NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

May 14, 2019

Mr. Kenneth Shulman
Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Shulman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2017-S-63 entitled, "Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018."

Please feel free to contact Estibaliz Alonso, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

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

Enclosure

cc: Estibaliz Alonso

Department of Health
Comments on the Office of the State Comptroller's Final Audit Report 2017-S-63 entitled, "Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2017-S-63 entitled, "Medicaid Claims Processing Activity October 1, 2017 Through March 31, 2018."

General Comments:

Individuals with comprehensive third-party health insurance (TPHI) are eligible for Medicaid if they otherwise meet income and other eligibility criteria. Under New York's current Medicaid managed care policies, an individual confirmed to have comprehensive TPHI, defined as including thirteen specific services, is not enrolled in a Medicaid Managed Care (MMC) plan and instead receives coverage through Medicaid fee-for-service (FFS).

In this audit, the identified premiums are not offset by Medicaid FFS payments that would have occurred. Most Medicaid eligible individuals not enrolled in managed care still have access to covered services through Medicaid FFS. However, the audit's projection does not recognize the fact that if the individual was in Medicaid FFS, Medicaid would not have paid a managed care premium, but it would have paid for covered services not reimbursed by the TPHI and, if cost effective, the premium for the TPHI.

Because monthly premium payments made to managed care plans are based on averages, as are all insurance premiums, the amount paid by FFS could have been greater than the payment to the managed care plan in some instances. The offset should be recognized by OSC to provide the full picture of potential costs to the Medicaid program.

Recommendation #1:

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

Response #1:

The Department continues to work with the Office of the Medicaid Inspector General's (OMIG) contractor to further identify individuals with TPHI. The Local Departments of Social Services (LDSS) are required to disenroll an individual with comprehensive TPHI when known. The Department, recognizing that LDSS may not have the staff to review available reports, has developed a monthly process to identify, prospectively disenroll and notify individuals of disenrollment due to comprehensive TPHI.

Recommendation #2:

Review the managed care premium payments we identified and make recoveries, as appropriate.

Response #2:

OMIG's contractor will review the premium payments identified and pursue recovery of any payment determined to be inappropriate.

Recommendation #3:

Review the $1,119,113 in overpayments and make recoveries, as appropriate.

Response #3:

OMIG's contractor will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #4:

Review the $2.1 million in improper payments and make recoveries, as appropriate.

Response #4:

OMIG's contractor will review the identified overpayments for those recipients who gain Medicare coverage and pursue recovery of any payment determined to be inappropriate.

Recommendation #5:

Strengthen eMedNY controls over claims on behalf of QMB-only recipients to ensure that only correct claims for deductibles, coinsurance, or copayments are paid, including, but not limited to, re-evaluating the existing eMedNY edit to determine whether it can be activated to deny claims.

Response #5:

The Department activated the eMedNY edit (01027) on October 17, 2018 to strengthen controls over claims for Qualified Medicare Beneficiary-only recipients.

Recommendation #6:

Review the $342,009 in overpayments and make recoveries, as appropriate.

Response #6:

OMIG reviewed the identified payments and will pursue recovery of any payment determined to be inappropriate.

Recommendation #7:

Review the one claim that overpaid $97,353 and make recoveries, as appropriate.

Response #7:

OMIG reviewed the identified payment and recovered $97,353.

Recommendation #8:

Formally advise the hospital to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment.

Response #8:

The Department is in the process of determining an appropriate course of action to advise the hospital to accurately report alternate levels of patient care when billing Medicaid to ensure appropriate payment.

Recommendation #9:

Review the $609,915 in overpayments and make recoveries, as appropriate.

Response #9:

OMIG's contractor will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #10:

Ensure the planned eMedNY system change prevents multiple CPEP payments for an individual episode of care, and prevents CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Response #10:

The Office of Mental Health is working with the Department to update the process for billing Comprehensive Psychiatric Emergency Program (CPEP) to prevent multiple CPEP evaluation payments for an individual episode of care, and to ensure that CPEP claims are not paid for the same date of service as a psychiatric inpatient admission. A change request will be submitted to update the rate type for rate codes 4007 and 4008 to a "monthly" rate type which will prevent the double payment issue.

Recommendation #11:

Review the $350,439 ($341,106 + $3,472 + $5,861) in overpayments and make recoveries, as appropriate.

Response #11:

OMIG will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #12:

Review the $46,461 in overpayments and make recoveries, as appropriate.

Response #12:

OMIG will review the identified overpayments and pursue recovery of any payment determined to be inappropriate.

