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

Division of State Government Accountability

Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance

Department of Health
Medicaid Program

Report 2016-S-60 June 2018

Executive Summary

Purpose

To determine whether the Department of Health (Department) made Medicaid mainstream managed care premium payments on behalf of individuals who had comprehensive third-party health insurance coverage. The audit covered the period January 1, 2012 to September 1, 2017.

Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. The Department administers the State's Medicaid program. For the State fiscal year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claims totaled about $58 billion. Under managed care, Medicaid pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient, and the MCOs arrange for the provision of services their members require. As of August 2017, 4.4 million people were enrolled in mainstream managed care plans – about 2.5 million were enrolled through New York State of Health (NYSOH), New York's online health insurance marketplace, and the remainder were enrolled through other means, including the Local Departments of Social Services (LDSS).

Many Medicaid recipients have additional sources of health care coverage. In accordance with the New York State Social Services Law, the Department's policy is to exclude Medicaid recipients from mainstream managed care when they have concurrent comprehensive third-party health insurance (TPHI). Furthermore, according to the Medicaid Managed Care Model Contract (Model Contract), when the Medicaid managed care provider and the comprehensive TPHI provider are the same, the State can disenroll the recipients from managed care retroactively and recover premiums paid to the MCO for those recipients during the period of overlapping coverage.

Key Findings

- During the audit period, the Department paid about $1.28 billion in Medicaid managed care premium payments on behalf of enrollees who also had concurrent comprehensive TPHI:
  - $26.9 million (about 73,000 premiums) can be recovered because the recipients' MCO is the same legal entity as the recipients' third-party insurer.
  - $70.6 million (about 191,000 premiums) were paid to MCOs that were related through some form of ownership (such as parent, subsidiary, or affiliate) to the third-party insurer. The Department must review these relationships to confirm the premiums are recoverable.
  - $1.17 billion (about 3.2 million premiums), representing about 91 percent of the $1.28 billion, are not recoverable because the MCO and third-party insurer are not related.
- Although some instances of concurrent Medicaid managed care and comprehensive TPHI coverage are unavoidable, we identified scenarios where inappropriate managed care premium payments could be minimized with improved oversight and management by the Department:
  - The Department often becomes aware of enrollees' comprehensive TPHI coverage after the coverage has taken effect. Our audit determined Medicaid paid over $691 million (about 54 percent of the $1.28 billion) in managed care premiums while enrollees' comprehensive TPHI was in effect, but not known by the Department. To prevent such

premium payments – and, in the case of unrelated-provider coverages, unrecoverable premium payments – it is imperative that comprehensive TPHI be identified timely.

- Medicaid paid over $591 million (about 46 percent of the $1.28 billion) in inappropriate managed care premiums despite the enrollees' comprehensive TPHI having been identified by the Department and recorded in eMedNY, the Department's Medicaid claim processing and payment system. Since June 2016, the Department has improved payment controls that use TPHI information to prevent such improper premium payments; however, these efforts only target NYSOH-enrolled recipients. The Department has not implemented similar controls with regard to non-NYSOH-enrolled recipients, such as recipients enrolled through the LDSS.

Key Recommendations

- Improve monitoring efforts to assist in the prevention, detection, and recovery of inappropriate managed care premiums.
- Implement controls to remove non-NYSOH-enrolled recipients with comprehensive TPHI from managed care.
- Review the managed care premiums we identified and recover as appropriate.
- Amend the Model Contract language to allow the Department to recover premiums from all MCOs regardless of the relationship with recipients' third-party insurer.

Other Related Audits/Reports of Interest

Department of Health: Unnecessary Managed Care Payments for Medicaid Recipients With Medicare (2010-S-75)

Department of Health: Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus (2015-S-47)

State of New York
Office of the State Comptroller

Division of State Government Accountability

June 13, 2018

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

Dear Dr. Zucker:

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 that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance*. 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.

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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Background

The New York State Medicaid program is a federal, state, and locally funded program administered by the Department of Health (Department) that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $58 billion. The federal government funded about 55.3 percent of New York's Medicaid claim costs; the State funded about 29 percent; and the localities (the City of New York and counties) funded the remaining 15.7 percent.

