolled in managed care plans, and it is the opinions of these individuals that were required by the contract extension.

We also note that, in its response to the Department's RFP for the new enrollment broker contract that began in July 2002, Maximus stated that it used a survey to obtain feedback from recipients about their satisfaction with community presentations. This statement was made in response to the RFP's requirement that such surveys be performed under the new contract. Maximus further stated in its response to the RFP that its survey results were tabulated monthly, distributed monthly within Maximus, and distributed quarterly to HRA and the Department. We determined that the survey described by Maximus in its response to the RFP was the pilot survey that was conducted between February 26 and April 18 of 2001. Since this survey process was in effect for less than two months, the statements made by Maximus in the response to the RFP appear to misstate the extent of Maximus's experience in this area. In the interests of fairness, we believe Maximus should have been requested by the Department to correct this misstatement. However, no such request was made.

Department officials stated that this inconsistency in Maximus's response to the RFP was inadvertent, relatively minor and not intended to mislead the reviewers. However, during the course of our audit, we readily identified another inconsistency in Maximus's response to the RFP. Specifically, in the Maximus Policies and Procedures Manual that was in effect at the time that Maximus responded to the RFP (September 2001), Maximus stated that for each staff making a presentation

(known as Field Enrollment Counselors), its Quality Assurance Department monitored one community presentation a month. However, in the response to the RFP, Maximus stated that the Quality Assurance Department monitored three presentations a month for each staff making a presentation. This appears to be another misstatement of Maximus's qualifications for the contract award.

The Office of the State Comptroller was ultimately responsible for approving the new contract with Maximus. In doing so, it relied on the accuracy of the information provided by bidders in their responses to the RFP. If Department officials knew that some of this information was not accurate, and they should have known that the information about the recipient surveys was not entirely accurate, they either should have sought to have the information corrected or disclosed the inaccuracies to the Office of the State Comptroller.

Community Presentations

In its performance of community presentations, during the period covered by the original contract and contract extension, Maximus was assisted by a number of Community-Based Organizations (CBOs). In some instances, the CBO provided the meeting space, while Maximus staff made the presentation. In other instances, the CBO was responsible for attracting recipients to the presentations, which were given by Maximus staff. There were also instances in which the CBO was expected both to attract recipients to the presentation and provide education and enrollment services for the recipients. In these instances, the staff of the CBO had to be trained to provide these services. In the new contract, the majority of the community-based services will be coordinated by a single subcontractor: Community Services Society of New York (CSS). Maximus plans to keep a small field staff to oversee CSS and maintain existing relationships with certain CBOs.

HRA created a unit that is responsible for monitoring the performance of Maximus. The unit reviews monthly performance reports submitted by Maximus, conducts annual on-site reviews of Maximus, assesses the effectiveness of the community presentations, and assesses the performance of the CBOs subcontracted by Maximus. The monthly performance reports contain information about the community presentations,

including the number of presentations held each month and the attendance at each presentation.

We examined the monthly reports submitted by Maximus during the contract extension. We compared the hard copy version of one of the reports, which was submitted to the Department and HRA, to the electronic version, which was submitted only to HRA (a separate electronic version was submitted to HRA so that information could readily be extracted by HRA for analysis) for the period January 2001 through March 2001. We also compared the information in the monthly reports to certain other information maintained by Maximus about its community presentations. This other information related to three CBOs that were judgmentally selected by us. We selected these CBOs from the 99 that were contracted by Maximus during the audit period because they appeared to be performing poorly based on enrollment figures from the area where the CBOs are located.

We found that the information in the hard copy monthly report did not always agree with the information in the electronic monthly report, as follows:

- One of the electronic monthly reports did not record a community presentation attended by 350 individuals (93 percent of the total attendees for that month). This presentation was recorded on the hard copy version of the report.

- Another electronic report did not record that a presentation in Queens was attended by no recipients, while the hard copy version of the report correctly indicated that there were no attendees.

- Two other electronic reports incorrectly recorded that presentations in Queens were attended by no recipients, while the hard copy version of the reports correctly indicated that the presentations were attended by a total of 21 individuals.

Department officials stated that the errors in the electronic reports were data-entry errors.