Recommendation #13:

Review the $290,676 ($143,922 + $117,361 + $29,393) in improper payments and make recoveries, as appropriate.

Response #13:

Due to the complexity of the claims and services provided, OMIG will extract its own data and perform analysis, and pursue recovery of any payment determined to be inappropriate.

Recommendation #14:

Determine the status of the remaining three providers relating to their future participation in the Medicaid program.

Response #14:

Of the three providers, OMIG has determined that two have been excluded, and one is under review.

Office of the State Comptroller's Comments:

OSC Comment #1:

If a Medicaid recipient has comprehensive third-party health insurance (TPHI), that insurance covers 13 specific types of health services, including (but not limited to) hospital services, physician services, clinic services, pharmacy, and hospice care. Therefore, the expectation is that the outside comprehensive insurance would cover most services for many, thereby avoiding costly Medicaid FFS payments.

Response to Comment #1:

The premise provided by OSC that comprehensive coverage covers most service expenses presents an incomplete depiction of costs to Medicaid for these individuals. In addition to Medicaid covering the TPHI premium in some cases, commercial plans typically cover services with deductibles, co-pays or other co-insurance and have more limited benefit packages. Had the consumers been covered by FFS Medicaid, instead of enrolled in a managed care plan, Medicaid would still cover co-insurance for services provided up to the Medicaid rate, and fully cover services traditionally not covered by or of limited duration under commercial benefit packages, such as skilled nursing home care and community-based long-term services and supports.

OSC Comment #2:

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 noted on page 9 of our report, we found that neither of the two LDSS we contacted had established a process on how to effectively identify and disenroll recipients having comprehensive TPHI from managed care – despite having access to the monthly reports referenced by the Department. We are pleased the Department started taking new steps to work with the LDSS to disenroll individuals no longer eligible for managed care coverage due to comprehensive TPHI, including initiating a new monthly disenrollment process with its enrollment broker, New York Medicaid Choice.

Response to Comment #2:

The Department appreciates OSC's recognition of the new steps the Department has taken to work with the LDSS to disenroll individuals no longer eligible for managed care coverage due to comprehensive TPHI, including the Department's initiation of a new monthly disenrollment process with its enrollment broker, New York Medicaid Choice.

OSC Comment #3:

The statement "The Department is concerned that OSC's identification of nearly 80,000 consumers with comprehensive TPHI over six months from 2017 to 2018 is not aligned with the 6,800 successful 2018 disenrollments due to verified comprehensive TPHI" is misleading. The Department does not explain that its analysis is limited to only one month, whereas our analysis addressed six months. Additionally, the Department's reported total of 6,800 only represented New York City enrollees who were, at the time of the Department's review, still Medicaid-eligible and enrolled in a Medicaid managed care plan. The Department's reported number does not account for all identified members, both throughout the rest of the State and those no longer eligible for Medicaid or Medicaid managed care (in which case, retroactive recoveries would need to be made). When we followed up with Department officials about the 6,800 enrollees they reported on, officials stated the actual total number of all enrollees identified as having comprehensive TPHI was approximately 19,000. Therefore, after all factors are considered, the total number of enrollees we identified appears more in line with the Department's totals. We encourage the Department to review all of the identified enrollees and take appropriate action to make prompt disenrollments and recoveries.

Response to Comment #3:

For all of 2018, The Department identified 28,797 Welfare Management System MMC-enrolled consumers with comprehensive TPHI and has taken appropriate action for disenrollment and recoveries. The Department continues to believe that OSC's number of 80,000 enrollees with comprehensive TPHI over a 6-month period is high. Per the October 1, 2015 MMC/Family Health Plus Model Contract, managed care premiums can be recouped if the enrollee is simultaneously enrolled through another product offered by the Managed Care Organization (MCO).

The Department remains committed to reviewing all identified enrollees with comprehensive TPHI and to take appropriate action to promptly disenroll those enrollees and recover inappropriate payments to MCOs.

OSC Comment #4:

We disagree with the Department's conclusion that the three claims were paid appropriately. As noted on page 11 of our report, Medicaid made a fee-for-service payment while the recipient was enrolled in an MCO. The MCOs are responsible for reimbursing the services provided to recipients enrolled in their plans. The eMedNY system edits did not deny the inappropriate payments because the recipients' eligibility files were not updated with their managed care enrollment information in a timely manner. The Department should reevaluate its decision on the appropriateness of these payments.

Response to Comment #4:

The comment was addressed with changes to the Department's response above.