New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus

Medicaid Program
Department of Health

Report 2015-S-47 July 2017

Executive Summary

Purpose

To determine whether the Department of Health (Department) made inappropriate premium payments to Medicaid mainstream managed care plans and Family Health Plus managed care plans (Plans) for recipients who were no longer enrolled. Our audit covered the period October 1, 2010 through September 30, 2016.

Background

Under the Department's managed care arrangements, managed care plans receive monthly premium payments for individuals enrolled in their plans. In return, managed care plans arrange for the provision of health care services their members require. The State's Medicaid program offers different types of managed care. Most Medicaid recipients are enrolled in mainstream managed care, which provides comprehensive medical services that range from hospital care and physician services to dental and pharmacy benefits. In addition to Medicaid managed care, during the audit period, Family Health Plus (FHP) was a publicly funded managed care program for individuals whose income was too high to qualify for Medicaid. As a result of the Affordable Care Act of 2010, the State Fiscal Year 2013-14 Enacted Budget eliminated FHP effective January 1, 2015, and the majority of FHP enrollees transitioned to the Medicaid program.

For the period October 1, 2010 through September 30, 2016, the Department paid Plans approximately $94 billion in monthly premium payments. The Department can recover inappropriate premium payments made to Plans. An inappropriate payment can occur when a premium payment was made to a Plan for a recipient who was later retroactively disenrolled from the Plan, and the Plan was not "at risk" for the provision of medical services during the disenrollment period. (Note: A Plan is not at risk if it did not pay for medical services for a recipient.) Plans can either void their claims for the improperly paid premiums or refund the inappropriate premiums by check.

Key Findings

- For the period October 1, 2010 through September 30, 2016, the Department made 314,287 improper and questionable premium payments totaling about $122 million for 171,936 recipients who were subsequently disenrolled retroactively from a Plan, and the Plan was not at risk during the disenrollment periods. As of June 16, 2016, the Plans voided premium payments totaling about $7.4 million, potentially leaving several tens of millions of dollars that still needed to be recovered from the Plans.[1]
- Local Departments of Social Services (LDSS), including the New York City Human Resources Administration (HRA), determine retroactive disenrollment periods and notify Plans to void inappropriate premium payments. Our testing at HRA found that officials misinterpreted guidelines governing when Plans are considered not at risk and when corresponding premium

[1] Because Plans do not always void claim payments in the Medicaid claims processing system, but rather repay improper premiums in the form of checks, we were unable to account for check payments and thus eliminate them from our population of improper premium payments. We informed officials of this, and they agreed to match certain overpayments we identified to check payment information so that we could eliminate these recoveries from our population. However, at the end of our audit fieldwork, officials were still in the process of performing this match.

payments should be recovered. This resulted in improper premium payments being deemed as appropriate when they were not.

- The Office of the Medicaid Inspector General (OMIG) regularly performs Plan-specific audits of premium payments made on behalf of recipients who were retroactively disenrolled from managed care plans. However, the OMIG's identification of improper premium payments is based on LDSS notifications to Plans of retroactive disenrollments during periods when Plans were deemed not at risk, which we found were not always complete. The OMIG's identification of improper premiums is also based on matches with limited recipient date of death information. Therefore, improper premium payments for many retroactively disenrolled recipients can remain unaddressed.

Key Recommendations

- Review the improper and questionable premium payments we identified and recover overpayments, as appropriate.
- 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 such 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 managed care model contract.
- 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 corresponding improper payments are voided.
- Determine the reasons for the differences in the improper premium payments identified by our office and the OMIG audits, 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.

Other Related Audits/Reports of Interest

Department of Health: Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care (2014-S-5)

Department of Health: Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans (2015-S-9)

State of New York
Office of the State Comptroller

Division of State Government Accountability

July 11, 2017

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for 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 *Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus*. 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.

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,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York State Medicaid program is a federal, State, and locally funded program administered by the Department of Health (Department) that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2016, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $56 billion, of which managed care accounted for over $30.7 billion. The federal government funded about 53.2 percent of New York's Medicaid claim costs; the State funded about 30.6 percent; and the localities (the City of New York and counties) funded the remaining 16.2 percent.

New York's Medicaid program offers different types of managed care. Mainstream managed care provides comprehensive medical services that range from hospital care and physician services to dental and pharmacy benefits. Based on December 2015 data, 4.3 million people were enrolled in Medicaid mainstream managed care plans. Other types of managed care, such as managed long-term care and Medicaid Advantage, are specific to certain populations, such as those needing certain long-term care or those who also have Medicare coverage.

During the audit period, another publicly funded managed care program in New York was the Family Health Plus (FHP) program. FHP enrolled individuals whose income was too high to qualify for Medicaid. FHP offered comprehensive medical services ranging from prevention and primary care to hospital care and prescriptions. As a result of the Affordable Care Act of 2010, the State Fiscal Year 2013-14 Enacted Budget eliminated FHP effective January 1, 2015, by which time most FHP enrollees had moved into Medicaid.

The Department pays managed care plans (Plans) a monthly premium payment for each recipient enrolled in a Plan. The Plans are then responsible for ensuring enrollees have access to a comprehensive range of health care services. Plans typically have networks of participating providers that they reimburse directly for services provided to their enrollees. Plans are also required to submit "encounter" claims to the Department's Medicaid claims processing system (eMedNY), which informs the Department about each medical service provided to recipients enrolled in managed care.

There are several ways individuals are enrolled in a Plan, including through Local Departments of Social Services (LDSS) and, as of January 2014, the NY State of Health (NYSOH), which is the State's online marketplace for obtaining health insurance. LDSS, which includes the New York City Human Resources Administration (HRA), are responsible for enrolling certain categories of individuals, such as individuals receiving SSI (Supplemental Security Income). Certain other individuals are enrolled through NYSOH, including adults between the ages of 19 and 64 who are not eligible for Medicare.

LDSS update an individual's enrollment and disenrollment information though the State's Welfare Management System (WMS). Eligibility information in the WMS is ultimately communicated to the Department's eMedNY claims processing and payment system. NYSOH communicates with

eMedNY and other systems to coordinate the enrollment and disenrollment activities associated with NYSOH-enrolled individuals.

Enrollment rosters are key controls over the enrollment process. The Department generates enrollment rosters monthly based on WMS data listing every recipient who is eligible for Plan enrollment for the upcoming month, and NYSOH generates enrollment rosters daily. These documents are used to disseminate enrollment data and serve as the official notification to Plans advising them who they should cover and who they are allowed to submit claims for each month. Specifically, the Plans use these rosters to bill claims for the enrollees' monthly premium payments. Information on the rosters is systematically updated to eMedNY, and enrollment information in eMedNY is regularly uploaded to the Medicaid Data Warehouse (MDW), where Plan members' historical enrollment periods are maintained.

If, subsequent to enrollment in a Plan, a recipient is determined to be ineligible for enrollment in a Plan (for instance, an individual died or was incarcerated), they may be disenrolled retroactively back to the effective disenrollment date. Because the eMedNY system uses enrollment data to process premium claims paid to the Plans, it is essential that this information be updated in eMedNY in a timely manner to ensure premium payments are appropriate and are not made on behalf of recipients who were inappropriately enrolled in managed care.

All claims submitted to eMedNY by the Plans are subject to various payment controls (eMedNY edits) to help ensure that premium payments are appropriate. One edit, in particular, ensures that premium payments are made to a Plan only if the member for whom the claim was submitted was enrolled for the period covered by the premium. Members' enrollment data in eMedNY must cover the months corresponding to the premium payments; otherwise, the payments will be denied. However, due to retroactive disenrollments, payments already made could later be found to be improper.

