Department of Health

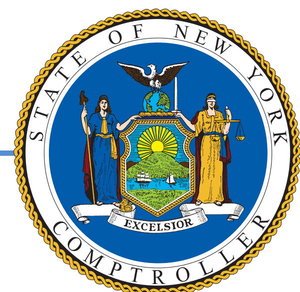
Medicaid Program: Excessive Premium Payments for Dual-Eligible Recipients Enrolled in Mainstream Managed Care and Health and Recovery Plans

Report 2021-S-37 | October 2022

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability



Audit Highlights

Objective

To determine whether Medicaid overpaid Mainstream Managed Care and Health and Recovery Plan premiums on behalf of dual-eligible individuals. The audit covered the period from March 2021 through March 2022.

About the Program

The Department of Health (Department) administers the State's Medicaid program. Many Medicaid recipients are enrolled in Medicare and are referred to as "dual-eligibles." Additionally, many of the State's Medicaid recipients receive their services through managed care, including Mainstream Managed Care (MMC), which provides comprehensive coverage, and Health and Recovery Plans (HARP), which provide specialized care to recipients aged 21 or older with serious mental illness and/or substance use disorders.

Within MMC and HARP is the Integrated Benefits for Dually Eligible Enrollees Program (IB-Dual), which became effective April 1, 2021. IB-Dual offers a special (lower) MMC and HARP premium rate for certain Medicaid recipients who enroll in Medicare and do not need long-term services and support. However, recipients in MMC or HARP who enroll in Medicare but are not eligible for IB-Dual should be disenrolled from MMC and HARP and moved to Medicaid fee-for-service (FFS) because the cost of the managed care premiums generally exceeds the cost of deductibles and coinsurance that Medicaid would pay on FFS claims for dual-eligibles.

In response to the coronavirus disease 2019 state of emergency, the federal government passed the Families First Coronavirus Response Act, which, in part, increased the federal medical assistance percentage to state Medicaid programs. In order to receive the increase, states were required to maintain managed care coverage for enrolled recipients throughout the public health emergency. In response, the Department paused disenrollment of dual-eligible recipients from MMC and HARP plans. However, in November 2020, the federal regulation was updated and allowed states to change a recipient's eligibility group as long as minimum essential coverage (e.g., Medicaid FFS) was maintained.

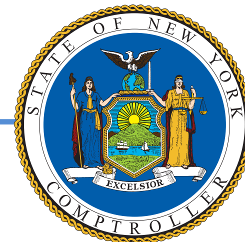
Key Findings

We identified over $194.1 million in excessive MMC and HARP premium payments, as follows:

- Over $190.6 million was paid on behalf of dual-eligible recipients who were ineligible for IB-Dual. These recipients should have been removed from their MMC or HARP plan and provided FFS coverage. The excessive premium payments occurred because the Department chose not to restart disenrollment of dual-eligibles from managed care as allowed by federal regulations.
- Over $3.5 million was paid on behalf of dual-eligible recipients who appeared eligible for IB-Dual but were not enrolled timely. We found the Department's rollout of IB-Dual did not initially include recipients who became dual-eligible prior to the date the new IB-Dual rate became effective.

Key Recommendations

- Disenroll dual-eligible recipients from MMC and HARP plans who are ineligible for IB-Dual, or who opt out, and provide them with FFS coverage.
- Review the $194.1 million in excessive premium payments and make recoveries.



Office of the New York State Comptroller
Division of State Government Accountability

