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**New York State Office of the State Comptroller**  
Thomas P. DiNapoli

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Division of State Government Accountability

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# **Unnecessary Managed Care Payments for Medicaid Recipients with Medicare**

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## **Medicaid Program Department of Health**

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Report 2010-S-75

April 2012

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## Executive Summary

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### Purpose

To determine whether the Department of Health (Department) made premium payments to Medicaid managed care plans for Medicaid recipients who also had Medicare health insurance coverage.

### Background

Medicaid recipients who also have Medicare coverage are referred to as “dual eligibles”. Generally, as payer of last resort, Medicaid only pays a dual eligible recipient’s coinsurance and deductible amounts. In accordance with Department policy, dual eligible recipient should not be enrolled in managed care plans as the premium payment for managed care normally exceed what Medicaid would have paid for a recipient’s coinsurance and deductibles. The Department should ensure that dual eligible recipients are disenrolled from managed care plans to avoid payment of monthly premiums.

### Key Findings

- For the three years ended May 31, 2010, auditors 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 disenrolled timely from managed care plans once their Medicare data was posted to eMedNY.

### Key Recommendations

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

### Other Related Audits/Reports of Interest

[Department of Health: Medicaid - Payments for Medicare Part A Beneficiaries \(2009-S-36\)](#)

[Department of Health: Medicaid Payments for Dual Eligible Individuals \(2009-S-64\)](#)

**New York State  
Office of the State Comptroller**

**Division of State Government Accountability**

April 18, 2012

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

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls intended to safeguard assets.

Following is a report of our audit of the Medicaid Program entitled *Department of Health: Unnecessary Managed Care Payments for Medicaid Recipients with Medicare*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

*Office of the State Comptroller  
Division of State Government Accountability*

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This report is also available on our website at: [www.osc.state.ny.us](http://www.osc.state.ny.us)

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## Background

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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 to people with permanent kidney failure.

Medicaid is a federal, State and local health insurance program. At the federal level, Medicaid is administered by CMS. In New York, the Medicaid program is further administered by the State Department of Health (Department), local county departments of Social Services and the New York City Human Resources Administration (HRA). Medicaid serves low-income and financially-needy people and includes the Family Health Plus (FHP) component. FHP provides health care to about 400,000 adults with incomes and/or assets slightly above the normal thresholds for Medicaid eligibility.

In recent years, the Medicaid program grew significantly with enrollments increasing from 4.6 million individuals in 2007 to 5.2 million individuals in 2010; an increase of almost 600,000 enrollees. Between March 31, 2008 and March 31, 2011, Medicaid costs increased about \$10 billion to total \$53 billion (including about \$1.1 billion annually for FHP). In some instances, Medicaid pays providers directly under fee for service arrangements. In other instances, Medicaid recipients are enrolled in a managed care organization (MCO) and the MCO charges the Medicaid program a monthly premium for each enrolled Medicaid 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 cost of their Medicaid managed care monthly premium usually exceeds the cost of coinsurance and deductibles that Medicaid is obligated to pay when medical services are rendered to these individuals. During our audit period, the average monthly premium for managed care coverage for a Medicaid recipient was \$412, and the average monthly cost to cover coinsurance and deductibles for a dual eligible person averaged only \$278. Hence, the Medicaid claims for dual eligible individuals should be reimbursed on a fee-for-service basis. The Department’s eMedNY computer system processes and pays Medicaid claims, including those for dual eligible individuals.

Pursuant to Section 364-j of the Social Services Law, the Department contracts with an “enrollment broker” to provide education, outreach and enrollment services for the Medicaid managed care program. The enrollment services include the responsibility to remove recipients from Medicaid managed care programs, when necessary. The Department contracts with Maximus, Inc. to provide these services in New York City and a number of other counties in the State. 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.