The Department has the right to recover premium payments from Plans for inappropriately enrolled recipients either for a portion of the enrollment period retroactive to the effective disenrollment date or for the entire enrollment period, in which case the entire enrollment period is retroactively deleted. However, the Department may only recover premium payments if it is determined that the Plan was not "at risk" for the provision of medical services during any portion of the payment period. The Plan is considered to have been at risk if it paid for medical services provided to a recipient during the month covered by the premium payment. The NYSOH and LDSS are responsible for determining whether Plans made payments to health care providers on behalf of recipients who were disenrolled or who face disenrollment. For each such recipient, the responsible agency (LDSS or NYSOH) and the Plan will agree on a retroactive disenrollment or prospective disenrollment date. Plans can either void the claims for the inappropriate premium payments in eMedNY or repay the premiums by check. According to the managed care model contract, Plans must void premium payments within 30 business days of notification from the NYSOH or LDSS for any full month of retroactive disenrollment.

Audit Findings and Recommendations

For the period October 1, 2010 through December 31, 2014, the Department made 190,686 improper or questionable premium payments, totaling about $72.6 million, on behalf of 105,358 recipients who were subsequently disenrolled retroactively from Plans and who did not receive medical services during the disenrollment periods. This included more than $10.5 million related to 7,415 deceased recipients. We provided details about the improper payments we identified, along with the methodology used to identify them, to the Department for review. During the six-month period after we provided the claim details to the Department, 14,209 claims totaling more than $7.4 million in improper premium payments had been voided, leaving 176,477 premium payments totaling about $65.2 million that still needed to be reviewed and, if warranted, recovered (see table on page 8). This included:

- 136,786 payments totaling about $50.5 million for recipients whose enrollment information was readily obtainable on eMedNY or the MDW; and
- 39,691 payments totaling about $14.7 million for recipients whose enrollment data was not on eMedNY or the MDW. (Note: For these cases, the enrollment information had been improperly deleted.) To assess the appropriateness of these payments, we relied on other information from the MDW that indicated whether members were disenrolled. Therefore, we consider these payments to be questionable since enrollment data was missing.

As was previously stated, by January 2015, most FHP enrollees were moved into Medicaid. In addition to the findings above, for the period January 1, 2015 through September 30, 2016, using the same methodology, we determined Medicaid made 123,601 additional improper or questionable premium payments, totaling about $49.8 million, on behalf of 77,078 recipients who were also subsequently disenrolled retroactively from a Plan and who did not receive medical services during the disenrollment period. This included 113,879 payments totaling about $46 million for recipients whose enrollment information was readily obtainable on eMedNY or the MDW and 9,722 payments totaling more than $3.8 million for recipients whose enrollment data was not on eMedNY or the MDW.

Plans do not always void claim payments within the eMedNY claims processing system; rather, some repay improper payments by check. However, the MDW does not reflect Plans' repayments that were made in the form of checks, and thus, we were unable to account for any such payments and eliminate them from our population of improper premium payments. We informed Department officials of this and made recommendations for them to review and recover any inappropriate premium payments. We also recommended enhancements to the Office of the Medicaid Inspector General's (OMIG) recovery of premium payments. Further, we recommended that the Department fully assess the reasons for the outstanding inappropriate payments and strengthen controls to address those weaknesses, and provide guidance to LDSS to address misinterpretations of policies that will help ensure LDSS notify Plans of all improper premium payments and that improper payments are properly voided.

Overpayments for Recipients Whose Enrollment Information Was Readily Obtainable

For the period October 1, 2010 through December 31, 2014, Plans received $59.7 billion in premium payments for individuals enrolled in mainstream managed care and FHP. During this period, the Department made 136,786 premium payments totaling about $50.5 million for recipients who were subsequently disenrolled retroactively from a Plan (per eMedNY and the MDW) and the Plan was not at risk during the disenrollment period.

As illustrated in the following table, in most instances, the Plans received one month of inappropriate premium payments for recipients who were disenrolled retroactively. (Note: These payments did not necessarily reflect the first month of disenrollment.) We also found instances where Plans received multiple months of improper premium payments prior to a recipient's disenrollment. For example, Medicaid made 23 months of premium payments, totaling $21,697, to a Plan from July 2012 through May 2014 for a recipient who was disenrolled retroactively. However, according to the Department's eMedNY enrollment information, the recipient was not enrolled in the Plan during this period. Additionally, the Plan had not voided any of these improper payments.

Monthly Breakdown of Improper and Questionable Premium Payments for the Period October 1, 2010 Through December 31, 2014

Number of Months of Improper Premium Payments	Number of Recipients	Percentage of Total Recipients	Improper Premium Payments	Percentage of Total Improper Premium Payments
1	76,338	76.85%	$29,309,768	44.95%
2	7,979	8.03%	6,070,676	9.31%
3	3,850	3.87%	4,049,199	6.21%
4	2,623	2.64%	3,550,938	5.44%
5	2,361	2.38%	3,932,174	6.03%
6	1,992	2.01%	4,069,085	6.24%
7	1,716	1.73%	4,195,478	6.44%
8	1,177	1.18%	3,388,970	5.20%
9	438	0.44%	1,451,980	2.23%
10	210	0.21%	743,505	1.14%
11	142	0.14%	564,925	0.87%
12	116	0.12%	528,035	0.81%
13	46	0.05%	273,200	0.42%
14	41	0.04%	188,730	0.29%
15	41	0.04%	252,535	0.39%
16-51	265	0.27%	2,625,079	4.03%
Totals	**99,335**	**100%**	**$65,194,277**	**100%**

To verify the impropriety of payments, we provided the Department with a judgmental sample of 63 premium payments totaling $27,363 for Plan recipients who, according to eMedNY or MDW enrollment information, were retroactively disenrolled. Department officials reviewed the payments and confirmed that all were for recipients who were no longer enrolled. Officials based their assessment on enrollment information from the WMS, which maintains and processes eligibility and enrollment information for individuals who are eligible for multiple public assistance programs administered by LDSS. For the improper payments, the WMS showed that either the recipient's entire enrollment period was rescinded or the recipient was disenrolled retroactively for a portion of the enrollment period.

Since eMedNY has edits to ensure premium payments are made only when enrollment exists, improper payments were made because either the managed care enrollment data was updated after the premium payments were made or the recipients were retroactively disenrolled from managed care. We found various reasons for disenrollment, including loss of managed care eligibility, death, or third-party health insurance coverage. For example, a recipient had comprehensive third-party health insurance coverage for calendar years 2012 through 2014 through a Plan and was simultaneously enrolled in mainstream managed care with the same Plan. The mainstream managed care enrollment data showed enrollment was effective for only one month (February 2012). However, Medicaid made 34 premium payments totaling $5,773 for this recipient from March 1, 2012 through December 31, 2014. (Note: The Plan voided all of these improper payments after we provided the claim details to the Department.) In another example, records indicated a recipient died on December 9, 2012. However, managed care enrollment for this recipient was effective from May 1, 2012 through April 30, 2014. Consequently, Medicaid made 16 premium payments totaling $16,093 after the recipient's date of death.