October 31, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
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Dear Dr. Bassett:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the 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 *Excessive Premium Payments for Dual-Eligible Recipients Enrolled in Mainstream Managed Care and Health and Recovery Plans.* This audit was performed pursuant to the State Comptroller's authority under 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,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
Department	Department of Health	*Auditee*
D-SNP	Dual Special Needs Plan	*Key Term*
Dual-eligibles	Individuals enrolled in both Medicaid and Medicare	*Key Term*
eMedNY	Department’s Medicaid claims processing and payment system	*System*
Encounter	Record of a health care service provided to a recipient	*Key Term*
FFS	Fee-for-service	*Key Term*
HARP	Health and Recovery Plans	*Key Term*
IB-Dual	Integrated Benefits for Dually Eligible Enrollees Program	*Program*
MCO	Managed care organization	*Key Term*
MMC	Mainstream Managed Care	*Key Term*
TPHI	Third-party health insurance	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2022, New York's Medicaid program had approximately 7.8 million recipients and Medicaid claim costs totaled about $74.6 billion (comprising $27.5 billion in fee-for-service [FFS] health care payments and $47.1 billion in managed care premium payments). The federal government funded about 57.1% of New York's Medicaid claim costs, and the State and the localities (the city of New York and counties) funded the remaining 42.9%.

The Department of Health (Department) administers the New York State Medicaid program. The Department uses two methods to pay for Medicaid services: FFS and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays health care providers directly for services rendered to Medicaid recipients. Under the managed care method, the Department makes monthly premium payments to managed care organizations (MCOs) for Medicaid recipients enrolled in their plans. In return, MCOs arrange for the provision of health care services and reimburse providers for those services. New York's Medicaid program offers different types of managed care. For example, Mainstream Managed Care (MMC) provides comprehensive medical services that range from hospital care and physician services to dental and pharmacy benefits, while Health and Recovery Plans (HARP) provide specialized care, including prescription drugs, to Medicaid recipients aged 21 or older with serious mental illness and/or substance use disorders.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health care program for people aged 65 and older and people under age 65 with certain disabilities. Individuals enrolled in both programs are referred to as "dual-eligibles." Medicare is the primary payer for medical services provided to dual-eligible recipients, while Medicaid is the payer of last resort and typically pays the recipients' deductibles and coinsurance on these claims.

As a general rule, dual-eligibles should not be enrolled in MMC or HARP because the cost of the corresponding managed care premiums usually exceeds the cost of deductibles and coinsurance that Medicaid FFS would be obligated to pay on claims for medical services for dual-eligible individuals. Accordingly, Medicaid recipients who enroll in Medicare should be disenrolled from their MMC or HARP plan and placed into FFS. The Department also has the authority 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 the MCO for any payments made to providers for medical services rendered to the recipient (i.e., encounters) during those months.

However, within MMC and HARP is the Integrated Benefits for Dually Eligible Enrollees Program (IB-Dual). IB-Dual offers a special (lower) integrated premium group reimbursement rate for dual-eligibles who do not need long-term services and supports and who are enrolled in their MMC or HARP plan's aligned Medicare Dual Special Needs Plan (D-SNP). The MMC/HARP plans and Medicare plans are

considered aligned when offered by the same entity (e.g., when a recipient receives their HARP and Medicare services through the same health plan). The IB-Dual group rate became effective on April 1, 2021. MMC and HARP plans must apply to the Department to participate in IB-Dual and the approval is added to the plan's certificate of authority. There were four MCOs with approved IB-Dual rates as of March 2022.

Audit Findings and Recommendations

In response to the coronavirus disease 2019 state of emergency, the federal government passed the Families First Coronavirus Response Act, which, in part, increased the federal medical assistance percentage to state Medicaid programs that followed certain criteria. In order to receive the increase, states were required to maintain Medicaid managed care coverage for enrolled recipients throughout the public health emergency. In response, the Department paused disenrollment of dual-eligible recipients from MMC and HARP plans. However, in November 2020, the federal regulation was updated and allowed states to change a recipient's eligibility group as long as minimum essential coverage (e.g., Medicaid FFS) was maintained. Although the Department resumed disenrollment of MMC and HARP recipients receiving comprehensive third-party health insurance (TPHI) in February 2021, it decided not to disenroll dual-eligible recipients with Medicare. As a result, we identified over $194.1 million in excessive MMC and HARP premium payments, as follows:

- $190.6 million in payments for dual-eligible recipients who did not meet the eligibility requirements for IB-Dual, and
- $3.5 million in payments for dual-eligible recipients who appeared to be eligible for IB-Dual but were not enrolled timely.