New York's Medicaid program offers different types of managed care options. Mainstream managed care (the managed care program most Medicaid recipients enroll in) provides comprehensive medical services that range from hospital care and physician services to dental and pharmacy benefits. The Department pays managed care organizations (MCOs) a monthly premium for each recipient enrolled in a plan. As of August 2017, 4.4 million New Yorkers were enrolled in mainstream managed care plans – about 2.5 million were enrolled through New York State of Health (or NYSOH, New York's online health insurance marketplace) and the remainder were enrolled through other means, including the Local Departments of Social Services (LDSS).

Not uncommonly, Medicaid beneficiaries may have additional sources of coverage for health care services (i.e., third-party health insurance, or TPHI), such as Medicare or health insurance offered through an employer. The federal Government Accountability Office estimated that, in 2012, 13.4 percent of Medicaid recipients nationwide had a third-party insurer. In accordance with the New York State Social Services Law, Section 364-j(3)(e)(xx), the Department's policy is to exclude Medicaid recipients from participating in mainstream managed care when they have comprehensive TPHI. Per the Department's policies, TPHI is considered comprehensive TPHI if it covers 13 specific types of health services, among them: hospital care, physician services, pharmacy, and hospice care. Conversely, comprehensive TPHI does not include certain partial (or non-comprehensive) coverage such as: accident-only coverage or disability income insurance; liability insurance, including auto insurance; workers' compensation; long-term care insurance; or dental-only or prescription-only coverage.

The Department's Office of the Medicaid Inspector General (OMIG) contracts with Health Management Systems, Inc. (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 also obtained from recipients who self-report through their NYSOH account or to their LDSS. TPHI information is updated in eMedNY, the Department's claim processing and payment system.

The Department, LDSS, and NYSOH are responsible for disenrolling recipients from managed care when comprehensive TPHI is identified and, as the Managed Care Model Contract (Model Contract) also explicitly states, for initiating disenrollment promptly. Furthermore, according to the Model Contract, where the Medicaid managed care provider and the comprehensive TPHI provider are the same, the State can disenroll a recipient from managed care retroactively and recover premiums paid to the MCO for the recipient during the period of overlapping coverage.

Audit Findings and Recommendations

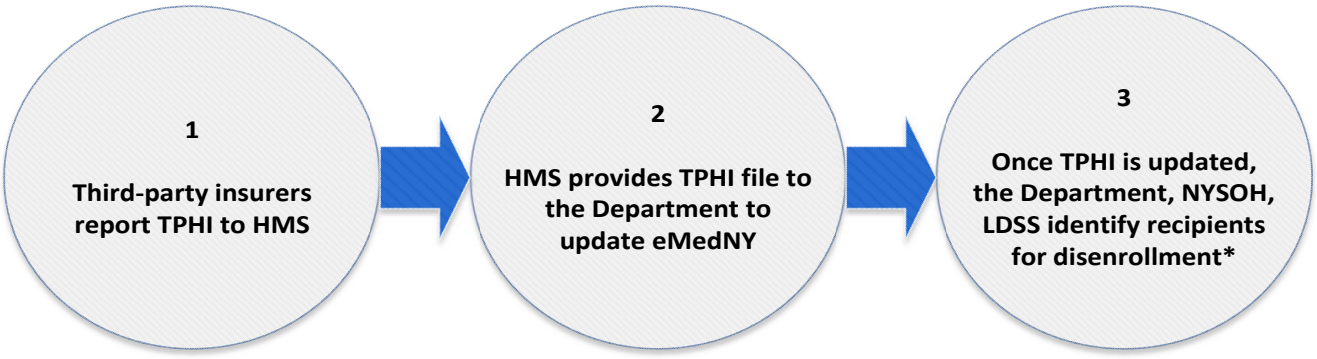
To prevent mainstream managed care premium payments for Medicaid recipients covered by comprehensive TPHI, recipients' third-party coverage data must be identified and updated in eMedNY in a timely manner. Furthermore, once comprehensive third-party coverage is identified, the Department, NYSOH, and LDSS must use this information to remove these recipients from managed care. Our audit identified impediments to these processes that resulted in managed care premium payments being made to MCOs on behalf of enrollees with comprehensive TPHI – which, for the audit period, accounted for more than 3.5 million managed care premium payments totaling about $1.28 billion.