Overpayments for Retroactively Disenrolled Recipients Whose Enrollment Data Was Not in eMedNY or the MDW

For the period October 1, 2010 through December 31, 2014, the Department made 82,509 premium payments totaling about $31.7 million on behalf of 12,946 recipients who did not have managed care enrollment data in eMedNY or the MDW during the audit period. In response to our preliminary findings, Department officials informed us that this enrollment data was inadvertently deleted from eMedNY. Further, according to officials from CMA Consulting Services, consultants for the MDW, when the Department deletes any segment of the managed care enrollment period from eMedNY, the same segments are automatically deleted from the MDW. Department officials informed us they identified the problems causing enrollment data to be deleted and initiated system evolution projects to correct the problems.

We provided a judgmental sample of 25 recipients with missing enrollment data to the Department for review. Of the 25 recipients, 23 were enrolled through NYSOH, and Department officials confirmed that their enrollment data was inappropriately deleted from eMedNY. The remaining two recipients were enrolled in managed care through LDSS, but were not eligible, and were retroactively disenrolled. At the end of our fieldwork, we observed that some of the sampled recipients' enrollment data had been subsequently updated. As a result, we reviewed

the eMedNY enrollment history for the 12,946 recipients again and found that eMedNY contained enrollment data for 570 of these recipients – and we noted that some of them still had premium payments outside of the corrected enrollment periods.

Despite the missing enrollment data, we determined the MDW contained other disenrollment data for 11,988 of the 12,946 recipients. Since 11,988 of these recipients had disenrollment data, we performed additional analyses to determine whether disenrollment data could be used to identify improper premium payments when enrollment data did not exist. To test the reliability of the disenrollment data, we analyzed premium payments for 103 recipients of the 570 who had both enrollment and disenrollment data. We found that the disenrollment data was reliable, as the disenrollment periods always corresponded to the time periods that enrollment data showed the recipients were not enrolled. Therefore, when it was available, we used disenrollment data to review premium payments for the recipients whose enrollment data was deleted from eMedNY and the MDW.

Using the disenrollment data for the 11,988 recipients and newly available enrollment data for the 570 recipients, we found the Department made 39,691 improper premium payments totaling about $14.7 million for 9,504 recipients who were disenrolled retroactively. These payments appear improper because, according to MDW disenrollment data, these recipients were not eligible for managed care during the months that premium payments were made and the Plans were not at risk during the disenrollment periods.

To further test the reliability of the data we used, we provided the Department with an additional judgmental sample of 25 premium payments totaling $8,704 for 25 recipients. The Department used the WMS and eMedNY to assess these payments and determined the following:

- 16 recipients were disenrolled from Plans due to overlapping enrollment periods with Medicaid fee-for-service;
- 4 recipients were retroactively disenrolled due to death;
- 3 recipients were retroactively disenrolled for other reasons, such as third-party health insurance; and
- 2 recipients had no enrollment or disenrollment data at the time of the Department's review, for unknown reasons, and the assessment was thus inconclusive.

Because enrollment data was missing from eMedNY and the MDW, upon our request, the Department provided a comprehensive list of 78,029 recipients who (per the Department) needed their eMedNY managed care enrollment data corrected. From our population of 39,691 improper premium payments totaling about $14.7 million, we determined that more than half – 22,834 claims totaling $8.4 million – were on the Department's list. As the Department continues to update missing eMedNY enrollment data, some of these premium payments that we identified as improper may later be found to be appropriate. The remaining 16,857 claims (39,691 – 22,834), totaling about $6.3 million, were not identified by the Department for correction. Nevertheless, we concluded that there was material risk that these payments were improper.

Overpayments After FHP Recipients Transitioned to Medicaid

By January 2015, most FHP enrollees had transitioned into Medicaid. Accordingly, for the period January 1, 2015 through September 30, 2016, we determined Medicaid made 123,601 improper or questionable premium payments, totaling about $49.8 million, on behalf of 77,078 recipients who were subsequently disenrolled retroactively from a Plan and did not receive medical services during the disenrollment period. These included 113,879 payments totaling about $46 million for recipients whose enrollment information was readily obtainable on eMedNY or the MDW and 9,722 payments totaling more than $3.8 million for recipients whose enrollment data was not on eMedNY or the MDW. We provided these payments to the Department for its review.

HRA Disenrollment Process

LDSS are responsible for notifying Plans at the time of disenrollment of the Plans' responsibility to void premium claims. Plans must void premium payments within 30 business days of the notification for any full months of retroactive disenrollment. Based on our testing, we determined HRA did not always notify Plans (in a timely manner or at all) that payments should be voided. We determined HRA misinterpreted certain guidelines pertaining to when premium payments are allowed during disenrollment periods, which resulted in improper premium payments being deemed as appropriate. Also, Plans did not always void payments within 30 days.

To identify why certain improper payments were made, we reviewed a judgmental sample of 25 recipients enrolled by HRA. HRA officials agreed that premium payments were made for periods when each of the recipients was not enrolled in managed care. For 12 of the 25 recipients, HRA officials agreed that premium payments were improper. For five of the 12, HRA had notified the Plans that payments should be voided; however, at the time we selected our sample, these inappropriate payments were still outstanding. By the end of our fieldwork, payments on behalf of only three of the five recipients had been voided; the payments for the remaining two recipients had not been voided, even though they had been disenrolled for more than two years. For seven of the 12 recipients, HRA sent notifications to the Plans subsequent to our meeting with HRA officials.

For the remaining 13 (of the 25) recipients, HRA officials agreed that premium payments were made for periods when recipients were not enrolled in managed care. However, officials asserted that the premium payments were appropriate because the Plans were responsible for providing services for the periods covered by the payments. According to HRA officials, the Plans were responsible because the recipients' cases were not closed in a timely manner due to delays in obtaining information impacting the recipients' eligibility status. However, we determined HRA officials misinterpreted guidelines pertaining to premium payments made during disenrollment periods. As previously mentioned, the Department is responsible for payment of premiums if a Plan was considered to have been at risk – in other words, if the Plan paid for medical services provided to recipients during the disenrollment period. Consequently, because no medical services were provided to the recipients during the periods in question, the Plans were not at risk. Therefore, the premium payments were improper and should have been voided.

For example, one recipient's managed care eligibility ended September 30, 2013 and HRA disenrolled the recipient 15 days later, on October 15, 2013. According to HRA officials, the premium payment ($184) for October was appropriate, although the recipient's enrollment ended in September, because retroactive disenrollment was not determined until October 15, 2013. Another recipient, who was initially enrolled in managed care in November 2012, was disenrolled in February 2013 after it was determined the recipient was never eligible for managed care. Four monthly premium payments totaling $4,079 were made on behalf of this recipient for the period November 2012 to February 2013. HRA officials also believed these premium payments were appropriate since retroactive disenrollment was not determined until February 2013. We determined, however, that the Plan was not at risk during three of the four months. Therefore, as noted previously, because the Plan was not at risk, the premium payments corresponding to the three months were improper.

OMIG Audits

The OMIG regularly performs Plan-specific audits of premium payments made on behalf of recipients who were retroactively disenrolled from Plans. Individual audits are based on either a match with dates of death from the Department's Vital Statistics data or on a match with retroactive disenrollment data maintained by the Department's Office of Health Insurance Programs (OHIP). The OHIP disenrollment data is based on retroactive disenrollment notifications sent to the Plans by LDSS and NYSOH. These notifications identify recipients who have been retroactively disenrolled and for whom the Plans should have voided premium claims and refunded premium payments.

