

Department of Health

Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility

Report 2020-S-52 | August 2022

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability



Audit Highlights

Objective

To determine whether the Department of Health (Department) made improper Medicaid managed long-term care (MLTC) premium payments on behalf of ineligible enrollees. The audit covered the period from January 2015 to March 2021.

About the Program

Many of the State's Medicaid recipients are enrolled in MLTC plans, which provide long-term care services, such as home health care and nursing home care, for people who are chronically ill or disabled. For the year ended December 31, 2020, Medicaid paid MLTC plans \$15.5 billion in premiums for 329,618 recipients enrolled in MLTC.

The Department contracts with Maximus Health Services, Inc. (Maximus) to conduct initial eligibility assessments for individuals who choose to voluntarily enroll in MLTC (other individuals meeting certain criteria are automatically enrolled). To be eligible, all individuals must be assessed as needing community-based long-term care (CBLTC) services for more than 120 days. After the initial assessment, MLTC plans were responsible for performing semi-annual assessments of their own members to determine whether the members should remain in their plans.

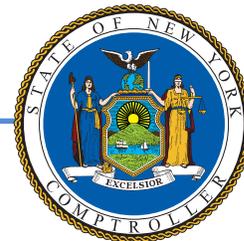
MLTC plans are responsible for initiating disenrollment of enrollees when it is determined they are no longer MLTC eligible (e.g., enrollees who did not receive any CBLTC services in a month, deceased recipients), and Maximus is responsible for processing the disenrollments. The Department can recover premium payments made to MLTC plans for ineligible enrollees.

Key Findings

- Medicaid paid about \$701 million in improper MLTC premium payments on behalf of 52,397 recipients who were no longer eligible for MLTC. The Department has not developed adequate oversight to ensure MLTC plans timely identify individuals who are ineligible for MLTC.
- Medicaid paid \$2.8 billion in MLTC premium payments on behalf of 51,947 recipients who received a limited number of CBLTC services. For instance, 22,048 recipients only received between 1 and 30 days of services during 6-month assessment periods. Given that the average monthly MLTC premium for these recipients was about \$4,500, the Department should develop a process to monitor the MLTC program to ensure members are properly assessed and are receiving the care they need.

Key Recommendations

- Review the \$701 million in premium payments and make recoveries, as appropriate.
- Develop a process to ensure timely MLTC disenrollment of recipients who are no longer eligible.
- Monitor MLTC recipients to ensure they were properly assessed for enrollment and are receiving the appropriate level of care.



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

August 5, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Bassett:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Oversight of Managed Long-Term Care Member Eligibility*. 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,

Division of State Government Accountability

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Glossary of Terms

| Term | Description | Identifier |
|-------------|--|-------------------|
| ALP | Assisted Living Program | <i>Key Term</i> |
| CBLTC | Community-based long-term care | <i>Key Term</i> |
| Contracts | Managed long-term care Model Contracts | <i>Key Term</i> |
| Department | Department of Health | <i>Auditee</i> |
| eMedNY | Department's Medicaid claims processing and payment system | <i>System</i> |
| FFS | Fee-for-service | <i>Key Term</i> |
| FIDA | Fully Integrated Duals Advantage | <i>Key Term</i> |
| MAP | Medicaid Advantage Plus | <i>Key Term</i> |
| Maximus | Maximus Health Services, Inc. | <i>Contractor</i> |
| MLTC | Managed long-term care | <i>Key Term</i> |
| OMIG | Office of the Medicaid Inspector General | <i>Agency</i> |
| PACE | Program of All-Inclusive Care for the Elderly | <i>Key Term</i> |
| UAS-NY | Uniform Assessment System for New York | <i>System</i> |

Background

The New York State Medicaid program is a federal, State, and locally funded program that provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (Department). For the fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million enrollees and Medicaid claim costs totaled about \$68.1 billion. The federal government funded about 56.5% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5%.

