NEW YORK STATE OF OPPORTUNITY. Department of Health

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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 19, 2020

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2019-F-33 entitled, "Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance" (Follow Up to Report 2016-S-60).

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Jeffrey Hammond
Geza Hrazdina
Daniel Duffy
Erin Ives
Brian Kiernan
Timothy Brown
Jill Montag
James Dematteo
James Cataldo
Lori Conway
OHIP Audit

Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2019-F-33 entitled, "Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance" (Report 2016-S-60)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2019-F-33 entitled, "Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance (Report 2016-S-60)".

Recommendation #1:

Work with HMS to amend data-sharing agreements with third-party insurers to require more frequent insurance updates, such as weekly updates.

Status – Partially Implemented

Agency Action – Our initial audit found that timely identification of recipients' comprehensive TPHI is essential to preventing inappropriate managed care premium payments. Although we found HMS updated data-sharing agreements with some insurers to increase the frequency of TPHI updates, we found no updates to agreements with the vast majority of insurance carriers who still provide insurance information monthly or less frequently, such as quarterly. According to OMIG, HMS is continuing to pursue weekly update files from insurance carriers. We analyzed mainstream managed care premium payments made during the one-year period from October 2018 through September 2019, and identified $199 million in premiums that were paid on behalf of recipients who also had comprehensive TPHI coverage (see Table 1).

TPHI Information	Premiums Paid	Percent of Total
Not in eMedNY	$158,385,325	80%
In eMedNY	40,330,614	20%
Total	**$198,715,939**	

As shown in Table 1, about 80 percent of the improper premium payments were made on behalf of enrollees whose comprehensive TPHI was unknown to the Medicaid program at the time premium payments were made. We provided the claim data for these premium payments to the Department and OMIG for their review and recovery, as appropriate. Although New York State law does not specify how frequently insurers must provide coverage information, it does require insurers to provide coverage information upon the State's request. Therefore, the Department, OMIG, and HMS should continue to pursue more frequent insurance updates from carriers to reduce improper Medicaid premium payments.

Response #1:

The Office of the Medicaid Inspector General's (OMIG's) contractor, Health Management Systems, Incorporated (HMS), has updated agreements with several insurers to increase the frequency of insurance updates, and continues to pursue weekly update files from the remaining insurers to ensure Third Party Health Insurance (TPHI) information is loaded timely into eMedNY. When the TPHI information is loaded into eMedNY, the Department notifies recipients of their prospective disenrollment from their managed care plan and afforded due process rights should they wish to challenge the disenrollment.

Recommendation #2:

Work with the LDSS to implement new processes that would allow for more effective, efficient, and timely identification and disenrollment of individuals with comprehensive TPHI from managed care.

Status – Implemented

Agency Action – The Department relies on LDSS to promptly remove LDSS-enrolled recipients with comprehensive TPHI from managed care. To help with this process, the Department produced a monthly report for use by each LDSS that listed all mainstream managed care enrollees with TPHI. During our initial audit, however, we found this report listed enrollees with other third-party insurance, like Medicare, and was not limited to – and did not specify – enrollees with comprehensive TPHI. LDSS officials explained that, as a result, they were not able to efficiently and effectively use the report to identify enrollees with comprehensive TPHI and initiate disenrollment.

After our initial audit, the Department worked to develop a more useful report for the LDSS. According to the Department, this report provides only the listing of active Medicaid mainstream managed care recipients with comprehensive TPHI coverage. Our follow-up review found that the percentage of improper payments that occurred after TPHI information was updated on eMedNY has decreased from 46 percent in our initial audit period to 20 percent during the past year. This indicates the revised report has reduced improper payments by reducing the average time to initiate disenrollment.

Response #2:

The Department appreciates the recognition that it has implemented processes in partnership and with input from the Local Departments of Social Services (LDSS) and the New York City Human Resources Administration (HRA) to further assist them in carrying out their responsibilities.