The OMIG's audits use these notifications to identify any premium claims that have not yet been voided or repaid by a Plan. However, we determined these particular OMIG audits do not include any payments for recipients who have not been identified by LDSS (including HRA) or NYSOH and who have not been included on the file of retroactive disenrollment data maintained by OHIP. We also determined the OMIG's identification of improper premiums based on matches with recipient dates of death was not sufficiently comprehensive.

To determine whether the OMIG's process effectively identified questionable payments for deceased or retroactively disenrolled recipients, we compared the results of the OMIG's audits of two Plans with the inappropriate payments we identified for the same Plans, and found inconsistencies between the two. For example, for the same period covered by an OMIG audit involving recipient dates of death, using date of death information from eMedNY, we identified an additional 705 claims totaling $383,275 that were not included in the OMIG's audit. We provided these claims to the OMIG which, at the conclusion of our fieldwork, was looking into the reason for the difference. Similarly, for the second OMIG audit, which was based on OHIP's file of retroactive disenrollment data, we identified an additional 7,389 claims totaling about $2.7 million that were not included in the audit. The differences we noted were likely due to the following:

- Our use of eMedNY date of death information;
- LDSS actions, such as those we identified at HRA, including inadvertent omissions of inappropriate premium payments and misinterpretation of Department guidelines (e.g.,

when Plans are considered at risk); and
- Improper payments that were recovered and paid in the form of checks, but not reflected in the MDW as voided premium payments.

According to OMIG officials, their audits of premium payments for deceased recipients are generally limited to data in the Annual Report of Vital Statistics, which officials consider to be the official record for New York State. Further, the OMIG does not use eMedNY dates of death because officials consider them to be unreliable since eMedNY is updated by multiple offices. However, when we compared the premium payments in our population based on eMedNY dates of death (9,781 premium payments totaling more than $5.5 million for 3,404 recipients) with dates of death from an independent third-party service that maintains information from the federal Social Security Administration's (SSA) Death Master File, we found that 4,102 premium payments totaling more than $2.5 million for 1,891 recipients were made after the SSA's dates of death. Therefore, to provide a more comprehensive review of premium payments, the OMIG should consider other date of death sources, including eMedNY and the SSA, when performing its audits. In response to our preliminary findings, OMIG officials stated they will consider using other sources to obtain date of death information.

To help us determine other reasons why improper payments were not identified by the OMIG's audits, we asked OMIG and Department officials to provide the retroactive disenrollment data that the LDSS and NYSOH provided to OHIP for one of the Plans. This data was used in the second OMIG audit we reviewed. However, by the end of our audit fieldwork, the officials had not yet provided the requested data. OMIG officials also agreed to match the claims data we provided to check payment information so that we could eliminate any premium payments that had already been recovered from our population. However, by the end of our audit fieldwork, officials had not yet completed this match. Therefore, we could not further refine our audit findings.

Recommendations

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

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.

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.

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.

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.

Audit Scope, Objective, and Methodology

The objective of our audit 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. Our audit covered the period October 1, 2010 through September 30, 2016.

To accomplish our objective and assess internal controls, we interviewed officials from the Department and HRA about the retroactive disenrollment process; examined the Department's model contract with Plans; and analyzed claim and encounter data in eMedNY as well as enrollment information contained in eMedNY and NYSOH. To assess the accuracy of pertinent eMedNY data, as well as the propriety of premium payments made to the plans, we judgmentally selected a sample of 113 claims for Department review. Of these, 63 claims were for recipients whose managed care enrollment information was readily obtainable from the Department's eMedNY system or the MDW, and 50 claims were for recipients whose managed care information was not obtainable from eMedNY or the MDW.

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. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

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.

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 to it. In their response, Department officials concurred with most of the audit's recommendations and indicated that certain actions have been and will be taken to address them. Officials, however, disputed a significant portion of the improper and questionable premium payments we identified and asserted that they were properly paid. We analyzed the basis for the Department's assertion and determined that it was materially flawed. As such, we maintain that the Department should review the $115 million ($122.4 total - $7.4 million already voided/recovered) in remaining improper and questionable premium payments that we identified and recover overpayments, as appropriate. Also, our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

Within 90 days of the 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.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 20, 2017

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2015-S-47 entitled, "Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-47 entitled,
Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2015-S-47 entitled, "Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

General Comments

The Office of the Medicaid Inspector General (OMIG) performs audits of deceased and retroactively-disenrolled Medicaid managed care recipients on a continual basis. OMIG staff utilize data from New York State (NYS) Vital Statistics, which is considered the official record for NYS, when conducting audits of deceased enrollees. One of the main functions of the Vital Statistics office is to record individual dates of death. This data is used to identify capitation payments made for enrollees after their date of death. Based on its analysis, OMIG has determined solely utilizing eMedNY dates of death to be inaccurate, since the eMedNY file is updated by multiple offices, which can ultimately leave more room for error within the data. OMIG recently revised the process for the annual audit of deceased Medicaid managed care enrollees to include dates of death contained in the Medicaid Data Warehouse (MDW) eligibility file in addition to information contained on the NYS Vital Statistic file. OMIG is also in the process of obtaining access to the Federal Social Security Administration Death Master File, which will be utilized for future reviews of deceased Medicaid managed care enrollees. OMIG relies on submissions of retroactive disenrollment notifications from the local social service districts (LDSS), New York City Human Resources Administration (HRA), or New York State of Health (NYSoH) when auditing retroactively-disenrolled enrollees. These notifications indicate the reason for the retroactive disenrollment, which provides OMIG with the support necessary to pursue recovery. Additionally, a point of contact is identified at the LDSS, HRA, and NYSoH to provide clarification on any questionable disenrollments.

* Comment 1

The removal of managed care eligibility is not outlined in the NYS Medicaid Managed Care Model Contract (Model Contract) as a circumstance warranting retroactive disenrollment. Situations warranting the retroactive disenrollment of an enrollee are limited to those scenarios/circumstances outlined at Section 3.6 and in Appendix H of the Model Contract. These

* Comment 2

*See State Comptroller's Comments, Page 28.

circumstances include death, incarceration, issuance of a duplicate client identification number (CIN), and placement in an institution.

The Medicaid program has undergone a significant transformation in recent years. In the past, eligibility information was housed on the Welfare Management System (WMS), which consisted of an upstate and a downstate system. NYSoH is responsible for managing the eligibility information for a large number of Medicaid enrollees whose eligibility was previously managed by WMS.

Specific Comments to Report

OSC Report: An inappropriate payment can occur when a premium payment was made to a Plan for a recipient who was later retroactively disenrolled from the Plan, and the Plan was not "at risk" for the provision of medical services during the disenrollment period. (Note: A Plan is not at risk if it did not pay for medical services for a recipient.) (p. 1)

Response: This definition of "at risk" is contingent on whether an individual has met the circumstances for retroactive disenrollment outlined in Section 3.6 and Appendix H of the Model Contract. These circumstances include death, incarceration, issuance of a duplicate CIN, and placement in an institution. The deletion of managed care eligibility on its own is not outlined as a circumstance warranting retroactive disenrollment. Unless an individual meets the specifically described circumstances outlined in the Model Contract a Plan is considered to be "at risk" for any individual listed on the monthly roster as being eligible to receive services. Medicaid Managed Care is a risk-based system that assumes a number of months during which no services will be rendered to balance out other months when many services will be rendered.

* Comment 3

OSC Report: Our testing at HRA found that officials misinterpreted guidelines governing when Plans are considered not at risk and when corresponding premium payments should be recovered. This resulted in improper premium payments being deemed as appropriate when they were not. (p. 1-2)

Response: The OSC's definition of "at risk" does not take into account the fact that an individual must meet one of the circumstances outlined in the Model Contract in order to be retroactively disenrolled. HRA's understanding of "at risk" recognized that an individual must meet one of those circumstances in order to be eligible for retroactive disenrollment.