The Department should review the $194.1 million in excessive premium payments and make recoveries, where appropriate. We also encourage the Department to disenroll dual-eligible recipients from MMC and HARP who do not meet IB-Dual eligibility requirements, and place them in FFS in a timely manner to avoid future excessive premium payments.

Excessive Premium Payments for Recipients Ineligible for IB-Dual

In November 2020, the federal coronavirus regulation was updated to allow Medicaid recipients to be moved between eligibility groups as long as minimum essential coverage was maintained. Subsequently, in February 2021, the Department resumed MMC and HARP disenrollment for recipients receiving comprehensive commercial TPHI coverage. However, this was not done for the dual-eligible population, including those in MMC and HARP who did not meet the eligibility requirements for IB-Dual. As a result, for the period March 2021 through March 2022, we found 667,090 Medicaid MMC and HARP premium payments totaling over $645 million on behalf of 87,022 dual-eligible recipients who were ineligible for IB-Dual. We determined Medicaid overpaid MMC and HARP plans more than $190.6 million, after accounting for encounters paid during the months covered by the premium payments.

According to Department officials, the policy decision not to restart disenrollment for dual-eligibles was done to avoid confusion and benefit disruption in anticipation of the April 1, 2021 IB-Dual implementation and as part of a broader strategy to encourage dual-eligible recipients into integrated care options. However, the recipients we identified did not meet the eligibility requirements for IB-Dual because

they were either: (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.

For example, one dual-eligible recipient we identified was enrolled in an HIV Special Needs Plan and therefore ineligible for IB-Dual. However, Medicaid made 13 premium payments of $6,558 for each month from March 2021 through March 2022 for this individual's continued enrollment in the HIV Special Needs Plan. Had the person been disenrolled and placed into FFS (as was done prior to the public health emergency), Medicaid would have saved $85,254.

Department officials stated that all recipients eligible for IB-Dual are being enrolled as they meet enrollment criteria. As such, the Department's rationale for not resuming disenrollment in anticipation of IB-Dual implementation is no longer relevant. Despite this, the Department has not resumed MMC and HARP disenrollment for dual-eligible recipients who are ineligible for IB-Dual. The Department should recover the $190.6 million in excessive Medicaid payments we identified, as appropriate, and start disenrollment of dual-eligibles from MMC and HARP plans who do not meet IB-Dual eligibility.

Recommendations

1. Disenroll dual-eligible recipients from their MMC or HARP plan who are ineligible for IB-Dual and provide them with FFS coverage, as appropriate.
2. Review the $190.6 million in excessive premium payments and make recoveries, as appropriate.

Excessive Premium Payments for Recipients Eligible for IB-Dual

The Medicaid program's IB-Dual default enrollment process applies to recipients who are newly eligible for Medicare on or after the IB-Dual default enrollment launch date of April 1, 2021. The Department initiates the default enrollment process by sending each MCO a file of their Medicaid recipients 90 days before the recipients will become Medicare eligible. The MCOs must then contact recipients 60 days prior to their Medicare eligibility date with information about IB-Dual, and recipients are given the option to opt out. Recipients who do not choose to opt out are then auto-enrolled into IB-Dual, and Medicaid pays the MMC or HARP plan's IB-Dual rate.

Currently, the Department allows recipients who are eligible for IB-Dual but who choose to opt out to remain in their MMC and HARP plan and Medicaid will continue to pay their monthly premiums. During the audit period, the average monthly MMC and HARP premium payment paid by Medicaid was $989, while the average monthly IB-Dual premium payment was $134. For individuals who opt out, the Department should disenroll them from their MMC or HARP plan and provide them with FFS coverage.

Further, we identified one MCO that did not consistently enroll recipients into IB-Dual timely. We found Medicaid made 7,084 MMC and HARP premium payments totaling $6.4 million to the MCO for 1,948 dual-eligible recipients who appeared eligible for IB-Dual but were not enrolled. The payments covered the period April 2021 through March 2022 (note that default enrollment for this MCO started April 1, 2021). Had Medicaid paid the monthly IB-dual premium rate for this time period (instead of the standard monthly MMC and HARP premiums), Medicaid would have saved $3.5 million.