Recommendation #3:

Implement controls, such as a system edit, to identify non-NYSOH-enrolled recipients with comprehensive TPHI and promptly remove them from managed care.

Status – Partially Implemented

Agency Action – The Department has system edits, or rules, within NYSOH to automatically disenroll individuals found to have comprehensive TPHI from managed care. However, our initial audit determined the Department did not develop similar controls to identify non-NYSOH-enrolled individuals – individuals enrolled by LDSS using the Welfare Management System (WMS). In response to our audit, the Department stated it did not intend to pursue system edits (for non-NYSOH-enrolled recipients) because it was continuing to transition many of these recipients (WMS Modified Adjusted Gross Income [MAGI] Medicaid recipients) to NYSOH.

According to Department officials, as of May 2019, all LDSS except for New York City transitioned their MAGI population into NYSOH. The NYC transition was paused due to system issues, but the Department expects to resume it in February 2020. However, Department officials could not

anticipate the timeline for completion of this transition. Even after this transition is complete, some of the MAGI population (e.g., pregnant women) in addition to the non-MAGI population will continue to be enrolled through LDSS. Therefore, Medicaid will continue to be at risk of making improper payments on behalf of this population without additional controls.

As of September 2019, LDSS enrolled 1.2 million (about 28 percent) of the mainstream managed care recipients. Of this number, 288,623 were enrolled by a LDSS where the transition of the MAGI population to NYSOH had already been completed. As shown in Table 1, over $40 million of the $199 million in improper premium payments we identified were on behalf of mainstream managed care enrollees whose third-party information was known at the time of payment. Therefore, we strongly encourage the Department to consider additional system controls to prevent future improper payments.

Response #3:

The Department has implemented controls to identify non-New York State of Health (NYSOH)-enrolled recipients with comprehensive TPHI and promptly remove them from managed care. First, as stated above, the Welfare Management System New York City transition to NYSOH is ongoing. Once concluded, the Department expects this transition will address most of these payment issues. Second, the Department has allocated additional resources to take over the prospective disenrollment process from LDSS and HRA who are not able to complete the disenrollment process from managed care to fee-for-service timely. As a result, the average time for this process has been reduced from six to two months. Since December 2018, the Department has successfully disenrolled 23,066 members, resulting in avoidance of $41.5 million in premium payments. Third, the Department has implemented processes in partnership and with input from the LDSS and HRA to further assist them in carrying out their responsibilities for both prospectively and retroactively disenrolling recipients with comprehensive TPHI.

Recommendation #4:

Perform more frequent reviews to identify and recoup premium payments from MCOs for recipients with comprehensive TPHI beyond those payments already reported by the LDSS.

Status – Implemented

Agency Action - As a result of our initial audit, OMIG's contractor, HMS, initiated ongoing reviews of paid premiums for recipients with comprehensive TPHI. Upon request, OMIG provided a summary of HMS' findings for the first three quarters of 2019 and an example of a letter sent to an MCO directing it to review and refund any overpayments.

Response #4:

The Department confirms agreement with this report.

Recommendation #5:

Maintain lists of MCO and insurer relationships to aid in the identification of managed care premium recovery opportunities.

Status – Partially Implemented

Agency Action - The Managed Care Model Contract stipulates that the Department may recover premiums paid to MCOs for enrollees who have concurrent comprehensive TPHI provided by the same entity as the MCO or by a parent, subsidiary, or sister entity of the MCO. During our audit scope, the Department could not recover premium payments when the MCO and third-party insurer were not related.

As a result of our initial audit, the Department sent emails to mainstream MCOs requesting a list of their other insurance products. Based on the responses, the Department compiled a list of MCO and insurer relationships, and shared the list with LDSS to assist in the identification of premium recovery opportunities. Department officials stated they are still working on a process to update this list on a continuous basis. We note that some of the largest MCOs did not comply with the Department's request. The Department should continue to pursue this information as it is important to the managed care premium recovery process.