* Comments 3, 4

OSC Report: However, the OMIG's identification of improper premium payments is based on LDSS notifications to Plans of retroactive disenrollments during periods when Plans were deemed not at risk, which we found were not always complete. (p. 2)

Response: OMIG regularly conducts audits to identify instances where retroactive disenrollments might not have been issued pursuant to the specific circumstances warranting retroactive disenrollment as identified in Section 3.6 and Appendix H of the Model Contract. These audits identify enrollees who are incarcerated, deceased, enrolled in an institution under circumstances that render an individual ineligible for managed care, assigned more than one CIN, and enrolled in one or more managed care plans.

* Comment 5

OSC Report: The Department has the right to recover premium payments from Plans for inappropriately enrolled recipients either for a portion of the enrollment period retroactive to the

effective disenrollment date or for the entire enrollment period, in which case the entire enrollment period is retroactively deleted. (p. 6)

* Comment 2

Response: As stated in OMIG's response to the Preliminary Report, OSC failed to consider the limitations on the New York State Department of Health's (SDOH) right to recover capitation payments for retroactively-disenrolled individuals, which is specifically outlined in Section 3.6 and Appendix H of the Model Contract. Eligibility line deletion alone is not a sufficient justification for retroactive disenrollment. Instead, Section 3.6 states, "SDOH has the right to recover premiums from the Contractor in instances where the Enrollee was inappropriately enrolled into managed care with a retroactive effective date, or when the enrollment period was retroactively deleted in accordance with Appendix H." Appendix H 7(a)(ix) states, "The NYSoH or LDSS is responsible for ensuring that retroactive Disenrollments are used only when absolutely necessary" and lists specific circumstances for which retroactive disenrollments are permitted. Retroactive deletion of an enrollment period alone is not listed as one of the specific circumstances.

OSC Report: However, the Department may only recover premium payments if it is determined that the Plan was not "at risk" for the provision of medical services during any portion of the payment period. The Plan is considered to have been at risk if it paid for medical services provided to a recipient during the month covered by the premium payment. (p. 6)

* Comment 3

Response: The Plan is "at risk" for all enrollees listed on the monthly roster, unless the specific circumstance(s) warranting retroactive disenrollment, outlined in Section 3.6 and Appendix H of the Model Contract is met. If one of those circumstances exists, i.e., the individual was dead, incarcerated, receiving services from another managed care plan, etc., then the Plan is not "at risk" and therefore the Plan was not responsible for providing care for that enrollee. If the Plan can provide evidence of having provided care for that recipient, that would indicate that the Plan was "at risk" and the capitation payment would not be recovered. An updated recovery process is under development that would allow for the recovery of capitation payments for individuals who meet the circumstances warranting retroactive disenrollment even if the Plan produces evidence of providing services. Removal of managed care eligibility will remain a circumstance that does not warrant retroactive disenrollment.

OSC Report: During the six-month period after we provided the claim details to the Department, 14,209 claims totaling more than $7.4 million in improper premium payments had been voided, leaving 176,477 premium payments totaling about $65.2 million that still needed to be reviewed and, if warranted, recovered (see table on page 8). This included:

• 136,786 payments totaling about $50.5 million for recipients whose enrollment information was readily obtainable on eMedNY or the MDW; and
• 39,691 payments totaling about $14.7 million for recipients whose enrollment data was not on eMedNY or the MDW. (Note: For these cases, the enrollment information had been improperly deleted.) To assess the appropriateness of these payments, we relied on other information from the MDW that indicated whether members were disenrolled. Therefore, we consider these payments to be questionable since enrollment data was missing.

As was previously stated, by January 2015, most FHP enrollees were moved into Medicaid. In addition to the findings above, for the period January 1, 2015 through September 30, 2016, using the same methodology, we determined Medicaid made 123,601 additional improper or questionable premium payments, totaling about $49.8 million, on behalf of 77,078 recipients who

were also subsequently disenrolled retroactively from a Plan and who did not receive medical services during the disenrollment period. (p. 7)

* Comment 6

Response: The Department disagrees with OSC's analysis and findings. OMIG analyzed the eligibility adjustments related to payments where the managed care eligibility was removed and determined that 76% of the adjustments were completed by two caseworker IDs, "NYDSS" and "511H". Any entity responsible for adjusting eligibility files is assigned a caseworker ID, i.e. HRA and LDSS. OMIG confirmed that these two caseworker IDs are associated with system updates that can result in inappropriate deletion of managed care eligibility.

Eligibility adjustments with a caseworker ID of "NYDSS" and "Disenrollment Code 95" are often the result of "stacking" issues that can delete earlier managed care eligibility segments when new managed care eligibility lines are created. This creates the appearance that an enrollee was/was not eligible for Medicaid managed care. Eligibility adjustments with caseworker ID "511H" completed between March and May 2015 are questionable because the new eligibility lines created by NYSoH during that time period resulted in earlier time periods being erroneously designated as "01-Medicaid Fee for Service coverage" instead of "30-Medicaid Managed Care coverage".

* Comment 12

As stated in the OSC Draft Audit Report, a correction of managed care enrollment data for 78,000 CINs is needed. Any payments associated with these CINs appear to be the result of an inaccurate eligibility file, and not a true overpayment.

Due to these circumstances, eligibility adjustments meeting the previously-described criteria may be the result of system errors, and not true retroactive disenrollments. The associated payments appear appropriate and are not true overpayments. Based on OMIG analysis, listed below is a summary of the claims, and related dollar amounts, considered to have been appropriately paid:

For the $65.2 million in capitation payments identified for the period October 1, 2010 through December 31, 2014:

- Local Caseworker ID NYDSS and Disenrollment Code 95: 61,773 claims totaling $23,652,802.09
- Local Caseworker ID 511 H adjustments made between March and May 2015: 48,985 claims totaling $17,442,270.47
- An additional 6,830 claims totaling $2,547,454.53 are associated with CINs known to have inaccurate eligibility files.
- TOTAL 117,588 claims totaling $43,642,527.09

For the $49.8 million in capitation payments identified for the period January 1, 2015 through September 30, 2016:

- Local Caseworker ID NYDSS and Disenrollment Code 95: 17,257 claims totaling $10,475,637.60

- Local Caseworker ID 511 H adjustments made between March and May 2015: 37,480 claims totaling $12,767,807.16

- An additional 14,883 claims totaling $5,298,875.35 are associated with CINs known to have inaccurate eligibility files.

- TOTAL 69,620 claims totaling $28,542,320.11

TOTAL CLAIMS TO REMOVE FROM OSC FINDINGS: 187,208 claims totaling $72,184,847.20

Additionally, 7,586 claims totaling $2,229,884.63 have dates of service prior to July 1, 2011, and will therefore be precluded from being recovered by OMIG pursuant to regulatory requirements.

The remaining 91,923 claims totaling $34,280,617.06, can be included in upcoming OMIG audits of retroactive disenrollment notifications.

In addition, OMIG contacted two counties and NYSoH and requested they review a sampling of the claims identified by OSC in this audit. Based on the reviews by NYSoH and the counties, it was determined that 89 percent of the payments were appropriately made, and that the eligibility removal did not reflect a retroactive disenrollment.