We also found that some community presentations were not recorded in any of the monthly reports (hard copy or electronic). For example, four presentations in the Bronx were not recorded

on any monthly report, but other documentation maintained by Maximus indicates that the presentations were held and paid for. If the information in the monthly reports is not reliable, managed care enrollment outreach activities cannot be effectively monitored by HRA and the Department. We recommend that steps be taken to improve the accuracy of the information contained in the monthly reports.

We also identified the following inconsistencies in information maintained by Maximus about CBOs and community presentations:

- Payment records indicated that a Queens-based CBO was paid for two community presentations, but there was no other documentation indicating that the presentations were actually made. For example, there were no sign-in sheets recording the names of the recipients who attended the presentations, no records indicating the presentations were attended by HRA or Maximus staff, and no record of the presentations on the monthly reports submitted by Maximus.

- For two of the three CBOs selected for review, some of the payment invoices lacked any signatures indicating that Maximus had reviewed the invoice and approved it for payment. According to Maximus officials, these invoices were initially submitted for payment without signatures, were rejected by their Finance Office, and were resubmitted after the appropriate signatures were obtained. However, according to the officials, Maximus inadvertently provided us with copies of the original unsigned versions of the invoices.

- A listing of subcontracted CBOs that was compiled by Maximus at our request was not complete, as during the course of our audit, we identified additional CBOs that were used by Maximus.

These inconsistencies indicate that the activities of the CBOs may not always be adequately overseen and payments to CBOs may not be subject to an appropriate level of control. We recommend that steps be taken to improve this oversight and control.

Recommendations

6. Require Maximus to assess recipient satisfaction in accordance with the requirements in the new contract, report the results of the assessments to the Department in a timely manner, and act on any areas of concern identified by the assessment results.

7. When current contractors submit proposals for new contracts, take steps to ensure that the staff who review the proposals correct or disclose any inaccuracies that are identified by their review.

8. Instruct Maximus to establish controls that provide assurance its monthly reports are complete and accurate, and verify the effectiveness of these controls.

9. Instruct Maximus to strengthen its oversight of CBO activities and its controls over payments made to CBOs, and verify the effectiveness of these controls.

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Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 16, 2003

Kevin M. McClune
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Re: Draft Audit 2002-S-11

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report 2002-S-11 entitled "Enrollment of Medicaid Recipients in Managed Care Plans in New York City."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix B

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2002-S-11 Entitled Enrollment of Medicaid Recipients in Managed Care Plans in New York City

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2002-S-11 entitled "Enrollment of Medicaid Recipients in Managed Care Plans in New York City."

Background

The Department holds a contract with Maximus, Inc. to perform education, outreach and enrollment functions in support of the Medicaid Managed Care and Family Health Plus programs for New York City, Nassau County and Suffolk County. The Department awarded a new two-year contract to Maximus that began in October 2002. Maximus completed a contract that covered April 1998 through September 2002, which includes the OSC audit period. In New York City, Nassau County and Suffolk County, Maximus has processed over 1,500,000 new enrollments and transfers, and handled over two million incoming phone calls. Over 800,000 voluntary and mandatory enrollment packets have been mailed since August 1999.

Enrollment in New York City increased from 376,874 in August 1999 to 1,093,927 in April 2003. New York City represents over 71 % of the statewide enrollment, as of April 2003. At the start of mandatory enrollment in New York City in August 1999, that figure was 56%. Even accounting for an increase in the Medicaid population, this represents tremendous growth in managed care enrollment in New York City. It is clear that the enrollment growth in New York City would have been difficult to achieve without the services of an enrollment broker and the effective management and oversight of those services by the Department in coordination with the New York City Human Resources Administration and the City Department of Health and Mental Hygiene. While there are always opportunities for improvement, the Department has effectively monitored the enrollment program in New York City and has always given priority attention to areas where the health services of the Medicaid population are impacted. The Department's program of continual monitoring and improvement, including the oversight of Maximus, coordination with affected agencies and the community, and prompt responses to problems to remedy or enhance existing policies and procedures, has helped form an effective enrollment program.