The Department uses two methods to pay health care providers 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 plans for Medicaid recipients enrolled in their plans. In return, managed care plans arrange for the provision of health care services and reimburse providers for services provided to their enrollees. Managed care plans submit claims, known as encounters, to the Department's Encounter Intake System to inform the Department of each service provided to their enrollees.

The State's Medicaid program offers different types of managed care coverage, depending upon individual eligibility. One type of coverage is managed long-term care (MLTC). MLTC provides long-term care services, such as home health care and nursing home care, to people who are chronically ill or disabled and who wish to stay in their homes and communities.

In August 2012, the Centers for Medicare & Medicaid Services approved the State's request for the mandatory transition and enrollment of recipients of certain community-based long-term care (CBLTC) services into MLTC. CBLTC services include the following seven types of care:

- Nursing services in the home
- Therapies in the home
- Home health aide services
- Personal care services in the home
- Adult day health care
- Private duty nursing
- Consumer Directed Personal Assistance Services

The Department phased in the implementation of these services into the MLTC program beginning in New York City, with statewide implementation completed July 2015. There were four types of MLTC plans during our audit scope: Partial Capitation, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP), and Fully Integrated Duals Advantage (FIDA, ended 2019). All four

plan types provide CBLTC services, nursing home care, and ancillary and support services, including individualized care management. Additionally, PACE, MAP, and FIDA plans include benefits covered by Medicare. MLTC plans do not cover hospital services; rather, these services are paid under FFS.

In order to be eligible for MLTC, enrollees must be assessed as needing CBLTC services for more than 120 days. In addition, the following apply:

- MLTC enrollment is mandatory for Medicaid recipients who have both Medicaid and Medicare (dual eligible), are age 21 or older, reside in certain counties, and need CBLTC services for more than 120 days.
- For Partial Capitation plans, enrollment in MLTC is voluntary for recipients who are non-dual eligible, are age 18 or older, and need CBLTC services for more than 120 days.
- Certain other Medicaid recipients can voluntarily enroll in an MLTC plan if they meet age requirements, are nursing home eligible, and meet other eligibility requirements.

In recent years, enrollment in MLTC plans, and thus the premiums paid to these plans, has been increasing (see Table 1). Of the four MLTC plan types, Partial Capitation plans have significantly higher enrollment. For the calendar year ended December 31, 2020, Partial Capitation plans were paid \$13.7 billion of the \$15.5 billion in premiums (88%) paid to all MLTC plans.

Table 1 – Yearly Paid Premiums Including Member and Claim Counts

| Calendar Year | Premium Amounts | Number of Members | Number of Claims |
|---------------|-------------------------|-------------------|-------------------|
| 2021* | \$3,771,915,728 | 282,669 | 822,985 |
| 2020 | 15,522,643,308 | 329,618 | 3,284,332 |
| 2019 | 15,989,137,825 | 312,458 | 3,135,337 |
| 2018 | 13,636,975,901 | 278,214 | 2,761,939 |
| 2017 | 11,230,372,348 | 244,191 | 2,412,002 |
| 2016 | 9,009,809,388 | 210,257 | 2,057,669 |
| 2015 | 7,333,007,893 | 174,453 | 1,743,152 |
| Totals | \$76,493,862,391 | | 16,217,416 |

* Data through March 31, 2021.

The Medicaid MLTC Model Contracts (Contracts) set forth provisions for when MLTC plans must initiate disenrollment of their members and when premiums may be recovered by the Department. There is a separate Contract for each type of MLTC plan. For Partial Capitation plans, there were two Contracts in effect during our audit scope: one for calendar years 2015 and 2016 and the second beginning in 2017. Both Partial Capitation Model Contracts allow for recouping premium payments when it is determined an enrollee did not receive any MLTC plan-covered services in a month. However, the 2017 Partial Capitation Model Contract also allows for

disenrolling an enrollee and recouping premiums for months in which members did not receive any CBLTC services, even if other MLTC-covered services were provided (such as transportation). According to the Department and Office of the Medicaid Inspector General (OMIG), MLTC plans should initiate disenrollment when an enrollee has been without the required services for a month, and recoveries of associated premiums should be made.