Of the $3.5 million, the majority of the premiums (93%) were on behalf of Medicaid recipients who became Medicare eligible prior to the start of IB-Dual default enrollment (and, therefore, were not included in the default enrollment process). For example, one recipient began receiving Medicare in February 2021. We determined this individual was eligible for IB-Dual upon the rollout of the new rate on April 1, 2021 but was not enrolled until September 2021. Had this individual been properly enrolled in IB-Dual, Medicaid would have paid $620 in premiums during this 5-month period. Instead, Medicaid made five premium payments totaling $12,208 at the higher MMC rate, resulting in excessive payments of $11,588.

According to the Department, identifying and enrolling individuals who do not go through default enrollment is an ongoing process, done in conjunction with MCOs. We found the Department made significant progress enrolling these individuals in September 2021, and officials stated they now have a process to identify and transfer aligned dual-eligibles (non-default enrolled) into IB-Dual on a monthly basis. As of June 2022, most recipients from this population have transitioned to IB-Dual; however, some still have not. The Department should prioritize the remaining population to avoid future excessive premium payments.

Recommendations

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

Audit Scope, Objective, and Methodology

The objective of the audit was to determine whether Medicaid overpaid MMC and HARP premiums on behalf of dual-eligible individuals. The audit covered the period from March 2021 through March 2022.

To accomplish our objective and assess related internal controls, we interviewed officials and obtained information from the Department and all four MCOs approved for IB-Dual. We reviewed applicable federal regulations and guidance, and examined the Department's relevant Medicaid policies and procedures. We reviewed claims data from the Medicaid Data Warehouse and eMedNY, and determined the data was reliable.

We calculated the $190.6 million in excessive MMC and HARP payments for recipients who did not meet IB-Dual eligibility requirements by subtracting encounter payments that MCOs made for these recipients from the total premiums paid to the MCOs for the same month.

We calculated the $3.5 million in excessive MMC and HARP payments for recipients eligible for but not enrolled in IB-Dual by taking the lesser of either: MMC and HARP premium payments, reduced by any encounter payments that MCOs made for these recipients during the same months; or the difference between the MMC or HARP premium payment and the MCO's average IB-Dual premium payment for each month. We employed this method to account for recipients either being disenrolled to FFS if they decided to opt out or being transitioned to IB-Dual.

We performed an analysis of MMC and HARP premium payments for recipients who were eligible for but not enrolled in IB-Dual. We found that one MCO received 94% of the MMC and HARP premium payments on behalf of individuals in this population. As a result, we performed our subsequent audit steps on that specific MCO. We judgmentally sampled recipients and corresponding premiums to share with this MCO and the Department for review and to verify recipients' IB-Dual eligibility or enrollment. We sent six claims to the Department based on the premium payment dates, seven recipients to the MCO who became eligible after default enrollment, and 20 claims to the MCO for different recipients who were eligible for IB-Dual but were not enrolled. Because we selected judgmental samples, our results cannot be projected to the population as a whole.

We shared our methodology and findings with Department officials during the audit for their review. We took their comments into consideration when performing our analyses.

Statutory Requirements

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.

We conducted this 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. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of HARP and MMC premium payments on behalf of dual-eligible individuals.

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 it. Our response to certain Department comments are included in our State Comptroller's Comments, which are embedded in the Department's response.

Within 180 days after 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.

Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 23, 2022

Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
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Albany, New York 12236-0001

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2021-S-37 entitled, "Medicaid Program: Excessive Premium Payments for Dual-Eligible Recipients Enrolled in Mainstream Managed Care and Health and Recovery Plans."

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

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Department of Health Comments to Draft 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 Draft 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 Mainstream Managed Care (MMC) or Health and Recovery Plan (HARP) who are ineligible for Integrated Benefits for Dually Eligible Enrollees Program (IB-Dual) and provide them with fee-for-service (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 Dual-eligible Special Needs Plan (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 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. 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. 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 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.

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