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February 25, 2020

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

Re: Inappropriate Premium Payments
for Recipients No Longer Enrolled
in Mainstream Managed Care and
Family Health Plus
Report 2019-F-20

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, *Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus* (Report [2015-S-47](#)).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program. Most of the State's Medicaid recipients receive their services through Medicaid managed care. Managed care plans (Plans) receive monthly premium payments for individuals enrolled in their plans. In return, Plans arrange for the provision of health care services their members require.

Most Medicaid recipients are enrolled in mainstream managed care, which provides comprehensive medical services that range from physician services and hospital care to dental and pharmacy benefits. During the initial audit period, Family Health Plus (FHP) was a publicly funded managed care program for individuals whose income was too high to qualify for Medicaid. Effective January 1, 2015, FHP was eliminated and the majority of FHP enrollees transitioned to the Medicaid program.

Individuals can enroll in Medicaid through Local Departments of Social Services (LDSS) and through the New York State of Health (NYSOH, the State's online marketplace for obtaining health insurance). LDSS use the State's Welfare Management System (WMS) to process applicant data, while NYSOH processes applicant data through its own system. The Department's eMedNY claims processing and payment system relies on information sent by WMS and NYSOH to update eligibility and enrollment data necessary to make appropriate premium payments.

An inappropriate payment can occur when a premium is paid to a Plan for a recipient who is later retroactively disenrolled from the Plan – for instance, because of updates to death information. During the initial audit, the Department was only allowed to recover inappropriate premium payments made to a Plan if it was determined to be not “at risk” for the provision of medical services during any portion of the premium period (Plans are “at risk” if they paid for services provided to a recipient during the month covered by the premium payment).

LDSS and NYSOH are responsible for determining whether Plans made payments to health care providers on behalf of recipients who were disenrolled. Plans can either void the claims for the inappropriate premiums in eMedNY or repay the premiums by check. According to the Model Contract, Plans must pay back premiums within 30 days of being notified by LDSS or NYSOH.

We issued our initial audit report on July 11, 2017. The audit objective was to determine whether the Department made inappropriate premium payments to Medicaid mainstream managed care plans and FHP managed care plans for recipients who were no longer enrolled. The audit covered the period October 1, 2010 through September 30, 2016. We found the Department made \$122.4 million in improper and questionable premium payments (\$103.9 million in improper and \$18.5 million in questionable premiums) on behalf of 171,936 recipients who were retroactively disenrolled from a Plan. We provided the \$122.4 million in claim data to the Office of the Medicaid Inspector General (OMIG), and it recovered about \$7.4 million from the Plans by the end of the audit. We also found the largest LDSS (New York City Human Resources Administration [HRA]) misinterpreted guidelines governing when Plans were considered “at risk,” leaving many improper premiums uncollected. We recommended the Department review the remaining \$115 million in premiums and recover all overpayments, and strengthen controls to prevent the types of improper payments we identified.

The objective of our follow-up was to assess the extent of implementation, as of November 27, 2019, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made progress in addressing the problems we identified in the initial audit report; however, additional action is needed. In particular, OMIG recovered about \$20 million of the identified improper premiums; however, \$83.5 million still needed to be reviewed and recovered from the Plans. Of the initial report's five audit recommendations, one was implemented and four were partially implemented.

Follow-Up Observations

Recommendation 1

Review the \$115 million (\$65.2 million + \$49.8 million) in improper and questionable premium payments we identified and recover overpayments, as appropriate.

Status – Partially Implemented

Agency Action – As stated previously, \$7.4 million of the \$122.4 million in total payments identified was recovered during the initial audit. Of the remaining \$115 million: \$65.2 million was paid during the period October 1, 2010 through December 31, 2014, and \$49.8 million was paid during the period January 1, 2015 through September 30, 2016.

OMIG investigates and recovers improper Medicaid payments on behalf of the Department. OMIG's official Work Plan states it will safeguard Medicaid resources by responding to external audits and it will analyze the audit data and work to recover inappropriately paid claims. During the initial audit, we provided OMIG with a file containing the details of the \$115 million in premium payments. As of August 15, 2019, OMIG had recovered \$20.3 million and determined \$11.2 million of the \$18.5 million in questionable payments we identified was paid appropriately (because the Department corrected certain enrollment data after the initial audit), leaving \$83.5 million that still needed to be reviewed and recovered. According to OMIG officials, additional recoveries will be made through its normal audit process. However, we note that OMIG may have already lost the opportunity to recover over \$27 million in overpaid premiums for calendar years 2010 through 2013 due to federal lookback restrictions. We encourage OMIG to take prompt action on the remaining overpayments, in accordance with its Work Plan, to prevent loss of recoveries.