Background (continued):

The New York City enrollment program using Maximus has undergone numerous outside reviews and audits since it began in 1998. The Department has used these reviews and audits as an opportunity to reassess policies and procedures and make changes if needed. For example, the Department has already worked with Maximus to disenroll the Medicare-Medicaid dual eligible members, starting with the April 2003 enrollment roster, and improve the systems to prevent dual-eligible enrollments. Other observations in the report, such as those related to the pace of enrollment and actions that, in OSC's view, would improve enrollment, are not appropriate and in some cases overstate the significance of the findings.

The Department is committed to ensuring that the Medicaid population receives quality health care. How fast the managed care enrollment grows is important, but not at the expense of ensuring that the transition to managed care is done in an orderly and thoughtful manner that recognizes the sometimes difficult and dynamic life situations experienced by Medicaid consumers. That is why the Department closely monitors critical enrollment processes including the system to select consumers for mandatory enrollment, the auto-assignment process, and the exemption process, as well as post-enrollment quality indicators such as encounter data and satisfaction rates.

The following are the Department's responses to OSC's specific recommendations.

RECOMMENDATION #1:

Develop and implement automated controls that will disenroll all dual eligible recipients who are excluded from managed care participation.

RESPONSE #1:

In March 2003, the Department provided an electronic file to Maximus that identified the dual-eligibles enrolled in "mainstream" Medicaid managed care plans in New York City, Nassau County, and Suffolk County, as they appear on the State enrollment roster for April. Maximus disenrolled these dual-eligibles and sent notices to all affected members. Health plans were also advised of which members were being disenrolled because of the dual-eligible status. A similar file was provided for May enrollees. This process will continue on a monthly basis.

RECOMMENDATION #2:

Identify for Maximus the dual eligible recipients who are excluded from enrollment in managed care plans, monitor the enrollments to determine whether any of these recipients are enrolled, and take corrective action if inappropriate enrollments are made.

RESPONSE #2:

See the response to recommendation #1. Data on Medicare status is maintained on the Welfare Management System (WMS). That data is passed to Maximus through the eMedNY data system. In a recent sample, Maximus did not have Medicare data on 11 of 560 members that were identified on WMS. Although this would indicate only a small percentage of individuals are not correctly identified as having Medicare on the eMedNY and Maximus systems, the Department has chosen to provide its WMS data on Medicare status directly to Maximus to perform monthly disenrollments. Furthermore, an edit is now in place at WMS to prevent enrollments when Medicare status is showing on WMS. It is planned that WMS will eventually provide all eligibility data directly to Maximus rather than passing data through eMedNY, including the Medicare status. This will improve the synchronicity of the data systems.

The Department has noted cases where the Medicare status is not reflected in WMS and, conversely, cases where erroneous data on Medicare status has been passed from the federal Centers for Medicare and Medicaid Services (CMS) to the State. (OSC obtained its Medicare data directly from CMS.) The latter problem leads to inappropriate disenrollments that must be deleted to avoid disruption in care. The Department is working with the various agencies within the State that handle the Medicare data, as well as with CMS, to avoid false positives and false negatives. This demonstrates that what appear to be simple analyses like those performed by OSC to identify the enrolled dual eligibles, do not always lead to accurate results. While it is true that many dual eligibles were enrolled, proper identification is not as straightforward a process as OSC would lead readers to believe in its report.

* *Note 1*

RECOMMENDATION #3:

Revise the managed care enrollment form used by Maximus to enable recipients to disclose Medicare or other third-party insurance coverage.

RESPONSE #3:

The enrollment form used by Maximus was revised on February 24, 2003, to include a question that prompts the applicant to disclose third-party insurance, including Medicare. This will help prevent enrollments of dual-eligibles when the Medicare coverage is not shown in Maximus' or the State's data systems. However, most enrolled cases appear as a result of already-enrolled members gaining Medicare coverage, not new applicants.

RECOMMENDATION #4:

Improve the accuracy of the Department's measurement of the progress made by Maximus in achieving managed care enrollment goals by (a) determining the actual number of recipients eligible for participation in managed care plans and (b) adjusting enrollment targets monthly to account for increases or decreases in the number of eligible recipients.

