THOMAS P. DiNAPOLI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 17, 2020

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Managed Care Premium Payments
for Recipients With Comprehensive
Third-Party Insurance
Report 2019-F-33

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report *Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance* (Report 2016-S-60).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program. Many Medicaid recipients are enrolled in mainstream managed care, which provides comprehensive medical coverage ranging from hospital care and physician services to dental and pharmacy benefits. The Department pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient and the MCOs arrange for the provision of health care services their members require. Individuals can enroll in Medicaid through the New York State of Health (NYSOH, New York's online health insurance marketplace) and Local Departments of Social Services (LDSS).

Medicaid recipients may have additional sources of health care coverage (i.e., third-party health insurance, or TPHI), such as health insurance offered through an employer. The Department's policy is to exclude Medicaid recipients from enrollment in mainstream managed care (which provides comprehensive medical coverage) when they also have comprehensive TPHI. Recipients should, instead, be enrolled in Medicaid fee-for-service to avoid the expense of monthly managed care premiums (for instance, under fee-for-service, after the comprehensive TPHI paid for a medical service, Medicaid could be responsible for paying a coinsurance fee).

Medicaid recipients self-report comprehensive TPHI. The Office of the Medicaid Inspector General (OMIG) also contracts with Health Management Systems, Incorporated (HMS) to identify and verify third-party coverages. HMS enters into data-sharing agreements with third-party insurers to obtain this information. TPHI information is updated in eMedNY, the Medicaid claims processing and payment system. The Department, LDSS, and NYSOH are responsible for identifying enrollees with comprehensive TPHI and promptly disenrolling them from managed care.

We issued our initial audit report on June 13, 2018. The audit objective was to determine whether the Department made Medicaid mainstream managed care premium payments on behalf of recipients who had comprehensive TPHI coverage. The audit covered the period January 1, 2012 through September 1, 2017. Our audit identified $1.28 billion in premiums that were paid on behalf of recipients who had concurrent comprehensive TPHI. We recommended several actions the Department could take to minimize the occurrence of inappropriate premium payments and eliminate obstacles to their recovery, among them: work with HMS to amend data-sharing agreements with third-party insurers to require more frequent TPHI updates; work with LDSS to implement new processes that would allow for more timely identification and disenrollment of individuals with comprehensive TPHI from managed care; and amend the Managed Care Model Contract to allow the Department to recover premiums from all MCOs regardless of an MCO's relationship with a recipient's third-party insurer. In addition, we recommended the Department review the managed care premium payments we identified and make appropriate recoveries.

The objective of our follow-up was to assess the extent of implementation, as of December 3, 2019, of the seven recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made progress in addressing the problems we identified in the initial audit report; however, additional action is needed to reduce future improper payments. For instance, for the one-year period ended September 30, 2019, we found the Department paid another $199 million in Medicaid mainstream managed care premiums for recipients who had comprehensive TPHI. Timely identification of recipients' comprehensive TPHI is essential to preventing inappropriate managed care premium payments. We found OMIG's contractor, HMS, has not updated data-sharing agreements with the vast majority of insurance carriers to require more frequent TPHI updates. Of the initial report's seven audit recommendations, three were implemented and four were partially implemented.

Follow-Up Observations

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.

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.

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.

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.

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.

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.

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.

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.

Major contributors to this report were Salvatore D'Amato, Mostafa Kamal, Linda Thipvoratrum, and Danhua Zhang.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Thomas McCann, Department of Health
    Dennis Rosen, Medicaid Inspector General