The removal of dual eligible recipients from Medicaid managed care programs is often a two-stage process. First, the Department must identify Medicaid recipients that are Medicare eligible by periodically exchanging data with CMS. Once Medicare eligibility data is posted to eMedNY, the Department and the localities (as well as Maximus) can identify recipients who should no longer be enrolled in managed care. Generally, the Department relies on the local districts and the broker to remove dual eligible recipients from managed care programs, and thereby, avoid the unnecessary payment of monthly premiums.

## Audit Findings and Recommendations

To prevent improper managed care payments for Medicaid recipients covered by Medicare, recipients' Medicare enrollment data must be posted timely to eMedNY. Further, localities and the enrollment broker (Maximus) must use the Medicare data to remove these recipients from the State-funded managed care programs timely. However, we identified significant weaknesses in both of these processes. Consequently, for the three years ended May 31, 2010, we identified nearly 271,000 unnecessary Medicaid managed care payments (totaling about \$111.4 million) that were made on behalf of 45,000 Medicare recipients who were ineligible for Medicaid managed care programs.

The Department and the localities should have ensured that dual eligible recipients were removed from Medicaid managed care programs and provided with fee-for-service coverage. For such persons, Medicaid would pay their normal out-of-pocket costs (for deductibles, coinsurance or copayments). Thus, the avoidance of the \$111.4 million in improper managed care payments would have been partially offset by payments for recipients' out-of-pocket costs. Based upon the costs that should have been incurred, we estimate that the State could have realized net savings of about \$36 million by better ensuring that Medicare-eligible persons were removed from Medicaid managed care on a timely basis. As such, the Department should take actions promptly to correct the weaknesses that contributed to the improper managed care payments, as detailed subsequently in this report.

### Delays in Posting Recipients' Medicare Data to eMedNY

During our 36-month audit period, the Department improperly paid 207,425 monthly premiums (totaling about \$86.2 million) for 32,165 Medicaid recipients because their Medicare enrollment data was not posted to eMedNY timely. The improper payments included 22,022 claims (totaling about \$6.3 million) for FHP recipients. Once enrolled in Medicare, dual eligible persons were ineligible for Medicaid managed care programs. However, for one recipient, Medicaid paid monthly premiums (totaling \$19,680) for 36 months after the recipient became Medicare eligible.

The following table below summarizes the improper payments that resulted from delays in posting recipients' Medicare eligibility information to eMedNY.

Length of Delay in Posting Medicare Eligibility Date to eMedNY	Number of Improper Managed Care Claims Paid by eMedNY	\$ Amount of Improper Premium Payments
Less Than 31 Days	23,433	\$10,073,006
31 to 60 Days	19,573	\$8,169,249
Over 60 Days	164,419	\$67,953,006
Totals	207,425	\$86,195,261

Of the 164,419 managed care claims paid more than 60 days after recipients became Medicare eligible, 109,566 claims (totaling more than \$46 million - and representing nearly 68 percent of the amount of such claims) were paid at least six months after the recipients became Medicare eligible.

The Department could have avoided some of the improper premium payments if Medicaid staff made better use of the "Buy-In Span," a function within eMedNY's Third Party subsystem. The Buy-In Span function contains Medicare eligibility data which is posted when the Department elects to "Buy-In" for Medicaid recipients by paying their Medicare Part B premiums. However, Department staff generally did not use the Buy-In Span function to identify recipients' Medicare eligibility and, therefore, Medicaid made improper managed care payments. The Department could have prevented 4,785 payments (totaling nearly \$2.2 million), if staff accessed Medicare data through the Buy-In Span function and terminated recipient's enrollments in Medicaid managed care programs. In one instance, Medicaid paid 24 monthly premiums (totaling \$6,309) after the Buy-In Span function indicated the recipient was Medicare eligible.

We note that the Department has taken steps, in recent years, to post Medicare data to eMedNY sooner. Prior to October 2009, the Department obtained this data monthly. However, when obtained monthly, the data often was not posted to eMedNY as timely as possible. Thus, in October 2009, the Department started to obtain Medicare data from CMS weekly. Also, in July 2010, the Department began using a "third party query" which allows eMedNY to identify and assess potential Medicare recipients who did not meet the criteria for inclusion in the other files previously obtained from CMS.

