Department of Health

Medicaid Program: Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage

Report 2022-S-35 | September 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid made improper payments on behalf of recipients with Department of Health-authorized overlapping Medicaid and Essential Plan coverage. The audit covered the period from January 2017 through November 2022.

About the Program

The Department of Health (Department) administers New York's Medicaid program, which provides health care services to individuals who are economically disadvantaged. The Department also administers New York's Essential Plan, which provides health insurance to lower-income individuals who, generally, don't otherwise qualify for Medicaid. As income, household makeup, and other factors change, individuals may transition between Medicaid and the Essential Plan. Both programs provide comprehensive health insurance and cover many of the same types of services. When recipients transition from one program into the other, Medicaid and Essential Plan eligibility and enrollment rules can result in Department-authorized periods of overlapping insurance coverage.

Medicaid is the payer of last resort, which means recipients' other third-party health insurance coverage, such as insurance under the Essential Plan, must be exhausted before Medicaid pays. During periods of authorized overlapping Medicaid and Essential Plan coverage, the Essential Plan should be the primary payer and Medicaid, as secondary payer, should pay any remaining liabilities, such as deductibles and coinsurance.

Key Findings

Medicaid improperly paid $93.7 million in claims during periods of overlapping Medicaid and Essential Plan coverage because the Department did not account for the Essential Plan as a liable third-party health insurance. Despite administering both programs and having enrollment information for both in its systems, the Department never applied payment controls and, consequently, Medicaid has been improperly paying the full amount for services as the primary payer since inception of the Essential Plan. Our review identified Medicaid overpayments of:

- Approximately $69 million for health care services fully covered by the Essential Plan;
- Up to $14.1 million for health care services covered by the Essential Plan under certain circumstances and/or up to certain quantity limits; and
- $10.6 million for managed care premiums when recipients did not qualify for Medicaid managed care because they also had Essential Plan coverage.

Key Recommendations

- Review the $93.7 million in improper payments and make recoveries as appropriate.
- Recognize the Essential Plan as liable third-party health insurance and ensure proper processing of Medicaid claim payments.

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

September 14, 2023

James V. McDonald, M.D., M.P.H
Commissioner
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Dear Dr. McDonald:

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 entitled *Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage*. 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*
CMS	Centers for Medicare & Medicaid Services	*Agency*
eMedNY	Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
MCO	Managed care organization	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*

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 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 localities (the City of New York and counties) funded the remaining 42.9%.

The Department of Health (Department) uses two methods to pay for Medicaid services: fee-for-service (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 MCOs' health care plans and, in turn, MCOs arrange for the provision of health care services and reimburse providers for those services.

The Affordable Care Act of 2010 allowed states to establish and administer a Basic Health Plan, which provides minimum essential health insurance for individuals with lower incomes who are not eligible for Medicaid. The Affordable Care Act of 2010 specified that states should coordinate the administration and provision of benefits of their Basic Health Plan with their state Medicaid program and other state-administered health programs to maximize efficiency and improve continuity of care.

New York's Basic Health Plan, which has been available since January 2016, is known as the Essential Plan. The Essential Plan provides health insurance for individuals with lower incomes (up to 200% of the federal poverty level for State fiscal year ended March 31, 2022) who meet eligibility requirements. For the State fiscal year ended March 31, 2022, the Essential Plan had approximately 971,000 recipients and program costs totaled about $5.5 billion. According to the Department, Essential Plan program costs were 100% funded by the federal government and administrative costs were funded by the State. The Department makes monthly premium payments to Essential Plan insurers for Essential Plan recipients enrolled in the insurers' plans and, in turn, Essential Plan insurers arrange for the provision of health care services and reimburse providers for those services.

The Department administers both the Medicaid and Essential Plan programs. Both programs offer comprehensive health insurance, meaning they cover a wide range of services, such as doctor visits, emergency room care, inpatient hospital care, behavioral health care, prescription drugs, laboratory services, and hospice. Medicaid and Essential Plan enrollment information is processed by eMedNY, and payments are made by eMedNY for Medicaid FFS claims, Medicaid managed care premiums, and Essential Plan premiums.