During this period, the Department made 136,786 premium payments totaling about $50.5 million for recipients who were subsequently disenrolled retroactively from a Plan (per eMedNY and the MDW) and the Plan was not at risk during the disenrollment period. (p. 8)

Response: Eligibility deletion is not an appropriate way to identify retroactive disenrollments because:

(1) eligibility deletion alone is not listed in the Model Contract as a circumstance warranting retroactive disenrollment, and
(2) known issues with the eligibility systems have resulted in managed care lines being inappropriately deleted. SDOH is correcting the system issue going forward.

In addition, as stated in OMIG's response to OSC's Preliminary Report, relying on the presence or lack of encounter data to determine if a Plan was "at risk" is not accurate. This approach may not properly account for encounter data that cannot be processed if Managed Care eligibility has been deleted. This circumstance may result in an under-representation of encounter data for the capitation payments during periods of deleted managed care eligibility, which could prove a Plan was actually "at risk".

OSC Report: We found various reasons for disenrollment, including loss of managed care eligibility (p. 9)

Response: As stated in OMIG's response to the Preliminary Report, the phrase "loss of managed care eligibility" is vague and does not indicate whether the circumstances of the loss of eligibility meet the requirements for retroactive disenrollment outlined in Section 3.6 and Appendix H of the Model Contract. OMIG requests clarification from OSC on what is meant by this terminology so that a determination can be made regarding the circumstances for the disenrollment.

* Comment 6

* Comment 7

* Comment 8

* Comments 2, 3

* Comment 9

* Comment 10

OSC Report: Of the 25 recipients, 23 were enrolled through NYSOH, and Department officials confirmed that their enrollment data was inappropriately deleted from eMedNY. (p. 9)

Response: The inappropriate deletion of enrollment data for such a significant portion of this sample calls into question OSC's use of deleted eligibility lines as a means of identifying overpayments.

* Comment 11

OSC Report: The Department provided a comprehensive list of 78,029 recipients who (per the Department) needed their eMedNY managed care enrollment data corrected. (p. 10)

Response: As stated in OMIG's response to OSC's Preliminary Report, the significant number of individuals for whom the managed care enrollment data on eMedNY is inaccurate highlights how questionable it may be for OSC to rely on missing eligibility lines alone to accurately determine its findings.

* Comment 12

OSC Report: For example, one recipient's managed care eligibility ended September 30, 2013 and HRA disenrolled the recipient 15 days later, on October 15, 2013. According to HRA officials, the premium payment ($184) for October was appropriate, although the recipient's enrollment ended in September, because retroactive disenrollment was not determined until October 15, 2013. Another recipient, who was initially enrolled in managed care in November 2012, was disenrolled in February 2013 after it was determined the recipient was never eligible for managed care. Four monthly premium payments totaling $4,079 were made on behalf of this recipient for the period November 2012 to February 2013. HRA officials also believed these premium payments were appropriate since retroactive disenrollment was not determined until February 2013. We determined, however, that the Plan was not at risk during three of the four months. Therefore, as noted previously, because the Plan was not at risk, the premium payments corresponding to the three months were improper. (p. 12)

Response: The circumstances of the recipient's loss of managed care eligibility is not outlined here, and therefore OMIG cannot determine whether retroactive disenrollment was warranted. Retroactive disenrollment is only appropriate under the circumstances described in Section 3.6 and Appendix H of the Model Contract.

* Comment 13

OSC Report: The OMIG's audits use these notifications to identify any premium claims that have not yet been voided or repaid by a Plan. However, we determined the OMIG's audits do not include any payments for recipients who have not been identified by LDSS (including HRA) or NYSOH and who have not been included on the file of retroactive disenrollment data maintained by OHIP. (p. 12)

Response: OMIG routinely performs audits identifying overpayments for individuals who should have been retroactively-disenrolled and have not been identified by LDSS (including HRA) or NYSoH. These audits identify payments associated with individuals who meet the circumstances listed in Section 3.6 and Appendix H of the Model Contract, including enrollees who are incarcerated, deceased, enrolled in an institution under circumstances that render an individual ineligible for managed care, assigned more than one CIN, and enrolled in one or more managed care plans.

* Comment 5

OSC Report: Similarly, for the second OMIG audit, which was based on OHIP's file of retroactive disenrollment data, we identified an additional 7,389 claims totaling about $2.7 million that were not included in the audit. (p. 12)

Response: OMIG reviewed the additional 7,389 claims and found that 6,908 of these claims, totaling $ 2,643,903.50, had eligibility adjustments under caseworker ID NYDSS with Disenrollment Reason Code 95, which DOH has confirmed is a system update and likely not a true retroactive disenrollment. Therefore, this is not an appropriate or accurate finding on the part of OSC.

* Comment 14

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.

Response #1

* Comment 6

The Department disagrees with OSC's analysis and findings. OMIG analyzed the eligibility adjustments related to payments where the managed care eligibility was removed. Any entity responsible for adjusting eligibility files is assigned a caseworker ID- i.e. New York City Human Resources Administration and Local Departments of Social Services. From this analysis, OMIG determined that 76% of the adjustments were completed by two caseworker IDs, NYDSS and 511H. OMIG confirmed that these two caseworker IDs are associated with system updates that can result in inappropriate deletion of managed care eligibility.

Eligibility adjustments with a caseworker ID of "NYDSS" and "Disenrollment Code 95" are often the result of "stacking" issues that can delete earlier managed care eligibility segments when new managed care eligibility lines are created. An enrollee may have a number of managed care eligibility segments (time periods for which an individual is eligible for managed care). "Stacking" issues refers to instances where an inactive eligibility segment may inappropriately overwrite an active eligibility segment, i.e., an inactive eligibility segment is "stacked" on top of the active eligibility segment. "Stacking" creates circumstances where it may appear that enrollees were not eligible for managed care, when in fact they were. Eligibility adjustments with caseworker ID "511H" completed between March and May 2015 are questionable because new eligibility lines created by New York State of Health during that time period resulted in earlier time periods being erroneously designated as "01-Medicaid Fee for Service coverage" instead of "30-Medicaid Managed Care coverage". Eligibility deletion is not an appropriate way to identify retroactive disenrollments because eligibility deletion alone is not listed in the Model Contract as a circumstance warranting retroactive disenrollment.

* Comment 2

As stated in the OSC draft audit report, a correction of managed care enrollment data for 78,000 CINs is needed. Any payments associated with these CINs appear to be the result of the inaccurate eligibility file, and not a true overpayment.

* Comment 12

Due to these circumstances, eligibility adjustments meeting the previously-described criteria may be the result of system errors, and not true retroactive disenrollments. The associated payments appear appropriate and are not true overpayments. Based on OMIG analysis, listed below is a summary of the claims, and related dollar amounts, considered to have been appropriately paid:

* Comment 6

For the $65.2 million in capitation payments identified for the period October 1, 2010 through December 31, 2014:

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The remaining 91,923 claims totaling $34,280,617.06, can be included in upcoming OMIG audits of retroactive disenrollment notifications.

In addition, OMIG contacted two counties and NYSoH, and requested they review a sampling of the claims identified by OSC in this audit. Based on the reviews by NYSoH and the counties, it was determined that 89 percent of the payments were appropriately made, and that the eligibility removal did not reflect a retroactive disenrollment.

OMIG has recovered $6,554,000, and continues to pursue recovery of any payments determined to be inappropriate.

* Comment 6

* Comment 7

* Comment 8

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.