Nevertheless, despite the Department's recent efforts, eMedNY continued to make significant amounts of improper managed care payments at the time of our review. According to Department officials, Medicare eligibility information sometimes was not up-to-date for certain dual eligible recipients. They added that some improper payments were attributable to the retroactive enrollment of Medicaid recipients in Medicare. However, the Department had not formally determined how often retroactive Medicare enrollments took place and what actions could be taken to prevent the related managed care payments by eMedNY. Thus, Department officials should formally review this matter and develop new policies and procedures to address it.

Department officials acknowledged our findings and are developing steps to address them. Specifically, they will require localities to cross-reference managed care enrollment when establishing Buy-In cases. Department officials also indicated that they further enhanced processes (in September 2011 - after our audit fieldwork ended) to update eMedNY with Medicare eligibility data received from CMS. According to officials, the enhancements eliminated previous delays in posting Medicare eligibility data to eMedNY and improved the overall integrity of eMedNY's Medicare-related data.

## Recommendations

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.

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.

## Local District and Broker Delays in Removing Recipients from Managed Care

When the Department receives Medicare eligibility data from CMS, it updates WMS (which then updates eMedNY). The Department also provides the local districts with rosters that include Medicare eligibility data for recipients currently enrolled in a Medicaid managed care program. The local districts should review the Medicare eligibility data on eMedNY and remove recipients from managed care programs, when appropriate, on a timely basis. The Department also provides Maximus (the enrollment broker) with Medicare rosters which should be used to remove recipients from the Medicaid managed care programs. Although Department staff can remove Medicare recipients from Medicaid managed care, the Department generally relied upon the localities and the broker to do this.

However, the localities and enrollment broker did not remove many Medicare recipients from Medicaid managed care programs timely. As a result, the Department improperly paid 63,327 monthly premiums (totaling about \$25.2 million) for 32,607 dual eligible recipients who were ineligible for Medicaid managed care. Of these people, 19,417 were among the 32,165 recipients for whom Medicare eligibility data was not posted to eMedNY timely, as detailed previously. Also, the inappropriate payments included 22,377 claims (totaling more than \$5.6 million) for FHP recipients.

The table below summarizes the number of months that premiums were paid after the Medicare eligibility information was added to eMedNY and the amounts of the corresponding improper premium payments.

Period Between Date Medicare Data Was Posted to eMedNY and Date Managed Care Premium Was Paid	Number of Improper Managed Care Claims Paid by eMedNY	\$ Amount of Improper Premium Payments
Less Than 31 Days	1,654	\$992,781
31 - 60 Days	24,463	\$11,019,279
Over 60 Days	37,210	\$13,246,827
Totals	63,327	\$25,258,887

Local districts and the broker often need some time to respond to Medicare eligibility data posted to eMedNY and to remove recipients from managed care programs. Consequently, Department officials believe it is reasonable for Medicaid to make up to two monthly premium payments after Medicare eligibility data has been posted to eMedNY. However, as the table illustrates,

Medicaid made 37,210 monthly premium payments (totaling more than \$13.2 million) more than two months after eligibility data was posted to eMedNY. For one recipient, Medicaid paid 36 monthly premiums (totaling \$17,582) after the recipient's Medicare eligibility data was posted. The 63,327 improper payments include 20,011 claims (totaling more than \$4.9 million) for FHP enrollees.

Multiple factors contributed to these overpayments, as follows:

- The Department does not actively monitor local districts and the broker to ensure they remove ineligible recipients from managed care timely. In particular, the Department lacks a formal process, including quantitative analysis (such as those presented in this report), to assess efforts by the localities and the broker to terminate the managed care enrollment of recipients with Medicare coverage;
- The agreement between the Department and the broker has performance standards for several Medicaid program objectives. However, the agreement lacks measureable standards for removing dual eligible persons from Medicaid managed care. Consequently, there was less incentive for the broker to make the timely removal of such persons from managed care a high priority; and
- The Department did not adequately ensure that Medicare eligible recipients were removed from FHP managed care programs timely. Specifically, the Department has not emphasized the need for local districts, particularly those served by the broker (which does not handle FHP), to periodically evaluate FHP recipients' eligibility for Medicare coverage. This could have limited local districts' efforts to identify such recipients and end their enrollments in FHP managed care programs.