- The Model Contract allows the Department to recover managed care premium payments made on behalf of an enrollee with comprehensive TPHI when both coverages are from the same entity (of the $1.28 billion, 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]). We further determined that scenarios where an enrollee's managed care and comprehensive TPHI providers were unrelated accounted for $1.17 billion (91 percent of the $1.28 billion) in unrecoverable managed care premium payments.
- Enrollees' comprehensive TPHI coverage is often identified, and updated in eMedNY, in arrears, after TPHI coverage has taken effect. Our audit determined Medicaid paid over $691 million (about 54 percent of the $1.28 billion) in managed care premiums while enrollees' comprehensive TPHI was in effect, but not known by the Department. To prevent such premium payments – and, in the case of unrelated-provider coverages, unrecoverable premium payments – it is imperative that comprehensive TPHI be identified timely and accurately.
- Medicaid paid over $591 million (about 46 percent of the $1.28 billion) in inappropriate managed care premiums on behalf of enrollees despite their comprehensive TPHI having been identified and recorded in eMedNY. While the Department has improved controls for using TPHI information to prevent improper premium payments, its efforts only targeted NYSOH-enrolled recipients. The Department has not implemented similar controls with regard to non-NYSOH-enrolled recipients, such as recipients enrolled through the LDSS.

Although we acknowledge the Department may not always have the information necessary to prevent these payments, we identified a number of actions the Department could take to minimize the occurrence of inappropriate managed care premium payments and eliminate obstacles to their recovery.

Lag Time Between Identification and Disenrollment

The timely identification of recipients' comprehensive TPHI and their prompt disenrollment from managed care is essential to prevent inappropriate managed care premium payments. The nature of the process itself, involving multiple steps and input and action by multiple entities (see the following figure), presents inherent challenges to timeliness.



* Effective date of disenrollment takes 2-6 weeks depending on whether the transaction was processed in the first half or second half of the month.

Although there are many variables that impact timeliness, the pace of the process hinges largely on the frequency of third-party insurers' reporting to HMS, as established in their data-sharing agreements. While some third-party insurers report weekly, most report monthly; still others report quarterly, semi-annually, or annually.

More frequent coverage updates can help limit the number and amount of inappropriate premium payments, as shown in Table 1, which presents a sample timetable for three third-party insurers. To illustrate, Insurer C provides HMS with a quarterly file of third-party coverages and, as a result, a recipient with comprehensive TPHI coverage effective January 1, 2017 would not be disenrolled from Medicaid managed care until May 2017. During this time, Medicaid would have made four managed care premium payments on behalf of the recipient. Insurer A, in contrast, reports to HMS weekly – a schedule that minimizes the number of inappropriate premium payments.

Table 1 – Example of File Deliveries

Third-Party Insurer	Reports to HMS	TPHI Coverage Start Date	TPHI File Provided to HMS	Estimated Disenrollment	Inappropriate Premium Payments
Insurer A	Weekly	1/1/2017	1/8/2017	2/1/2017	1
Insurer B	Monthly	1/1/2017	2/1/2017	3/1/2017	2
Insurer C	Quarterly	1/1/2017	4/1/2017	5/1/2017	4

Although New York State law does not specify how frequently insurers must provide TPHI information, it does require insurers to provide coverage information upon the State's request. To minimize the number of inappropriate premium payments, the Department should increase the frequency of third-party insurers' reporting of TPHI.

Disenrollment of Recipients From Managed Care

Once HMS processes TPHI from third-party insurers and updates the coverage in eMedNY, it is then up to the Department, LDSS, and NYSOH to identify recipients for disenrollment from managed care and initiate the disenrollment process. We determined Medicaid made over $591 million (of the $1.28 billion) in inappropriate managed care premium payments despite recipients' comprehensive TPHI being recorded in eMedNY.