Response #5:

The Department has implemented this recommendation. It recently contacted Managed Care Organizations (MCO) to obtain a current listing of MCO/Insurer relationships. MCO responses were compiled and this listing is complete. The Model Contract currently under review by the Centers for Medicare and Medicaid Services contains a new contract provision affirming that the State can retroactively disenroll an enrollee if the enrollee is simultaneously enrolled or in receipt of comprehensive health care coverage, regardless of the Medicaid MCO and third-party insurer relationship. This expands the State's authority to recover premium payments whether or not the Medicaid MCO and third-party insurer are within the same legal entity. Once this provision is effective, this listing will not require future updating because the relationship will no longer be required for retroactive disenrollment.

Recommendation #6:

Review the managed care premium payments we identified and recover as appropriate.

Status – Partially Implemented

Agency Action - Our initial audit identified $1.28 billion of managed care premium payments made to MCOs on behalf of enrollees with comprehensive TPHI. This comprised $26.9 million where the Medicaid MCO and third-party insurer were the same legal entity and $70.6 million where they were related through some form of ownership (such as parent, subsidiary, or affiliate). OMIG investigates and recovers improper Medicaid payments on behalf of the Department. During our initial audit, we provided OMIG with a file containing the overpayments we identified. As of September 6, 2019, only about $19 million of the improper payments we identified was recovered, as shown in Table 2.

Year	Same Legal Entity		Related Company		Total	
	Recovered Amount	Unrecovered Amount	Recovered Amount	Unrecovered Amount	Recovered Amount	Unrecovered Amount
2012	$1,309,578	$1,668,203	$1,253,399	$5,627,102	$2,562,977	$7,295,305
2013	956,318	1,442,774	1,435,980	6,591,754	2,392,298	8,034,528
2014	909,081	3,197,171	1,612,232	8,637,478	2,521,313	11,834,649
2015	2,280,256	5,717,502	2,945,061	17,714,766	5,225,317	23,432,268
2016	2,332,324	3,459,205	1,925,571	14,977,435	4,257,895	18,436,640
2017	1,769,563	1,825,686	388,449	7,537,955	2,158,012	9,363,641
Total	**$9,557,120**	**$17,310,541**	**$9,560,692**	**$61,086,490**	**$19,117,812**	**$78,397,031**

Note: A total of about $1.17 billion (of the $1.28 billion) in premiums was unrecoverable because the MCO and TPHI provider were not related.

Our review found that over $17.3 million (64 percent) of the $26.9 million in improper payments we identified where the MCO and the third-party insurer were the same legal entity have not yet been recovered. Additionally, 85 percent of this unrecovered amount pertains to three MCOs.

At the conclusion of our follow-up review, OMIG stated it plans to continue pursuing recovery of any payment determined to be inappropriate. We note that OMIG may have already lost the opportunity to recover over $15 million in overpaid premium payments we identified for calendar years 2012 and 2013 due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the remaining improper payments to prevent further loss of recoveries, particularly payments made where the MCO and third-party insurer are the same entity.

Response #6:

OMIG's contractor, HMS, has recovered more than $19 million; and continues to review the $63 million in payments, and will recover those determined to be inappropriate.

Recommendation #7:

Amend the Model Contract language to allow the Department to recover premium payments from all MCOs on behalf of enrollees with concurrent comprehensive TPHI regardless of the MCOs' relationship with recipients' third-party insurer.

Status – Implemented

Agency Action - The March 1, 2019 Managed Care Model Contract contains new language that allows the Department to recover premium payments from all MCOs on behalf of enrollees with concurrent comprehensive TPHI regardless of the MCOs' relationship with the enrollees' third-party insurer. The contract is currently being finalized with the Centers for Medicare & Medicaid Services.

Response #7:

The Department appreciates the recognition that it has implemented this recommendation.