* See State Comptroller's Notes, Appendix C

RESPONSE #4:

OSC makes inaccurate statements in its report regarding the progress of enrollment. Under "Enrollment of Targeted Recipients" in the draft report, OSC states that if enrollment is completely successful, "all the recipients who are eligible for enrollment" will eventually be enrolled. Throughout the report, OSC conveyed the misconception that at some point, "all" the eligible population will be enrolled in managed care. Medicaid is a dynamic program, with new people coming in, and others losing (and often regaining) coverage. Furthermore, since consumers have 60 days to choose a managed care plan, and plan enrollment is prospective to the next month, or the month after, there will always be a large number of consumers who are not enrolled. It is never possible that "all" eligibles will be enrolled at a single point in time. What is important is that the process to select individuals for mandatory enrollment is accurate. While it is true that enrollment growth was slower than expected in the early mandatory phases, the Department took action, prior to the OSC audit, to improve its methods for selecting consumers for mandatory enrollment. Those actions had a positive effect on enrollment, and demonstrate the Department's commitment to monitoring the enrollment effort in the mandatory program.

* *Note 2*

In its report, OSC acknowledges the Department's actions but comments on the methods for measuring enrollment penetration. There are a number of ways to derive a figure to use as the number of Medicaid eligibles and to measure enrollment. Each method has its shortcomings, and OSC's methods result in inaccuracies. For example, OSC uses estimates as to who is eligible or should be enrolled. OSC did not identify all excluded populations, thus overstating the number eligible for enrollment. To account for the fact that individuals new to Medicaid are not immediately enrolled, OSC used a time estimate of four months to determine who was still unenrolled because they were new to the Medicaid system. The combination of errors due to the need to make certain assumptions will cause any method of counting to be less than 100 percent accurate. The Department believes the changes recommended by OSC may only lead to marginal improvement, if any, compared to the methods currently used. OSC suggests that resources be used to update the managed care eligibles numbers monthly to better monitor the progress of enrollment. However, the month-to-month adjustments recommended by OSC would not result in data that is so improved in quality that it could be used to make programmatic changes or decisions based on a one-month "trend". The Medicaid population totals do not change so dramatically in a month that enrollment penetration estimates are outrageously inaccurate using the current methods. Instead, trends must be analyzed over time.

* *Note 3*

The Department commits that it will make efforts to update the managed care eligibles figure used in its managed care reports on a quarterly basis. The methods currently used to estimate the number of eligibles, updated quarterly, are adequate for purposes of comparing enrollment to the eligible population.

* *Note 3*

RECOMMENDATION #5:

Analyze by zip code the extent to which targeted recipients are enrolled in managed care plans and use the results of this analysis to target particular communities for educational presentations and follow-up activities. Supplement the zip code analysis with analyses that relate geographic enrollment information to demographic data to determine whether follow-up activities can be further targeted within each community.

RESPONSE #5:

New York City is a completely mandatory district now that enrollment is required in all five of the phases; there is no longer a voluntary program. In 2001, the Department analyzed areas that seemed to have lower than expected enrollment. As a result of that analysis, a population-based solution was implemented wherein the selection process for mandatory enrollment was expanded, always within the parameters of the program in terms of who is required to enroll. Those efforts have been effective. OSC's recommendation about targeting certain areas with lower enrollment might be relevant in a voluntary program, where the goal is to increase voluntary enrollment by reaching out to those communities with low enrollment. In a mandatory program, individuals are selected for mandatory enrollment based on their eligibility status. When selected, a mailing is sent to the household with a variety of educational materials and information that may be helpful to choose a health plan. Individuals do not remain unenrolled because of a lack of outreach by the Department. If these individuals are selected for mandatory enrollment and do not make a voluntary choice, they will be auto-assigned to a health plan. The Department is committed to make every effort to have individuals make voluntary choices. However, once selected, individuals become enrolled through choices or assignment, unless they apply for an exemption or exclusion. In its report, OSC implies that once a mailing is sent, outreach effort is necessary to make sure that a health plan choice is made, and that the lack of a health plan choice in certain communities, and a lack of outreach is why certain zip codes are "under enrolled." This view overlooks the concept of "mandatory enrollment." Auto-assignment will occur if a choice is not made, and enrollment will continue to increase. Therefore, the Department does not believe the OSC recommendation is an effective means of increasing enrollment or a prudent use of resources.