Income criteria to qualify for Medicaid and the Essential Plan are similar, and, as income, household makeup, and other factors change, individuals may transition between the two programs. Individuals with Medicaid do not qualify for the Essential Plan; however, when recipients transition from one program into the other, Medicaid and Essential Plan eligibility and enrollment rules sometimes result in Medicaid and Essential Plan coverage overlaps that are considered allowable by the Department, such as:

- When a recipient transitions from one program to the other, the eligibility and enrollment business rules for the two programs may result in a new enrollment becoming effective (e.g., on the first day of the application month) before the prior program enrollment is terminated (e.g., at the end of the following month). In these cases, an overlap of 1 or 2 months could occur.
- When a recipient is determined to be eligible for retroactive Medicaid to allow providers to bill Medicaid for unpaid medical services, a 3-month period of retroactive Medicaid could overlap with Essential Plan enrollment.
- When a recipient's Medicaid coverage is limited and available only under certain circumstances and therefore it does not qualify as "minimum essential coverage," the recipient can also be in the Essential Plan.

Medicaid is the payer of last resort and, as such, a recipient's other health insurance must be used to pay for medical services before any Medicaid payments are made. Medicaid may pay any remaining costs, such as copayments and coinsurances, after all other insurance resources are exhausted. Federal and State regulations and Department Medicaid policies all build on this concept. For example, federal regulations[1] define a third-party as any individual, entity, or program that is or may be liable to pay all or part of the cost of Medicaid services rendered.

Essential Plan insurers are third-party health insurers responsible for paying for health care services because the Department contracts with and pays them to arrange for the provision of health care services and reimburse providers. Therefore, when recipients have permissible overlapping Medicaid and Essential Plan coverage, Essential Plan insurers should pay for health care services as the primary payer, and Medicaid (as the secondary payer) should pay any remaining liabilities. Additionally, when the Department knows of third parties that should be primary payers, such as the Essential Plan, but Medicaid claims do not indicate that the third-party insurance was billed first, the Department is required to deny the claims.

1 Code of Federal Regulations, Title 42, CFR 433 Subpart D

Audit Findings and Recommendations

When a recipient has Department-authorized overlapping Medicaid and Essential Plan coverage, the Essential Plan – as a comprehensive third-party health insurance – should be the primary payer over Medicaid. However, the Department did not account for the Essential Plan as a liable third-party insurance with primary payment responsibility in order to ensure that Medicaid is the payer of last resort. Despite administering both Medicaid and the Essential Plan and having enrollment information for both in eMedNY, the Department has not applied existing system payment controls to the Essential Plan to ensure it is treated as a liable third-party insurance that pays for services before Medicaid. Consequently, Medicaid has been improperly paying the full amount for services as the primary payer since the inception of the Essential Plan. Also, recipients do not qualify for certain Medicaid managed care plans when they have Essential Plan coverage.

For the period from January 2017 to November 2022, we identified improper Medicaid payments of $93.7 million consisting of $83.1 million in FFS medical claims and $10.6 million in managed care premiums. The Department should review the $93.7 million in Medicaid claims and make recoveries as appropriate. We also recommend that the Department account for Essential Plan enrollment in its Medicaid claims processing to prevent improper Medicaid payments.

Essential Plan Covered Services

According to officials from the Centers for Medicare & Medicaid Services (CMS), a state's Basic Health Plan, such as New York's Essential Plan, is a third-party health insurance that is liable as the primary payer for coverage of medical services during Department-authorized periods of overlapping Medicaid and Essential Plan coverage.

We determined Medicaid improperly paid as the primary insurance on 253,673 claims, totaling $83.1 million, for services provided during Department-authorized periods of overlapping coverage. This occurred because the Department did not identify Essential Plan coverage as third-party health insurance in eMedNY; therefore, the Medicaid claims were not denied during claims processing.

Fully Covered Services

The Essential Plan provides comprehensive health insurance and fully covers many types of services without limitations. We determined that 233,131 Medicaid claims, totaling $69 million (of the $83.1 million), were improperly paid for services that were fully covered by and should have been paid by the Essential Plan as primary payer. Medicaid policy requires providers to bill liable third parties before billing Medicaid; therefore, Medicaid should only be billed after Essential Plan coverage is exhausted (such as in cases where copayments or coinsurances are required to be paid by Medicaid or where services are not covered by the Essential Plan). For example, Medicaid paid $71 on a claim for a doctor's office visit – an Essential Plan-covered service with no limits on the number of visits. In this example, the recipient's Essential Plan coverage did not require any copayments or coinsurances.

