NEW YORK STATE OF OPPORTUNITY. Department of Health

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Acting Commissioner

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April 27, 2023

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

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 2021-S-37 entitled, "Excessive Premium Payments for Dual-Eligible Recipients Enrolled in Mainstream Managed Care and Health and Recovery Plans."

Please feel free to contact Mischa Sogut, Assistant Commissioner, Office of Governmental Affairs, at (518) 473-1124 or mischa.sogut@health.ny.gov, with any questions.

Sincerely,

Megan Baldwin

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Mischa Sogut

Department of Health Comments to Final Audit Report 2021-S-37 entitled, "Excessive Premium Payments for Dual-Eligible Recipients Enrolled in Mainstream Managed Care and Health and Recovery Plans" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Final Audit Report 2021-S-37 entitled, "Excessive Premium Payments for Dual-Eligible Recipients Enrolled in Mainstream Managed Care and Health and Recovery Plans" by the Office of the State Comptroller (OSC).

Recommendation #1:

Disenroll dual-eligible recipients from their MMC or HARP who are ineligible for IB-Dual and provide them with FFS coverage, as appropriate.

Response #1:

The Department was initially prohibited from disenrolling Medicaid enrollees per the Families First Coronavirus Response Act guidance issued in March 2020. In December 2020, the Centers for Medicare & Medicaid Services (CMS) issued updated guidance allowing the Department to resume disenrollments during the COVID-19 Public Health Emergency (PHE) under certain circumstances. The Department chose not to restart disenrollment for those in the dual-eligible (Medicare and Medicaid enrollees) category in an effort to maintain continuity of care and services for this vulnerable population. During this time, the Department also implemented the IB-Dual program allowing MMC enrollees becoming newly Medicare eligible to remain enrolled in MMC with an affiliated D-SNP. The CMS enrollment policy allowing for *default enrollment* of MMC enrollees becoming Medicare eligible enabled the decision to implement the program. The IB-Dual program is part of a broader Department strategy to encourage enrollment of dual-eligible individuals into integrated care options.

Moreover, on November 10, 2020, the Department applied for an 1115 Medicaid Waiver Amendment that would make the dual-eligible population exempt rather than excluded from MMC. This further factored into the Department's decision not to restart disenrollments for dual-eligible individuals. CMS approved this amendment on March 23, 2022.

State Comptroller's Comment – The Department's statement is misleading. During our audit, Department officials confirmed that the 1115 Medicaid Waiver Amendment does not apply to the recipients we identified as ineligible for IB-Dual because they were: (1) not enrolled in a Medicare Part C plan, (2) enrolled in a MMC or HARP managed care plan offered by a different company than their Medicare Part C plan (unaligned), (3) enrolled in a Medicare Part C plan that was not D-SNP, or (4) enrolled in an HIV Special Needs Plan. Since these individuals are not eligible for IB-Dual, they should be disenrolled from MMC and placed in fee-for-service (FFS) to prevent further loss of Medicaid dollars.

Recommendation #2:

Review the $190.6 million in excessive premium payments and make recoveries, as appropriate.

Response #2:

In collaboration with the Department, the Office of the Medicaid Inspector General (OMIG) is currently performing analysis on the OSC data and methodology provided. OMIG continues to review the program areas identified by OSC for additional potential recoveries within OSC's review scope. For any OSC findings after March 2020, OMIG will utilize guidance issued by the Department as to the ability of Plans to render services or disenroll during the PHE.

OMIG will perform its own extraction of data from the Medicaid Data Warehouse (MDW) which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #3:

Review the $3.5 million in excessive premium payments and make recoveries, as appropriate.

Response #3:

In collaboration with the Department, OMIG is currently performing analysis on the OSC data and methodology provided. OMIG continues to review the program areas identified by OSC for additional potential recoveries within OSC's review scope. For any OSC findings after March 2020, OMIG will utilize guidance issued by the Department as to the ability of Plans to render services or disenroll during the PHE.

OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #4:

Ensure that all dual-eligible recipients who meet IB-Dual enrollment requirements and who do not opt out are enrolled timely. For those recipients who opt out, disenroll them from their MMC or HARP plan and provide them with FFS coverage, as appropriate.

Response #4:

The IB-Dual program was created to allow MMC enrollees becoming dually eligible to remain in their Medicaid Managed Care Plan (MMCP) when they enroll in the affiliated D-SNP of the same organization. Enrollment into the IB-Dual premium rate cell occurs through a default enrollment process into the Medicare D-SNP. The dually eligible individual is enrolled into the Medicare D-SNP affiliated with the MMCP. MMCPs must receive approval for IB-Dual through the Department and approval for default enrollment from CMS. Enrollees are provided advanced notice of default enrollment by the Medicare D-SNP.