Response #2

The Department and OMIG have provided consistent support and education to LDSS regarding the retroactive disenrollment process. As issues are identified and changes implemented, LDSS and plans continue to be engaged, and this will continue. OMIG conducted a survey of LDSS to identify possible issues and worked to address any that were shared by the LDSS. In addition, OMIG is preparing a detailed PowerPoint outlining the retroactive disenrollment process, which will be shared with LDSS staff.

The Department provided training to all the counties between September and October 2014. The Department also sent a letter to the districts reminding them of the existing and new requirements in October 2015.

There are many reasons for retroactive disenrollment. The most common reason for delay in notifying plans is timing of information entered in eMedNY, whether it be the disenrollment date, Third Party Health Insurance (TPHI) information or other vital information that would determine payment to a plan.

When a consumer is disenrolled through the NYSoH, plans are notified by the NYSoH via the 834 process. This is a daily process. However, when disenrollment is done through the Welfare Management System (WMS), the plan is notified via the WMS Roster (consumer no longer being on the roster). This is done monthly.

The Department is working on a project, Evolution Project (EP) 1843 "eMedNY Takeover of Medicaid Enrollment Information Delivery to Managed Care Plans." This will allow all changes in eligibility to be transmitted to plans via the 834 process regardless where eligibility lies.

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.

Response #3

* Comment 4

eMedNY will not pay the premiums if appropriate coverage is not in the system at the time of billing. If the consumer made the Roster or the plan received an 834, they are considered "at risk." Plans are not at risk if a true retro disenrollment is processed (death, incarceration, same TPHI). The appropriateness of capitation payments is not typically the function of the LDSS or HRA, whose core function is eligibility determination.

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.

Response #4

EP 2069 went into production on November 17, 2016. Another project eMedNY is working on to align Managed Care Enrollment and Eligibility is EP 2058, which is currently in process, but is not scheduled to enter production until May 2017. Additionally, ongoing reconciliation efforts are being done to correct previous issues with previously submitted WMS and NYSoH transactions. When all projects have been implemented, The Department's Division of Operations and Systems (DOS) will defer to the Division of Health Plan Contracting and Oversight (DHPCO) to validate the full correction.

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.

Response #5

Discrepancies between OSC's findings and OMIG's retroactive disenrollment audits could be the result of OSC including in its findings capitation payments associated with inappropriate eligibility line deletions that do not reflect true retroactive disenrollments.

* Comments 2, 6

As previously discussed with OSC, OMIG used data from Vital Statistics, as it is considered the official record of New York State. OMIG has incorporated information from eMedNY into its audit process. OMIG is in the process of obtaining access to the Federal Social Security Administration Death Master File which will be utilized for future reviews of decease Medicaid managed care enrollees.

State Comptroller's Comments

1. We are pleased the OMIG is taking steps to implement audit recommendation No. 5.

2. The Department emphasizes that the removal of managed care eligibility is not detailed in the Model Contract as a circumstance warranting retroactive disenrollment, and that situations warranting retroactive disenrollment are limited to Section 3.6 and Appendix H of the Model Contract. To that extent, we agree. However, contrary to the Department's assertions, OSC did not state that the erroneous deletion of enrollment lines (i.e., the removal of managed care eligibility) automatically warranted a retroactive disenrollment and was the basis for the recovery of all premium payments in question.

   In fact, as stated on page 7 of our report, of the $122 million in improper and questionable premium payments we identified, $14.7 million (for the period October 1, 2010 through December 31, 2014) and $3.8 million (for the period January 1, 2015 through September 30, 2016) represented premium payments for recipients whose managed care enrollment information was improperly deleted from eMedNY and the MDW. Accordingly, we considered these payments to be *questionable* since the enrollment data was missing. We provided significant detail of this issue on pages 9-10 of the report. We also remind Department officials that, despite the deletion of the data, we assessed the propriety of the aforementioned $14.7 million in payments by using other information that indicated the members were disenrolled, and therefore, many of the corresponding premium payments were likely improper. Furthermore, as stated on report page 10, Department officials corroborated our conclusions for 7 out of a sample of 25 recipients whose premium payments we provided to them for review. (Note: For the remaining 18 recipients, Department assessments were inconclusive at the time of our review.)

   Lastly, when deleted enrollment information is later restored, we found that updated enrollment periods often did not coincide with the months when premium payments were paid on behalf of the recipients. Thus, for certain months, recipients were, in fact, not enrolled in managed care although plan administrators received premium payments. As such, we recommended that once the deleted enrollment information is restored, the Department should review the payments and recover any overpayments, *as appropriate*.

3. We agree with the definition of "at risk," and our audit methodology was consistent with that definition. Also, our application of "at risk" took into account the fact that a recipient must meet one of the circumstances prescribed in the Model Contract to be retroactively disenrolled. Moreover, the Department's assertion that we considered the deletion of enrollment lines to summarily warrant the recovery of premium payments is not true. As stated in Comment No. 2, we identified $18.5 million in premium payments ($14.7 million + $3.8 million) that corresponded to recipients who did not have managed care enrollment data in eMedNY or the MDW. Accordingly, we considered these payments to be *questionable* payments that warranted a follow-up review by the Department to determine their propriety.

4. When we met with HRA officials, their interpretation of "at risk" was merely whether or not a managed care plan received a premium payment; they did not take into consideration whether or not a plan paid for health care services for a recipient. We found that LDSS officials misinterpreted these Medicaid guidelines (see pages 11-12 of the audit report). We, therefore, encourage the Department to provide such clarification to HRA and other LDSS.

5. Page 1 of the Department's response acknowledges that the OMIG relies on submissions of retroactive disenrollment notifications from the LDSS when auditing retroactively disenrolled enrollees. Further, pages 12-13 of our report detail our observation that the OMIG's identification of improper premium payments based on LDSS notifications of retroactive disenrollments during periods when managed care plans were deemed not "at risk" were not always complete for the particular types of OMIG audits we tested. Specifically, we reported that the OMIG performed plan-specific audits of premium payments made on behalf of recipients who were retroactively disenrolled based on a match with retroactive disenrollment data maintained by the Department's Office of Health Insurance Programs (OHIP). The OHIP disenrollment data is based on retroactive disenrollment notifications sent to the plans by LDSS and NYSOH. These notifications identify recipients who have been retroactively disenrolled and for whom the plans should have voided premium claims and refunded premium payments. The OMIG's audits use these notifications to identify any premium claims that have not yet been voided or repaid by a plan.

   We also analyzed the results of an OMIG audit that was based on OHIP's file of retroactive disenrollment data for one plan, and we identified an additional 7,389 claims totaling about $2.7 million that were not included in the audit. We noted that the OMIG audits do not include payments for recipients who had not been identified by LDSS or NYSOH and who were not included on the file of retroactive disenrollment data maintained by OHIP.

6. According to the Department's response, the OMIG reviewed the audit exceptions and concluded differently from OSC regarding the deletion of managed care eligibility information. As discussed in Comment No. 2, we identified $18.5 million in premium payments ($14.7 million + $3.8 million) that corresponded to recipients who did not have managed care enrollment data in eMedNY or the MDW. (Note: As previously cited, despite the deleted data, we concluded that certain premium payments appeared improper based on the other information we tested.)