Local Departments of Social Services

The Department relies on each LDSS to promptly remove LDSS-enrolled recipients with comprehensive TPHI from managed care. On November 1, 2011, the Department issued guidance on how the LDSS can identify and disenroll recipients who also have Medicare coverage from managed care. The guidance refers the LDSS to a monthly report that lists Medicaid recipients with Medicare. Although the report also lists recipients with other third-party coverage, it does not indicate if the third-party coverage is comprehensive (covering the 13 specified types of health services), and therefore requires additional research to determine if the recipients should be disenrolled from managed care. As a result of our audit, the Department issued guidance to the LDSS on how they should identify enrollees with comprehensive TPHI.

We interviewed officials from two of the State's largest LDSS offices – New York City, administered by the New York City Human Resources Administration (HRA), and Nassau County, administered by the Nassau County Department of Social Services. HRA and Nassau County accounted for $569 million and $67 million of the $1.28 billion, respectively. According to officials, the LDSS are not equipped with the resources needed to efficiently and effectively identify enrollees with comprehensive TPHI and initiate disenrollment. As a result, there is a significant risk that inappropriate premium payments are being made for prolonged periods.

When asked what steps they take to identify and remove recipients with comprehensive TPHI from managed care, officials from both HRA and Nassau County explained that they do not perform routine checks but instead disenroll recipients when comprehensive TPHI coverage becomes apparent to them – at annual recertifications, for example.

- According to HRA officials, they rely on the Department to systematically disenroll recipients with comprehensive TPHI (specifically, the Department's enrollment broker [Maximus]). However, Department officials informed us that the Department seldom performs systematic checks, nor is this the responsibility of Maximus.
- Upon notification of our visit, Nassau County officials started a review to identify and disenroll recipients with comprehensive TPHI from managed care. Officials explained, however, that they do not perform routine reviews because of the challenges of analyzing the Department-generated reports, which do not discern between comprehensive and non-comprehensive TPHI coverages – a difficult and time-consuming task that would take a toll on limited resources.

We provided both HRA and Nassau County LDSS each with a random sample of 15 premium claims from our audit population paid on behalf of their enrollees, and solicited their feedback regarding the appropriateness of those claims. HRA officials reiterated that they believed Maximus is responsible for such claims and did not provide feedback for individual claims. Nassau County officials generally agreed that the managed care premiums were not appropriate. For seven of the 15 premium claims, however, they explained that the comprehensive TPHI information was not known to them before or at the start of the month that represented the premium claim.

New York State of Health

Since January 1, 2014, NYSOH has been generally responsible for processing the enrollment of individuals who are eligible for Medicaid through modified adjusted gross income (MAGI) eligibility rules. NYSOH enrollees' TPHI coverage information is updated in NYSOH when enrollees self-report such information or when significant account changes (e.g., address change) occur, which prompts the NYSOH system to query eMedNY for TPHI.

Prior to June 2016, insurance coverages posted on eMedNY – the primary location of third-party information – were not automatically shared with NYSOH. However, as a result of system improvements that the Department implemented, eMedNY now sends new third-party coverage information to NYSOH as soon as it becomes effective. In addition, the Department has system edits, or rules, within NYSOH to automatically disenroll individuals with comprehensive TPHI from managed care once the third-party coverage is known. We randomly sampled 10 NYSOH-enrolled recipients with managed care coverage in late 2016 whose third-party coverage was added after June 2016, and found that the notification from eMedNY and automatic disenrollments from managed care occurred as intended.

Notably, the Department has not developed similar controls to identify comprehensive TPHI among non-NYSOH-enrolled individuals (approximately 1.85 million enrollees as of August 2017) and initiate their automatic disenrollment. If such controls were in place, we estimate that the Department could have prevented $50 million in unrecoverable managed care premium payments for the nine-month period January 2017 through September 2017.

Generally, the Department plans to continue transitioning Medicaid managed care enrollees into NYSOH and therefore, according to Department officials, developing an edit for non-NYSOH enrollees is not a prudent use of resources. However, at the conclusion of our audit fieldwork, many recipients were not yet transitioned, including the New York City MAGI population. In the absence of preventable controls, we estimate, based on prior historical averages, approximately $4 million per month in unrecoverable premiums will be paid on behalf of the non-NYSOH-enrolled New York City population with comprehensive TPHI.