Therefore, the full amount should have been covered by the Essential Plan, with no claim submitted to Medicaid.

If this recipient's Essential Plan coverage had been properly accounted for as a liable third-party health insurance by the Department, eMedNY would have denied the claim, and the provider would have been notified by eMedNY to bill the third-party insurance (i.e., the Essential Plan) as the primary payer. Accordingly, the Essential Plan would have paid the claim, and because there were no copayments or coinsurances, no claim would have been submitted to Medicaid. However, because the Department did not account for Essential Plan coverage as third-party health insurance in eMedNY, Medicaid paid the claim as the primary payer, resulting in an overpayment of $71.

In instances like this where Essential Plan services do not have copayments and coinsurances, the entire Medicaid payment is overpaid. In other instances where Essential Plan services have copayments and coinsurances, Medicaid may be liable to pay these amounts on behalf of recipients.

The improper Medicaid payments for services that were fully covered by the Essential Plan are summarized by service type in the following table.

Improper Payments for Services Fully Covered by the Essential Plan

Service Type	Medicaid Payment Amount	Number of Claims
Inpatient	$46,050,996	3,447
Clinic	14,371,561	66,709
Practitioner	3,809,706	70,112
Pharmacy	2,701,942	32,454
Laboratory	900,770	51,094
Referred ambulatory	503,850	5,771
Transportation	494,570	2,122
Durable medical equipment	186,712	1,422
Totals	**$69,020,107**	**233,131**

Services With Limited Coverage

The Essential Plan covers some services only under certain circumstances and/or with quantity limits. For example, the Essential Plan limits coverage for skilled nursing facility services to up to 200 days per year and only covers medical services provided by skilled/licensed medical personnel but not custodial care. In contrast, Medicaid covers care in skilled nursing facilities, including custodial care, and does not limit the number of days per year.

Medicaid policy requires providers to bill third-party health insurance as the primary payer; therefore, Medicaid should only be billed after the third-party insurance (e.g., the Essential Plan liability) is exhausted. If a service is not covered by the Essential Plan due to coverage limitations, then Medicaid should pay as the primary payer. We identified Medicaid payments of $14.1 million on 20,542 claims that were for

services with limited Essential Plan coverage that did not indicate the Essential Plan was billed as primary payer. Although the Essential Plan may deny a portion of these claims due to coverage limitations, Medicaid is required to ensure Essential Plan liability is exhausted prior to paying these claims.

Managed Care Premiums

Department policy excludes Medicaid recipients from enrolling in certain Medicaid managed care plans (mainstream managed care plans, HIV Special Needs Plans, and Health and Recovery Plans) when the recipients also have comprehensive third-party health insurance. As mentioned, the Essential Plan is a comprehensive third-party health insurance. Therefore, according to Department policy, Medicaid recipients with Essential Plan coverage should not be enrolled in these Medicaid managed care plans.

We identified 18,046 Medicaid managed care premium payments, totaling $10.6 million, for Medicaid recipients who also had Essential Plan coverage. Medicaid improperly paid these managed care premiums because the Department did not account for the Essential Plan as a liable comprehensive third-party insurance. The Medicaid managed care contracts allow the Department to recover premium payments when recipients are simultaneously enrolled in other comprehensive third-party health insurance.

Recommendations

1. Review the $93.7 million ($83.1 million + $10.6 million) in improper payments and make recoveries as appropriate.
2. Recognize the Essential Plan as liable third-party health insurance and ensure proper processing of Medicaid claim payments.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper payments on behalf of recipients with Department-authorized overlapping Medicaid and Essential Plan coverage. The audit covered the period from January 2017 through November 2022.

To accomplish our objective and assess related internal controls, we interviewed officials from the Department and the Office of the Medicaid Inspector General (OMIG), and we consulted with CMS officials. We examined applicable federal and State laws and regulations and relevant Medicaid policies to gain an understanding of how Medicaid and Essential Plan coverage should be coordinated. We reviewed the NYS Essential Health Benefits Benchmark Plan and Essential Plan contracts to gain an understanding of the services covered by the Essential Plan. We also reviewed Medicaid managed care contracts regarding recoverability of Medicaid managed care premium payments.