   Conversely, as stated in the Department's response, the OMIG identified three codes that they determined "could" represent the deletion of managed care eligibility information: "NYDSS" (a generic case worker ID), disenrollment code 95 (lost managed care eligibility), and code "511H." Based on these codes, the Department and OMIG collectively recommended the removal of $72.2 million from our audit findings ($43.6 million for the period October 1, 2010 through December 31, 2014 and $28.5 million for the period January 1, 2015 through September 30, 2016). We conducted a limited review of the Department's and OMIG's conclusions and determined they were flawed, as detailed in

the following:

- During the audit, the Department provided a list of 78,029 recipients who needed missing mainstream and other types of managed care enrollment data corrected (i.e., these recipients had managed care enrollment periods that needed to be restored). We compared these recipients' IDs to the IDs associated with the $72.2 million that officials contend were appropriate. We found that over $42 million of this amount pertained to recipients who were not on the Department's list, and therefore, were not identified by the Department as needing correction. Thus, if there were no enrollment periods that required reinstatement for these recipients, then the corresponding $42 million in premiums were paid for periods when the recipients did not have managed care and, therefore, the premium payments appear improper.
- $3.3 million corresponded to premium payments that were made on behalf of deceased recipients after their corresponding dates of death.
- $1.1 million pertained to recipients who had comprehensive third-party health insurance and were, therefore, ineligible for managed care.
- $341,739 pertained to recipients who had duplicate Client Identification Numbers; therefore, more than one premium payment was made on behalf of the recipients, and the corresponding (duplicate) managed care premiums should be recovered.
- $237,293 was removed from the audit findings because we determined the managed care plans were "at risk" during the months that premium payments were made. We removed these payments from our findings prior to the issuance of the draft audit report.
- $89,718 pertained to recipients who were in child care facilities, private skilled nursing homes, or mental health facilities or were incarcerated at the time of the premium payments, making the individuals ineligible for managed care.
- As stated on page 7 of our report, of the $122 million in improper and questionable premium payments we identified, more than $7.4 million was voided (during the audit fieldwork) by managed care plans because the premiums were improper. Of the $7.4 million voided, $2.3 million pertained to recipients who had disenrollment codes NYDSS and 95.
- Some counties determined that certain recipients did not have managed care eligibility on the service dates in question. (For further detail, see Comment No. 8.)

Department and OMIG officials propose dismissal of about $72 million in premium payments from their review based on three codes (NYDSS, 95, and 511H). They assert that eligibility adjustments with these codes are *often* the result of "stacking" issues that can delete managed care eligibility segments, which *may be* the result of system errors and not true retroactive disenrollments, and that the associated payments *appear* appropriate and are not true overpayments. However, we disagree with the Department's and OMIG's position.

As previously detailed, we found major flaws in their analysis of payments totaling over $47 million. We maintain that the circumstances we identified warranting retroactive

disenrollment, per Section 3.6 and Appendix H of the Model Contract, indicate that many additional premium payments should be recovered. Further, regarding the remaining payments (approximating $25 million), one cannot use the three aforementioned codes alone to conclude that managed care eligibility existed. Thus, after the Department completes its project to restore deleted enrollment information, the Department and OMIG should assess all of the improper and questionable premium payments we identified and recover overpayments, as appropriate.

7. We encourage the Department to take prompt action on our audit recommendations to prevent further loss of recoveries.

8. The Department's response is misleading. First, the response fails to mention the size of the sample that the OMIG reviewed. We followed up with the OMIG to obtain details of the 89 percent of the payments that officials contend were appropriately paid, and were told the OMIG's tests were limited to 28 recipients. (Note: Our audit found improper and questionable payments for nearly 172,000 recipients.) Secondly, Department officials did not mention that the counties (i.e., the local districts) concluded that 27 of the 28 recipients that the OMIG selected did not have managed care eligibility on the service dates in question. Therefore, the counties pragmatically agreed with our audit findings for 27 of the 28 recipients.

   Further, we evaluated the Department's conclusion that "89 percent of the payments were appropriately made" and noted material deficiencies in the Department's methodology. The sample of 28 recipients corresponded to claims for which Department officials believed enrollment data was erroneously deleted. (Note: All related claims contained Local Caseworker ID 511H. See Comment No. 6 for a discussion of that code.) The payments in question were reviewed by two local districts and NYSOH officials. As previously stated, the local districts confirmed the 27 recipients had no managed care eligibility on the service dates in question.

   Conversely, NYSOH officials searched the recipients' NYSOH data and found managed care coverage for 25 (89 percent) of the 28 recipients on the service dates. However, we tested NYSOH data to verify enrollment for 220 recipients whose eMedNY enrollment data was initially missing and then later restored. For 169 (77 percent) of the 220 recipients, the NYSOH enrollment data did not match the updated (and correct) eMedNY data. We, therefore, concluded that NYSOH's enrollment data was not sufficiently reliable for assessing the propriety of managed care premium payments. Further, we brought this concern to the attention of Department officials during the audit's fieldwork.

9. We are pleased the Department is correcting the problems that caused managed care lines to be inappropriately deleted. Once those problems are corrected, Department officials should ensure they have accurate corresponding encounter data so that, consistent with audit Recommendation No. 1, they can review the questionable and inappropriate premium payments we identified and recover overpayments, as warranted.

10. As was reported to Department and OMIG officials during the audit, "loss of managed care eligibility" is a reason within eMedNY to describe one of the codes assigned to recipient disenrollment periods. It can, for instance, represent "death" or "third-party health insurance coverage" and other retroactive disenrollments, as outlined in Section 3.6 and Appendix H of the Model Contract. eMedNY does not give any further specifics as to the reason for the loss of managed care eligibility. Officials reviewed sampled claims, which we provided to determine the enrollment status of recipients as well as the propriety of related premium payments. These determinations, discussed on page 9 of the audit report, supported our conclusions that payments were improper and required further review to recover overpayments.

11. The Department's assertion is incorrect. The test of 25 recipients focused specifically on $14.7 million in premium payments (of the audit's total $122 million in problematic premium payments) for recipients we found had their managed care enrollment information improperly deleted from eMedNY and the MDW. As explained on pages 9-10 of our report, the results of the sample of 25 were used to explain that enrollment data was inappropriately deleted from eMedNY for this sub-population of exceptions (i.e., the $14.7 million in premium payments). Additionally, as previously stated, we determined other reliable data existed that allowed us to assess whether the recipients (whose enrollment data was deleted) were actually disenrolled. Based on the analysis of the other data, we determined there was a material risk that the $14.7 million in premium payments was improper, and Department officials corroborated this based on an additional sample review. Therefore, consistent with audit Recommendation No. 1, the Department should review the premium payments we identified and recover overpayments, as appropriate.

12. The Department's assertion is incorrect. As explained in Comment No. 6, the 78,029 recipients included recipients outside the scope of our audit. Specifically, our audit focused on recipients in mainstream managed care and Family Health Plus. However, the list of 78,029 recipients included recipients in other types of managed care (such as Managed Long Term Care). Also, as previously stated, we did not rely on missing eligibility lines alone to determine the audit findings. To this point, the Department's list of 78,029 recipients was addressed in our analysis of $18.5 million in premium payments ($14.7 million + $3.8 million), as discussed previously in Comment Nos. 2 and 11.

13. The circumstances of the recipients' loss of managed care eligibility represented retroactive disenrollment per the Model Contract. Further, the relevant information pertaining to the recipients in question was sent to the Department prior to the issuance of the draft audit report.

14. The Department's and OMIG's conclusion that eligibility adjustments under Caseworker ID NYDSS with Disenrollment Reason Code 95 are likely not true retroactive disenrollments is not accurate. Also, see Comment No. 6, which details how the Department's and OMIG's assessment is significantly flawed. Thus, the Department's assertion that "this is not an appropriate or accurate finding on the part of OSC" is incorrect.