Recovery Activities

As outlined in the Model Contract, when it is determined that a recipient in Medicaid managed care has concurrent comprehensive TPHI and the managed care provider and comprehensive

TPHI provider are the same, the recipient can be disenrolled from managed care retroactively, and the premium payments made during the retroactive period can be recovered. When the managed care and comprehensive TPHI providers are unrelated, disenrollment is prospective, and there is no recovery of premiums paid during the period of overlapping coverage. In cases of retroactive disenrollment, the LDSS notify OMIG and the appropriate MCO to initiate the recovery of managed care premium payments made during the overlapping insurance period. Any recovery that has not been made within 30 days of this notification is used as a basis for OMIG to initiate retroactive disenrollment audits.

To assess the results of LDSS's and OMIG's recovery efforts, we compared our list of 36,117 recipients who should have been retroactively disenrolled with a list of recipients with comprehensive TPHI who had been retroactively disenrolled by the LDSS between January 2, 2014 and June 30, 2016. We found over 26,000 recipients who were not identified by the LDSS and for whom premium payments were thus not recovered. As discussed earlier in this report, confusion about the LDSS's role in identifying and removing recipients from managed care likely contributed to this discrepancy.

We note that, during our audit scope, OMIG and HMS jointly performed a "revalidation project" to identify and disenroll recipients from managed care if they also had comprehensive TPHI coverage. However, all disenrollments were done prospectively. The revalidation project did not retroactively disenroll recipients or recover any associated managed care premiums.

Also, after our fieldwork was initiated, HMS began an additional project to identify and review managed care premium payments made on behalf of recipients who also had comprehensive TPHI coverage, similar to our audit objective. This project was still in progress at the conclusion of our audit fieldwork and is covering a similar scope of claims. According to HMS officials, the project is based on HMS's analysis, rather than solely on claims reported by the LDSS. We encourage OMIG and HMS to incorporate this methodology into future, and more frequent, audits rather than solely relying on the reports generated by the LDSS.

Department's Ability to Recover Premiums

As mentioned, the Model Contract stipulates that the Department may recover premiums paid to MCOs for enrollees who have been identified as having concurrent comprehensive TPHI provided by the same entity (note: during our audit, the Department developed amendments to the Model Contract clarifying that recoveries can be made when the third-party insurer is a parent, subsidiary, or a sister entity of the MCO). However, the Department had not issued guidance to the LDSS or OMIG on how to determine which companies are the same. Without formal guidance, the Department, OMIG, HMS, and LDSS have been left to make their own determinations.

We asked officials from each of these entities how they determine whether a third-party insurer is the same organization as the MCO. Officials from each explained the various methodologies they use, ranging from a simple comparison of company names to a review of corporate structures. In addition, there was no consensus on how to treat instances where the third-party insurer was either the parent, a subsidiary, or an affiliate of the MCO. Furthermore, the Department does

not maintain a list to keep track of mergers, acquisitions, or name changes that occur within the health insurance industry. While the Department is not required to do so, maintaining such a list would alleviate the redundancy of OMIG, HMS, and LDSS each having to make their own – and potentially inconsistent – determinations.

In the absence of clear guidance, we utilized various resources to determine if companies were related, including (but not limited to): public tax records; information obtained from the New York State Department of Financial Services website; and industry news updates. We identified instances where the managed care provider and comprehensive TPHI provider were related through a merger/acquisition, a parent/subsidiary relationship, or an affiliate relationship. For example, we considered Wellcare of NY, Inc. and WellCare of Louisiana, Inc. to be related because they have the same parent company, WellCare Health Plans, Inc.

Of the $1.28 billion in managed care premium payments (3.5 million claims) made on behalf of recipients with comprehensive TPHI, we determined:

- $26.9 million (72,857 claims) can be recovered because the recipients' Medicaid MCO is the same legal entity as the recipients' third-party insurer.
- $70.6 million (191,426 claims) was paid to MCOs that were related to the third-party insurer (e.g., subsidiary). The Department should review these relationships to confirm the premiums are recoverable. We note that OMIG and the LDSS have taken action in similar situations in the past.
- $1.17 billion (3,211,254 claims) is not recoverable because the MCO and third-party insurer are not related in any way.