* ***Note 4***

With regard to existing outreach efforts, the Department has taken a number of steps to ensure that the Medicaid community is well informed. Demographic information and, in particular, language and related cultural nuances have been carefully considered and whenever possible integrated into the outreach and enrollment activities developed for the Medicaid managed care program. For example, the Department directed Maximus to conduct outreach efforts in several different languages and to develop informational materials in accordance with national standards for adult low literacy.

The Department directed targeted enrollment and outreach efforts through Maximus. Maximus conducted 58 targeted outreach activities in 2000, 74 events in 2001 and 82 targeted enrollment activities in 2002.

* See State Comptroller's Notes, Appendix C

RESPONSE #5 (continued):

Areas were targeted for various reasons including areas with high percentages of Medicaid beneficiaries, areas reflecting higher than average auto-assignment rates and zip codes that reflected specific language needs. In addition, mothers with young children were targeted through a publicized storytelling campaign in 2002 and through numerous events that were co-sponsored with the YMCA.

RECOMMENDATION #6:

Require Maximus to assess recipient satisfaction in accordance with the requirements in the new contract, report the results of the assessments to the Department in a timely manner, and act on any areas of concern identified by the assessment results.

RESPONSE #6:

The Department directed Maximus to resume consumer presentation surveys in June 2002. Sufficient data is available that show an overwhelmingly positive and consistent response to the presentations by consumers who attended and completed the survey. The Department plans to continue with presentation surveys. Should the results continue to be as consistent as they have been to date, the Department will reassess the usefulness of the surveys compared to the resources expended.

RECOMMENDATION #7:

When current contractors submit proposals for new contracts, take steps to ensure that the staff who review the proposals correct or disclose any inaccuracies that are identified by their review.

RESPONSE #7:

The Department was methodical in its approach to the reprocurement process for managed care enrollment broker services. This includes designing an RFP that was extremely detailed in its requirements, conducting a thorough evaluation of the responses in accordance with established guidelines, and being vigilant to maintain a level playing field for the incumbent and the new bidder. The OSC report states that Maximus made misstatements of its qualifications, implying that perhaps Maximus was improperly awarded the enrollment broker contract. There is no evidence to support a conclusion that Maximus is not qualified to perform the work it has been successfully performing for over four years. It is not appropriate for OSC to make broad comments on the procurement process based on chance findings made during an audit that did not include the procurement process in its scope. To imply that the Department was careless in its review based on the findings presented in the report is questionable.

* *Note 5*

RESPONSE #7 (continued):

The question of experience in the tasks involved in the response (the presentation surveys and quality assurance reviews) is not an issue. It is accurate that Maximus completed the development work, and actually used the survey in the field, and had full capability of carrying out the survey program as designed. Likewise, it is also accurate that at the time of the proposal Maximus had a fully functioning quality assurance program that included monitoring field enrollment counselors. In the context of a complex procurement and a proposal of over 800 pages, the minor inconsistencies noted do not support a finding that the procurement review and the actions of the Department were inadequate to support the contract award.

* *Note 5*

RECOMMENDATION #8:

Instruct Maximus to establish controls that provide assurance its monthly reports are complete and accurate, and verify the effectiveness of these controls.

RESPONSE #8:

Maximus produces a community presentation report (CPR-12) that is provided to the Department and the New York City Department of Health and Mental Hygiene, and the NYC Human Resources Administration (HRA). The hard copy of the CPR-12 is the report of record related to the presentations. Although the electronic version produced for HRA should be consistent with the hard copy of the CPR-12, it was not. It should be noted that the electronic version was only used by HRA for a special project, and not routine monitoring. OSC's assertion that this discrepancy affected the monitoring program on a long-term basis, or throughout the audit period, is incorrect. However the electronic report can be an important tool for oversight and the Department will work with Maximus to develop a quality assurance program that ensures the data is consistent across all reporting mechanisms.

* *Note 6*

RECOMMENDATION #9:

Instruct Maximus to strengthen its oversight of CBO activities and its controls over payments made to CBOs, and verify the effectiveness of these controls.