The Department contracts with Maximus Health Services, Inc. (Maximus) to conduct initial assessments of all individuals who choose to voluntarily enroll in MLTC (for involuntary enrollments, Medicaid systems identify certain information, like recipients receiving CBLTC services, that is used to automatically determine eligibility and allow Maximus to auto-enroll such recipients). If Maximus determines an individual is eligible, the person can choose an MLTC plan available to them. Maximus is also responsible for providing centralized eligibility and enrollment processing for Medicaid managed care plans in New York. During our audit scope, after the initial assessments, MLTC plans were responsible for performing semi-annual reassessments of their own members to determine whether the members should remain in their plans.

In March 2013, the Department implemented the Uniform Assessment System for New York (UAS-NY). This is where, among other data, MLTC eligibility information is maintained. The UAS-NY contains reporting functionality on individuals assessed as well as aggregate or agency-wide information.

Audit Findings and Recommendations

The Department has not developed adequate oversight to ensure MLTC plans timely identify enrollees who are ineligible for MLTC. As a result, for the period January 2015 through March 2021, we determined the Department made improper premium payments totaling about \$701 million to MLTC plans on behalf of 52,397 recipients who were ineligible for MLTC coverage. We identified various reasons a member was determined to be ineligible, as shown in Table 2 below.

Table 2 – Improper Premium Payments by Ineligibility Determination

| Year | Required Services Not Received [‡] | Deceased | Inpatient for More Than 45 Days | Not Medicaid and/or Not MLTC Eligible | In Assisted Living Facility | Totals [§] |
|-------------------|---|---------------------|---------------------------------|---------------------------------------|-----------------------------|----------------------|
| 2021* | | \$1,620,557 | | | | \$1,620,557 |
| 2020 [†] | \$53,409,585 | 2,939,769 | \$210,429 | \$102,749 | \$4,538 | 56,667,070 |
| 2019 | 174,485,022 | 1,975,999 | 894,753 | 491,153 | 311,855 | 178,158,782 |
| 2018 | 161,058,996 | 1,645,797 | 681,514 | 516,493 | 279,394 | 164,182,194 |
| 2017 | 154,043,682 | 881,183 | 923,988 | 373,851 | 166,715 | 156,389,419 |
| 2016 | 71,024,116 | 758,600 | 943,317 | 244,575 | 125,481 | 73,096,089 |
| 2015 | 71,746,002 | 778,025 | 731,524 | 214,718 | 162,074 | 73,632,343 |
| Totals | \$685,767,403 | \$10,599,930 | \$4,385,525 | \$1,943,539 | \$1,050,057 | \$703,746,454 |

* Data through March 31, 2021.

[†] Data through March 31, 2020, except for “Deceased.”

[‡] For 2015 and 2016, the numbers refer to no MLTC-covered services received; for 2017 and beyond, the numbers refer to no CBLTC services received (other MLTC-covered services may or may not have been provided).

[§] Certain members were deemed ineligible for multiple reasons, so a premium may be included in multiple categories in the table; however, the amount of non-duplicated improper premiums totaled \$700,807,654.

Due to the Contract change for Partial Capitation plans beginning in 2017, there was a significant increase in the population of ineligible members and, consequently, the amount of premiums that were overpaid (see Table 2 column, “Required Services Not Received”). Also, due to the onset of the COVID-19 pandemic, the Department stopped involuntarily removing enrollees from MLTC plans in order to provide for continuity of care. As a result, we only included premiums paid through March 2020, with the exception of the “Deceased” category, where we included premiums paid through March 2021.

The audit determined the Department should develop a process to ensure timely MLTC disenrollment of members who are no longer eligible and recover improper MLTC premium payments made on behalf of ineligible members.