The Department works closely with its enrollment broker and the health plans to identify dually eligible individuals for default enrollment to ensure they are enrolled timely. For enrollees that choose to opt out of the Medicare D-SNP, the individual will remain in their MMC or HARP

during the PHE. Upon the end of the PHE, the Department will disenroll dually eligible individuals not in the IB-Dual rate cell in accordance with CMS unwind guidance procedures.

State Comptroller's Comment – As discussed on page 8 of our report and referenced in the Department's Response #1, CMS issued guidance in December 2020 that allowed the Department to resume disenrollment during the COVID-19 PHE. The Department resumed disenrollment of MMC and HARP recipients receiving comprehensive third-party health insurance (TPHI) in February 2021. It is unclear why the Department decided to wait until the end of the PHE to resume disenrollment of the dual-eligible population who opt out of the Medicare D-SNP.

The following are responses to the State Comptroller's Comments in the final report.

State Comptroller's Comment 1 (page 14):

The Department's statement is misleading. During our audit, Department officials confirmed that the 1115 Medicaid Waiver Amendment does not apply to the recipients we identified as ineligible for IB-Dual because they were: (1) not enrolled in a Medicare Part C plan, (2) enrolled in a MMC or HARP managed care plan offered by a different company than their Medicare Part C plan (unaligned), (3) enrolled in a Medicare Part C plan that was not D-SNP, or (4) enrolled in an HIV Special Needs Plan. Since these individuals are not eligible for IB-Dual, they should be disenrolled from MMC and placed in FFS to prevent further loss of Medicaid dollars.

Response to the State Comptroller's Comment 1:

The Department statement regarding the 1115 Medicaid Waiver Amendment indicated that MMC enrollees becoming newly Medicare eligible would remain in MMC or a Health and Recovery Plan (HARP) when enrolled in an affiliated Medicare dual eligible special needs plan (D-SNP) of the same organization as part of the integrated care strategy for dual eligible members. Per previous responses to OSC, the Department chose not to disenroll dual members from MMC in accordance with CMS rules to maintain a member's level of benefits during the PHE.

Please refer to our final State Comptroller's Comment on page 4.

The OSC report findings recommended recoupment of overpayments for MMC/HARP enrollees not eligible for a Medicare Integrated Benefit (IB) Dual. This recommendation is inconsistent with the principles of the federally-approved risk-based methodology the Department utilizes to reimburse managed care plans. It would be inappropriate to recoup from plans after it was demonstrated that the reimbursement rate was above what was actually necessary to service a plan member, since plans would not receive more in instances where reimbursement was less than what was actually necessary to service a plan member. Further, rate development during the PHE assumed dual members would remain enrolled in MMC and the premium was commensurately adjusted. When dual members are disenrolled, changes to the actuarial rate build will be incorporated.

State Comptroller's Comment – We disagree with the Department's statement that it would be inappropriate to recoup from plans. In fact, as noted on page 6 of the report, the Medicaid Mainstream Managed Care Model Contract authorizes the Department to recover MMC and HARP premium payments made for recipients in months that they were in receipt of Medicare. In doing so, the Department must reimburse managed care plans for any payments made to providers for medical services rendered to recipients (i.e., encounters) during the month.

State Comptroller's Comment 2 (page 15):

As discussed on page 8 of our report and referenced in the Department's Response #1, CMS issued guidance in December 2020 that allowed the Department to resume disenrollment during the COVID-19 PHE. The Department resumed disenrollment of MMC and HARP recipients receiving comprehensive TPHI in February 2021. It is unclear why the Department decided to wait until the end of the PHE to resume disenrollment of the dual-eligible population who opt out of the Medicare D-SNP.

Response to the State Comptroller's Comment 2:

The Department was initially prohibited from disenrolling Medicaid enrollees per the Families First Coronavirus Response Act (FFCRA) guidance issued in March 2020. In December 2020, CMS issued updated guidance allowing for resumption of disenrollments during the PHE under certain circumstances. The Department chose not to restart disenrollment for those in the dual-eligible (Medicare and Medicaid enrollees) category in an effort to maintain continuity of care and services for this more vulnerable population. The Department conducted an assessment based on FFCRA rules and scenarios to determine where potential loss of Medicaid and/or access to community-based services outweighed disenrollment to Medicaid FFS.

State Comptroller's Comment – The Department stated it did not restart disenrollment (and subsequent placement into FFS) of dual-eligibles who did not meet IB-Dual enrollment requirements, and those who did meet IB-Dual enrollment requirements but who opted out, from MMC and HARP because of the impact on recipients' continuity of care. However, the Department acted inconsistently when it did restart disenrollment of recipients with comprehensive third-party health insurance (TPHI) from MMC and HARP. When Medicaid recipients with comprehensive TPHI and dual-eligibles are removed from MMC and HARP, they are placed into FFS. It is unclear why the Department treated these populations differently.