Department officials indicated that they plan to take steps to address our findings. Specifically, they will determine the feasibility of upgrading the broker's current monthly Medicare file disenrollment process to a daily or weekly process. In addition, officials will formulate a plan to periodically review local district efforts to remove Medicare recipients from Medicaid managed care programs.

## Recommendations

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

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## Audit Scope and Methodology

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Our objective was to determine if the Department paid improper monthly premiums because Medicare recipients were not removed in a timely manner from Medicaid managed care programs. Our audit period included the prior three years ending May 31, 2010.

To accomplish our objectives, we interviewed Department officials, reviewed applicable sections of Federal and State laws and regulations, and examined the Department's relevant policies and procedures. We also analyzed pertinent eMedNY data and submitted small samples of questionable managed care payments to Department officials for their review and comment.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. 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 (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

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## Authority

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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.

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## Reporting Requirements

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We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials indicated that certain actions are planned or have been taken to enhance the processes for posting Medicare eligibility data to eMedNY and thereby eliminate improper Medicaid managed care payments. Also, our rejoinders to the Department's comments are included as State Comptroller's Comments.

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

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## Contributors to this Report

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**Brian Mason**, Audit Director  
**Dennis Buckley**, Audit Supervisor  
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**David Schaeffer**, Staff Examiner

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## Division of State Government Accountability

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### Vision

A team of accountability experts respected for providing information that decision makers value.

### Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

# Agency Comments



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

Sue Kelly  
Executive Deputy Commissioner

February 01, 2012

Brian E. Mason, Audit Director  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street, 11<sup>th</sup> Floor  
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2010-S-75 entitled "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Sue Kelly". The signature is written in a cursive style with a long, sweeping tail that extends to the right.

Sue Kelly  
Executive Deputy Commissioner

Enclosure

cc: James C. Cox  
Jason A. Helgeson  
Robert LoCicero, Esq.  
Diane Christensen  
Stephen Abbott  
Dennis Wendell  
Stephen LaCasse  
Ronald Farrell  
Barry Benner  
Irene Myron  
John Brooks

**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2010-S-75 on  
Unnecessary Managed Care Payments for  
Medicaid Recipients with Medicare**

The following are the Department of Health's (Department) comments in response to Office of the State Comptroller (OSC) Draft Audit Report 2010-S-75 on "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare."

**Recommendation #1:**

Advise Department staff to check the "Buy-In Span" subsystem to identify the potential Medicare eligibility of Medicaid recipients. Post such information, as necessary, to eMedNY to prevent improper 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.

**Responses #1 & #2:**

These OSC recommendations appear to be based on information in the draft audit report which does not fully reflect current operations and which also does not fully take into account limitations with the CMS data received by the Department which are beyond the Department's control.

Initial contact with potential enrollees occurs at the local district level where standard practice is for local district staff to inquire with each individual on their Medicare enrollment status. In cases where the individual indicates Medicare coverage, the local district staff person collects their Medicare data and enters it into the eMedNY Third Party subsystem (there is no Buy-in Span subsystem). In cases where the individual is eligible for Medicaid but has indicated they do not have Medicare coverage, the individual is enrolled in Medicaid by the local district and their personal identifying information is included in the Department's next routine data exchange with CMS for confirming Medicare enrollment. As of September 2011, these data exchanges occur weekly and eMedNY is directly updated with the Medicare coverage data received from CMS. These weekly CMS updates are sufficient to disenroll Medicare recipients from Medicaid managed care, although the CMS data sometimes reports retroactive Medicare coverage which is problematic since disenrollment from Medicaid managed care can only occur prospectively. The enhancements implemented in September 2011 have eliminated the previous delays in posting the Medicare eligibility data received from CMS, and have improved the overall integrity of the Medicare data maintained in eMedNY. Further significant improvement would require CMS to

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Comment  
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\* See State Comptroller's Comments, page 16.

resolve the causes for it needing to report retroactive Medicare coverage which the Department understands necessitates the involvement of the Social Security Administration.