Of note, we also found that a Department directive (not required by a Contract) has restricted Maximus’ ability to disenroll members within the first 3 months of their eligibility, such as in cases where an MLTC plan was unable to contact an enrollee who was auto-enrolled. This directive likely contributed to \$7.4 million in MLTC

premiums that were paid for the first 3 months of coverage on behalf of members who were auto-enrolled into the MLTC program but received no services.

In addition to overpayments for ineligible members, our audit identified 626,435 premium payments, totaling \$2.8 billion, made on behalf of members who received minimal services during the 6-month assessment periods, such as individuals who only received between 1 and 30 days of CBLTC services during the assessment periods. While these premium payments may not be recoverable as the members appear to have met eligibility requirements, the Department should develop a process to monitor the MLTC program to ensure members are properly assessed and are receiving the appropriate level of care.

Furthermore, in some cases, we found the amounts plans received in premium payments significantly exceeded the services they paid for. While part of this may be the nature of managed health care models (and we draw no overall/definitive conclusions on this point), we believe our findings raise enough questions to warrant increased monitoring by the Department.

Stronger oversight by the Department could look to identify why members are receiving few services, such as whether assessments are being done correctly and whether members are receiving the care they need.

Improper MLTC Premium Payments for Ineligible Recipients

Members Not Receiving Required Services

We identified over \$685 million in premium payments made on behalf of 50,738 recipients who did not receive the required services in a particular month (findings for calendar years 2015 and 2016 were related to premiums paid in a month where the recipient did not receive any services; findings for calendar year 2017 and beyond were related to premiums paid in a month where the recipient did not receive at least one of the seven CBLTC services – other MLTC-covered services may or may not have been provided). Of the \$685 million, over \$430 million (63%) in payments were on behalf of 26,924 recipients who did not receive CBLTC or any other services for at least 2 consecutive months.

Department officials reviewed the circumstances of six recipients who did not receive any services based on encounter information but who remained enrolled in MLTC. Department officials agreed that four of the six recipients should have been disenrolled. For the remaining two recipients, Department officials responded that care management notes indicated the recipients received Consumer Directed Personal Assistance Services. However, the MLTC plans could not provide any claim information to support that such services were provided. Thus, premiums related to these two recipients remain in the audit findings.

One of the recipients was enrolled in MLTC starting April 1, 2016 and was still enrolled at the end of our audit fieldwork (March 31, 2021). We found Medicaid made 48 premium payments, totaling \$151,490, on behalf of this enrollee without any encounter evidence of services provided by the MLTC plan. Department officials agreed the MLTC plan failed to initiate disenrollment, as required, and also agreed that the care management notes indicated no qualifying services were provided. This member was continually assessed as MLTC eligible according to UAS-NY reassessment information.

Recipients were not identified for removal from the MLTC program by the Department because it does not have a process or systems in place to systematically identify members who are not receiving the required services and to monitor whether they are removed timely from MLTC; rather, this is left to the individual MLTC plans.

No Encounters During First 90 Days of Enrollment

According to MLTC plan officials, one of the reasons premium payments with no corresponding services were made may be because certain members, such as those who are auto-enrolled, are difficult to contact. The Department issued a directive requiring MLTC plans to make 10 attempts to contact a member within a 90-day period prior to requesting Maximus process an involuntary disenrollment. Department officials stated that this allows adequate time for members to be reached before they are involuntarily disenrolled. However, this is a practice that is not outlined in the Contract or supported by Department-issued guidance or policy.