We also found that about $20.7 million is unrecoverable because the recipients' third-party coverage ended during the month of the corresponding premium payment. See Table 2 for a breakdown of our findings.

Table 2 – Schedule of Recoverable Claims

MCO and Third-Party Insurer Relationship	Amount Paid	Number of Claims	Are the Claims Recoverable?
Same legal entity	$26,867,661	72,857	Yes
Related company	70,647,183	191,426	Pending Department confirmation
TPHI ended within capitation month	20,664,514	54,906	No
No relationship	1,165,154,532	3,211,254	No
Totals	**$1,283,333,890**	**3,530,443**	

Department officials stated they are considering changes to the Model Contract that would impact the types of recoveries that could be made. However, upon auditors' request, they were unable to provide their proposed language changes. Given the significant amount of premium payments that are unrecoverable, we encourage the Department to amend Model Contract terms that would allow all managed care premiums to be recovered when it is determined a recipient also has comprehensive TPHI regardless of whether the providers are related.

Furthermore, the large amount of unrecoverable premium payments further underscores the importance of preventive controls. Over $473 million (37 percent) of the premium payments we identified are likely unrecoverable and were paid even though the comprehensive TPHI information was available to prevent payment.

Recommendations

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

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.

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

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.

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

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

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.

Audit Scope, Objective, and Methodology

Our audit determined whether the Department made mainstream managed care premium payments on behalf of recipients who had comprehensive TPHI coverage. Our audit covered the period January 1, 2012 to September 1, 2017.

To accomplish our objective and assess relevant internal controls, we interviewed officials from the Department, OMIG, and HMS to gain an understanding of how third-party coverage is

identified and how managed care recipients are disenrolled. We also visited two LDSS offices, Nassau County and New York City, with the largest population of managed care recipients with comprehensive TPHI. We retrieved Medicaid recipient, claim, and third-party data from the Medicaid Data Warehouse and analyzed it to determine our audit findings. We also reviewed applicable sections of federal and State laws and regulations, and examined the Department's Medicaid managed care enrollment and disenrollment policies and procedures. In addition to samples of premium payments provided to the two LDSS offices and NYSOH (discussed earlier in the report), we discussed our findings with, and provided a random sample of 50 premium payments from our audit findings to, the Department and OMIG to confirm the appropriateness of our conclusions. Additionally, the premium payments we identified (comprising $1.28 billion) were provided to the Department and OMIG at the conclusion of our audit.

To assess the reliability of comprehensive TPHI coverage effective dates, we selected 110 recipient comprehensive TPHI coverages from our findings population and contacted the insurers. Sixty of these coverages were judgmentally selected based on risk factors including: the source of the third-party coverage, the likelihood the third-party coverage was actually Medicaid managed care, and MCOs with the largest volume of claims. The remaining 50 coverages were randomly selected. Although we found errors with coverage dates in our sample, they generally affected the most recent coverages and resulted from delays in receiving updates from insurers. We also found a small number of instances where the Medicaid managed care coverage was erroneously entered as the third-party insurance coverage, and although we made adjustments to our data to identify and remove similar occurrences, some errors may remain. We discussed these issues with the Department, OMIG, and HMS during our audit. Officials were aware of such issues based on certain HMS reviews. We believe, despite the limitations identified in our samples, the coverage data is overall sufficient and reliable for the purpose of our audit conclusions.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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 to certain boards, commissions, and public authorities, some of whom have minority voting rights. 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.

Authority

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.

Reporting Requirements

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 the report. In their response, Department officials generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's 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.

Contributors to This Report

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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

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

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

April 27, 2018

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

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2016-S-60 entitled, "Managed Care Premium Payments for Recipients with Comprehensive Third-Party Insurance."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2016- S-60 entitled, Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance

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

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1

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

Response #1

OMIG's contractor, HMS, will explore the opportunity of receiving more frequent insurance updates from third party insurers. However, as stated in the OSC Draft Audit Report, NYS law does not specify on how frequently insurers must provide coverage information.

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.