RESPONSE #9:

The Department has confirmed that Maximus has procedures in place to review presentation information and Community Based Organizations (CBO) performance. We will work with Maximus to strengthen the existing procedures in the areas of reports and payment information. Some of the OSC findings reflect data-entry problems that will be rectified through enhanced quality assurance checks. Much of the CBO activity is reflected in the CPR-12 report. The supervisors and lead counselors sign off on all CPR-12 reports for their respective team. The Administrative Assistant then reviews the hard

* See State Comptroller's Notes, Appendix C

RESPONSE #9 (continued):

copy presentation reports against the CPR-12 report. The Administrative Assistant checks to make sure that the data in the CPR-12 report matches the data on the hard copy.

With regard to payments, Maximus takes a series of steps when a CBO submits an invoice as follows:

- Maximus prints out a schedule for each month and confirms that the CBO was scheduled to hold a presentation at the time referenced on the invoice.
- The Community Relations Department checks that a presentation actually occurred and checks the status of consumers signing the attendance sheet to verify that these consumers are Medicaid eligible.
- An Outreach Specialist makes any adjustments and submits a payment request to the Community Relations Manager;
- The Community Relations Manager then reviews the payment request and upon his approval signs off;
- The Community Relations Manager submits the request to Maximus' Finance Manager for payment with supporting documentation;
- The Maximus Finance Manager retains signed invoices on file.

Maximus provided OSC with a complete and correct listing of subcontracted CBOs in a timely manner as requested by OSC. During the course of the audit, additional organizations were identified by OSC for which Maximus did not have subcontracts. Maximus made arrangements with CBOs for use of space without a formal contract.

State Comptroller's Notes

1. For the four years ended June 30, 2002, our audit found that the Department made $46.3 million in monthly managed care premium payments that could have been avoided. Department officials did not provide us with any feedback that our analysis was in error. As stated in our report, our methodology involved obtaining information from CMS, matching the information with recipients who were enrolled in managed care plans, and making adjustments for dual eligible enrollments that were allowable. Hence, our analysis was thorough and done with due professional care.

2. We recognize that Medicaid is a dynamic program and that it is never possible that "all" eligibles will be enrolled at a single point in time. Hence, we clarified page 7 of our report to state as follows: "If the Department's program of mandatory managed care enrollment is successful in New York City, enrollment of eligible recipients (i.e., recipients who are not excluded or exempt) will be maximized."

3. The intent of our recommendation is to improve the accuracy of the Department's measurement of progress made by Maximus in achieving managed care enrollment goals. While no estimation method may be completely accurate, our audit found that the Department's method overstated progress, because it compared eligible recipients from a prior period to those enrolled at a later date. We did not develop or propose an alternative method in our report, as is stated in the Department's response, but recommended that in measuring success, the Department compare recipients (eligible and enrolled) for the same period. In its response, the Department has stated its commitment to updating the managed care eligibles figure used in its managed care reports on a quarterly basis. Although enrollment figures, which are updated monthly, will still be compared with eligible figures from an earlier time period, a quarterly update of eligible figures is an improvement over the process that is currently used.

4. The analysis of enrollment in our report focused on phases 1 and 2, which covered the mandatory enrollment of eligible recipients into managed care in certain parts of New York City. We found that despite the use of auto-assignment, enrollment of eligible recipients in certain zip code precincts was under 40 percent, and in one instance, under 20 percent. We believe that the Department needs to continue to use analyses, like the one we proposed, to determine why enrollment rates are not higher in certain areas. Further, reliance on the auto-assignment process can negatively affect recipient satisfaction and has been demonstrated to be an unreliable safety net for mandatory enrollment because, as we found in phases 1 and 2, all those eligible for enrollment who did not voluntarily choose a managed care plan were not enrolled through the auto-assignment process.

5. We do not conclude that Maximus is not qualified to perform the work it has been contracted to undertake. In fulfilling the objectives of our audit, we identified certain inaccuracies in the contract documents and stated that such inaccuracies should be corrected and disclosed.

6. We do not assert that the discrepancies we identified affected the monitoring program on a long-term basis or throughout the audit period. We state that managed care activities can not be effectively monitored without reliable information.