We identified Essential Plan recipients and their coverage periods based on Essential Plan premium payments. The Essential Plan recipients were then matched to Medicaid enrollments based on their Social Security number and combinations of their first name, last name, date of birth, and gender. For these recipients, we identified Medicaid claims for services during periods of Essential Plan coverage. We removed claims with third-party payments (such as Medicare and commercial insurance). We focused our review on Medicaid payments for services provided to recipients during Department-authorized overlapping Medicaid and Essential Plan coverage. We then included only Medicaid claims for health care services that are covered by Essential Plan, either in full or with limitations.

Our audit did not factor Essential Plan copayments and coinsurances into overpayments reported. When Essential Plan is the primary payer, some Essential Plan recipients may be liable for copayments and coinsurances up to an annual maximum limit. These copayments and coinsurances may be appropriately paid by Medicaid, but with limitations (i.e., Medicaid typically only pays up to the standard Medicaid fee; therefore, Essential Plan copayments or coinsurances will only be paid if the Essential Plan payment was less than the standard Medicaid fee).

Based on our audit work, we believe the Medicaid and Essential Plan claims and enrollment data obtained from the Medicaid Data Warehouse and eMedNY were sufficiently reliable for the purposes of this audit. We shared our methodology and findings with officials from the Department and OMIG during the audit for their review.

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 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. 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 Medicaid payments during overlapping Medicaid and Essential Plan coverage.

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 concurred with the audit recommendations and indicated certain actions have been and will be taken to address them. Our response to certain Department remarks is embedded within the Department's response as a State Comptroller's Comment.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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.

Agency Comments and State Comptroller's Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

July 7, 2023

Andrea Inman, Audit Director
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Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2022-S-35 entitled, "Medicaid Program: Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Executive Deputy Commissioner

Enclosure

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Department of Health Comments to Draft Audit Report 2022-S-35 entitled, "Medicaid Program: Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage" 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 2022-S-35 entitled, "Medicaid Program: Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage" by the Office of the State Comptroller (OSC).

General Comments:

The following comments address specific statements made in the audit report.

Key Findings (page 1)

Medicaid improperly paid $93.7 million in claims during periods of overlapping Medicaid and Essential Plan coverage because the Department did not account for the Essential Plan as a liable third-party health insurance. Despite administering both programs and having enrollment information for both in its systems, the Department never applied payment controls and, consequently, Medicaid has been improperly paying the full amount for services as the primary payer since inception of the Essential Plan.

Essential Plan Covered Services section (page 7)

According to officials from the Centers for Medicare & Medicaid Services (CMS), a state's Basic Health Plan, such as New York's Essential Plan, is a third-party health insurance that is liable as the primary payer for coverage of medical services during Department-authorized periods of overlapping Medicaid and Essential Plan coverage.

Department Comments:

The Department received clarifying guidance from CMS regarding the coordination of benefits between Medicaid and the Essential Plan on **March 9, 2023** in response to the Department's initial and follow-up requests (November 2022 and March 2023, respectively). Therefore, clarifying guidance that the Essential Plan coverage was to be treated as third-party health insurance was not received from CMS until well after OSC's audit period of January 2017 through November 2022. As soon as the Department received the guidance from CMS, the Department initiated steps to treat Essential Plan coverage as third-party health insurance.

State Comptroller's Comment – The Department sought this guidance from CMS as a result of this audit. The CMS guidance confirmed that Medicaid had been improperly paying as the primary payer for services provided to recipients with overlapping Medicaid and Essential Plan coverage since the inception of the Essential Plan in 2016. Department officials should have established the policies with CMS, as well as payment controls, well before the start of the Essential Plan – not over 6 years after the start of the Essential Plan upon our auditors' challenge of the appropriateness of not coordinating benefits with the Medicaid program.

Responses to Audit Recommendations:

The following are responses to the audit report recommendations.

Recommendation #1:

Review the $93.7 million ($83.1 million + $10.6 million) in improper payments and make recoveries as appropriate.

Response #1:

The Department is reviewing the claims data shared by OSC to determine if recoveries are appropriate.

Recommendation #2:

Recognize the Essential Plan as liable third-party health insurance and ensure proper processing of Medicaid claim payments.

Response #2:

The Department is pursuing options for viable implementation of this recommendation. At the outset, this will need to be a manual process. The Department is obtaining required approvals to hire staff to make the necessary entries to the eMedNY system. In addition, ongoing discussions are occurring with NY State of Health and eMedNY staff to initiate the system related projects needed to transform a majority of the manual activities to an automated process.

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