Recommendation 2

Formally assess the reasons for the outstanding improper payments and strengthen controls to address these weaknesses. This assessment should include, but not be limited to:

- *Engaging in a dialogue with all LDSS and determining the various reasons for, and solutions to, delays in identifying disenrollment and delays in notifying Plans of retroactive disenrollment once retroactive disenrollment is identified; and*
- *Engaging in a dialogue with all Plans and determining the various reasons for, and solutions to, delays in voiding premium payments within the timeframe specified in the model contract.*

Status – Partially Implemented

Agency Action – In the initial audit, we found delays in the processes for: identifying

retroactive disenrollments; notifying Plans of the disenrollments; and Plans' voiding of improper premiums – which caused significant amounts of outstanding improper payments. In response to our initial audit, OMIG conducted a survey of LDSS to identify problems in the processes related to retroactive disenrollments. OMIG also notified LDSS and NYSOH officials about an educational webinar posted on OMIG's website that provides an overview of the retroactive disenrollment process. The webinar explains the steps HRA, other LDSS, and NYSOH should take to report retroactive disenrollment decisions to the Plans and OMIG. Our follow-up review found the Department and OMIG were unable to provide evidence that officials had any dialogue with Plans regarding reasons for, and solutions to, delays in voiding premium payments.

Recommendation 3

Provide formal clarification to HRA and other LDSS regarding what constitutes “at risk” to help ensure: ineligible recipients are properly disenrolled; Plans are notified of all improper premium payments during periods when Plans are not at risk; and all corresponding improper payments are voided.

Status – Implemented

Agency Action – HRA and LDSS determine retroactive disenrollment periods and notify Plans to void inappropriate premium payments. During the initial audit, we found that HRA officials misinterpreted guidelines governing when Plans are considered “at risk” and when corresponding premium payments should be recovered. This resulted in improper premium payments being deemed appropriate.

In May 2017, the Department revised its policy regarding the recovery of improper premium payments when Plans are “at risk.” According to the amended Model Contract, the Department can now recover all inappropriately paid premiums, including those made during months when a Plan was “at risk.” The Department then may reimburse Plans for appropriate costs for services provided to recipients during “at risk” months.

Additionally, the Department issued several guidance documents regarding the retroactive disenrollment process and recovery of improper managed care premiums. The guidance provides clarification on the reasons for retroactive disenrollment, how to process retroactive disenrollment, and the process for recovering improper premium payments.

Recommendation 4

Upon completion of the evolution projects to recover deleted enrollment data in eMedNY and the MDW, conduct an assessment to ensure the problems with the deleted enrollment information were fully corrected.

Status – Partially Implemented

Agency Action – Our initial audit found a system flaw that led to the inadvertent deletion of certain Medicaid recipients’ managed care enrollment data from eMedNY and the Medicaid Data Warehouse (MDW). During the audit, the Department provided our office with a list of 78,029 recipients who (per the Department) needed their managed care enrollment data corrected. According to Department officials, they identified the problems causing enrollment to be deleted and initiated two system projects (referred to as evolution projects) and a data correction project to address the problems. During our follow-up review, the Department provided evidence of assessments it performed to confirm the problems had been corrected.

To verify the updates, we selected 52 of the 78,029 recipients with deleted enrollment data from the initial audit and asked Department officials for information to confirm that the managed care enrollment data had been corrected. In response, officials acknowledged they identified an eMedNY system problem, which prevented all the necessary updates to the enrollment information. Officials stated that, although the deleted eligibility information in eMedNY had been corrected, corresponding updates to managed care enrollment in eMedNY and the MDW had not been made. At the conclusion of our review, the Department was still in the process of updating the deleted enrollment information.

Recommendation 5

Determine the reasons for the differences in the improper premium payments identified by our office and the OMIG audits for the two Plans and enhance the methodology of the OMIG audits accordingly to help ensure all improper premium payments are recovered. In particular, the OMIG should assess using other date of death sources, including eMedNY and the SSA.

Status – Partially Implemented

Agency Action – In the initial report, we noted differences of \$2.7 million and \$383,275 in improper payments for two Plans between our and OMIG’s audits (our audits identified greater findings). In its response, OMIG stated that differences from the audit of the first Plan (\$2.7 million) could have resulted from our findings related to erroneously deleted enrollment data (as noted in the Agency Action section of Recommendation 4). However, we analyzed the premium payments that OMIG identified as appropriate based on data correction project updates (totaling \$11.2 million of the \$18.5 million in questionable payments we identified), and found that none of the \$2.7 million difference was related.

The differences we found in the audit of the second Plan likely resulted from different sources for determining recipients’ dates of death. OMIG stated that it now incorporates information from eMedNY into its audits and has recovered over \$300,000 of the improper payments we identified. Additionally, although OMIG’s response to our initial audit stated it was in the process of obtaining access to the Death Master File from the Social Security Administration (SSA), OMIG still did not have access at the time of our follow-up review.

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