Response #2

The Department has in place resources and guidance for Local Department of Social Services (LDSS) regarding comprehensive third-party health insurance (TPHI) and Medicaid managed care (MMC). Reports are generated monthly to identify managed care enrollees with TPHI. The TPHI indicator appears on the monthly rosters, and the Enrollment Broker produces monthly reports that identify current MMC enrollees with TPHI. The Department will continue to work with LDSS regarding their roles and responsibilities in disenrolling individuals no longer eligible for managed care coverage due to comprehensive TPHI. The Department sent out a letter to the

* Comment 1

* See State Comptroller's Comments, Page 20.

Managed Care Coordinators on January 10, 2018 reminding them of the policy and procedures for dis-enrolling consumers who are also in receipt of comprehensive TPHI.

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.

Response #3

The Department does not agree with this recommendation, and its position on implementing additional controls by making changes to the Welfare Management System (WMS) and eMedNY remains unchanged. The Department continues to transition WMS modified adjusted gross income (MAGI) individuals to NY State of Health at renewal. The Department is also working with OMIG and HMS to identify current MMC enrollees with valid comprehensive TPHI and disenroll and notify the consumer through the State Enrollment Broker, NY Medicaid Choice. The Department will investigate whether the report that LDSSs use to identify and disenroll recipients from managed care can be improved to be of better use to the LDSSs, while working with the LDSSs to review current TPHI notifications for improvements.

* Comment 2

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.

Response #4

OMIG's contractor, HMS, performs ongoing reviews of paid premium payments for recipients with comprehensive TPHI. HMS is sending quarterly reports of these findings to the managed care organizations (MCOs) for review and recovery where appropriate.

Recommendation #5

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

Response #5

The Department is working to create a comprehensive list of Managed Care plans and their TPHI products for use in its identification of Medicaid Managed Care (MMC) Organizations which may also provide TPHI.

Recommendation #6

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

Response #6

OMIG's contractor, HMS, is reviewing the identified managed care premium payments, and has recovered more than $34.7 million. HMS will continue to pursue recovery of any payment 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.

Response #7

The Department will consider the recommendation. As background, MCOs must accept enrollees upon notification from the Department, LDSS or NY State of Health and must begin to pay claims for services for such enrollees on and after the enrollment effective date. OSC proposes that the Department retroactively disenroll and recoup capitation from MCOs for months when neither the MCO nor the Department had contemporaneous knowledge of TPHI. In such a retroactive disenrollment and recoupment scenario, the MCO is no longer at risk but would be owed payment for the claims it paid in good faith. The Model Contract was recently amended to include recovery of premiums paid when MMC enrollee was or is simultaneously enrolled or in receipt of comprehensive health care coverage through any governmental health insurance program.

Additionally, OMIG will continue to explore Model Contract amendments which will allow the Department to recover premium payments, as appropriate, from all MCOs on behalf of enrollees with concurrent comprehensive TPHI.

State Comptroller's Comments

1. While the monthly reports referred to in the Department's response can be used to identify managed care enrollees who have TPHI, the reports do not indicate if the TPHI is comprehensive. As detailed on page 8 of our report, we identified significant limitations in the use of the monthly reports to identify recipients with comprehensive TPHI. We are pleased the Department will work with the LDSS to disenroll individuals no longer eligible for managed care coverage due to comprehensive TPHI and, as acknowledged in Response #3, that it will investigate how the reports can be improved and be of better use to the LDSS.
2. The Department's response indicates it does not agree with implementing controls, including automated controls in the WMS and eMedNY systems, to promptly remove non-NYSOH-enrolled Medicaid recipients with comprehensive TPHI from managed care. Yet we determined many recipients have not transitioned to enrollment through NYSOH (which has controls to identify recipients with comprehensive TPHI and remove them from managed care). In fact, during our audit, the Department could not provide a specific timeline for transitioning the non-MAGI (i.e., the non-NYSOH-enrolled) population. The Department's response acknowledges it is still transitioning MAGI individuals through NYSOH. As noted on page 9 of our report, without adequate controls (whether system or other controls) to promptly identify and remove non-NYSOH-enrolled recipients with comprehensive TPHI from managed care, the Medicaid program will continue to make improper premium payments, many of which are unrecoverable. We are pleased the Department will take steps to improve the TPHI reports used by the LDSS so that recipients (including non-NYSOH-enrolled recipients) with comprehensive TPHI can be identified and disenrolled from managed care.