Medicare coverage data maintained in eMedNY is routinely reviewed by Department staff which utilize this data as the basis for identifying cases for the enrollment manager, Maximus, to review and, where warranted, disenroll individuals from Medicaid managed care.

The Department will formally remind all local districts of the importance of timely entering Medicare eligibility data into eMedNY at the time of initial application and anytime thereafter when the information becomes known to the district.

**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.

**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.

**Responses #3 & #4:**

The Department does actively monitor the broker's performance which has been consistently satisfactory based on the timing of its receipt of data and program policy. The Department will, however, determine the feasibility of upgrading the broker's current monthly Medicare file disenrollment process to a daily or weekly process. The Department will additionally formulate a plan for periodically reviewing local district performance that recognizes local districts generally lack the resources needed to enhance their operations. The Department anticipates that overall improvement will result from the changes implemented in September 2011 (addressed above), and believes further improvement is possible if daily or weekly broker processing can be implemented. The optimal solution, however, requires changes in the provision of data from the source at the federal level.

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Comment  
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**Recommendation #5:**

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

**Response #5:**

The agreement with the broker already requires that disenrollments occur on a timely basis upon the broker's receipt of necessary data, which the broker continues to comply with.

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\* See State Comptroller's Comments, page 16.

**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.

**Response #6:**

The Department issued a General Information Service message on November 14, 2011, formally reminding all local districts of the importance of adhering to appropriate Medicare/Managed Care policy. The Department will additionally formulate a plan for reviewing the adequacy of current policy and procedures.

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## State Comptroller's Comments

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1. We updated our report to reflect enhancements the Department made, after the completion of our audit fieldwork, to further eliminate delays in posting Medicare eligibility data to eMedNY. In addition, we acknowledge that limitations in Medicare data (including retroactive Medicare enrollments) impair efforts to prevent improper Medicaid managed care payments. Nonetheless, most of the improper managed care payments we identified were within the control of the Department and/or the localities, and consequently, officials should take actions to prevent such improper payments in the future.
2. The Buy-In Span is a function, within eMedNY's Third Party subsystem, which indicates the effective date(s) of a Medicaid recipient's Medicare enrollment. As noted in our report, Medicaid could have avoided nearly \$2.2 million in improper managed care payments if State or local officials accessed pertinent Medicare data through the Buy-In Span function. We have amended our report to clarify the relationship between the Buy-In Span function and the Third Party subsystem.
3. We question the adequacy of the Department's monitoring of the broker's performance as well as the Department's assertion that the broker's performance was satisfactory. As detailed in our report, the Department lacked a formal process (including quantitative analysis) to assess the broker's and the localities' efforts to terminate Medicaid managed care for Medicare recipients timely. Further, during our audit period, Medicaid made nearly 63,000 improper managed care payments (totaling about \$25.3 million) for recipients after their Medicare data was posted to eMedNY. Most of the improper payments were authorized by localities served by the broker - and Department officials were unaware of the full extent of the improper payments.
4. Although the agreement requires the broker to remove Medicare recipients from Medicaid managed care timely, the agreement lacks measureable performance standards for timeliness. For example, the agreement does not require the broker to remove Medicare recipients from managed care within a specified period (i.e., within 60 days of Medicare enrollment). As detailed in our report, Medicaid made nearly 37,000 managed care payments more than 60 days after enrollees' Medicare data was posted to eMedNY. Most of these payments were authorized by localities served by the broker. Hence, the Department should add measureable performance standards to the broker agreement to help ensure that Medicare recipients are removed from Medicaid managed care timely.