We identified \$853 million in premium payments on behalf of 7,420 auto-enrolled MLTC members. Of this amount, \$11.1 million was paid on behalf of 734 members who did not receive any services during their entire MLTC enrollment. Furthermore, \$7.4 million in premium payments were made for the recipients' first 90 days of enrollment. For example, one member was auto-enrolled in September 2018, and in October 2018, the MLTC plan requested an involuntary disenrollment with the reason "not receiving qualifying services." Maximus overturned this request, likely due to the 90-day period restriction. According to information in the UAS-NY, a voluntary disenrollment was eventually processed in February 2019 because the member "didn't like the rules of the plan." The MLTC plan received \$31,615 in premium payments on behalf of this member for the period from September 2018 through February 2019 but provided no services.

Department officials stated that disenrollments processed after the initial 90-day period are done prospectively. As a result, premium payments made during the 90-day period are not recovered.

Deceased Members

The Contract allows the Department to recover premium payments made on behalf of members who were found to be deceased. Using dates of death from eMedNY, we found \$10.6 million in premium payments made to MLTC plans on behalf of 1,388 members the Department's system had reported as deceased. We requested

the Department verify dates of death for these members based on a match with the State On-Line Query System; however, the Department was unable to provide the results of its match by the end of our audit fieldwork.

In one case, we identified a member who died on May 25, 2020 but whose eligibility status wasn't updated in eMedNY until October 6, 2020. During this period, Medicaid paid monthly premium payments totaling \$25,900. In another example, a member died on February 4, 2012; however, in May 2014, the member was auto-enrolled back into MLTC, and the MLTC plan then collected 9 months of premium payments totaling \$37,145.

Payments for deceased members were made because the Department does not have a process to timely identify and disenroll deceased members. When deceased members are not disenrolled in a timely manner upon their death, Medicaid will continue to make improper monthly premium payments after the members' death.

Members in an Inpatient Setting for More Than 45 Days

MLTC plans do not cover inpatient services; rather, these services are paid under FFS. According to the Contract, an MLTC plan must initiate involuntary disenrollment within 5 business days from the date it knows an enrollee is hospitalized or is admitted to an Office of Mental Health, Office for People With Developmental Disabilities, or Office of Addiction Services and Supports residential program for 45 consecutive days or longer. The Department has the right to recover premium payments for these recipients beginning with premiums for the first full month following 45 consecutive days of the inpatient stay.

We identified nearly \$4.4 million in premium payments made on behalf of 577 members with an inpatient stay of more than 45 days. For example, one member was hospitalized from October 11, 2018 to December 12, 2019, and the MLTC plan received five premium payments, totaling \$24,468, for the period after the 45th day was reached. Upon review, Department officials agreed nothing should have prevented the disenrollment of this member, and MLTC plan officials confirmed that the disenrollment was not processed timely.

Based on meetings with officials from multiple MLTC plans, there is no consistent method used to identify members in an inpatient setting. Some MLTC plans' case managers rely on being informed by the service providers or family members. The Department should develop a process to identify members who are in an inpatient setting and ensure they are disenrolled timely, where applicable.

Members Who Are Not Medicaid Eligible or MLTC Eligible

Medicaid eligibility is a requirement for MLTC eligibility. Therefore, any member who loses Medicaid eligibility or has a type of Medicaid coverage that is not compatible with MLTC should be disenrolled from their MLTC plan. The eMedNY system uses coverage codes to identify members who are not MLTC eligible, such as members with community coverage that did not include long-term care, and members who

are no longer Medicaid eligible. MLTC plans must also initiate disenrollment if the enrollee no longer resides in their service area.

We identified approximately \$1.94 million in MLTC premium payments on behalf of ineligible members, as follows:

- \$1.58 million for members who had community coverage that did not include long-term care
- \$354,011 for members who had other incompatible coverage codes
- \$4,780 for members whom we identified as having premium payments made while they did not reside in the MLTC plan's service area

One member we identified lost Medicaid eligibility in January 2016 but maintained MLTC enrollment through February 2018. Over \$28,000 in MLTC premium payments were made during the period the member was not Medicaid eligible. According to Department officials, a new daily file transfer process was implemented in January 2021 that will be used to update Medicaid coverage on a daily basis, thereby allowing for more timely disenrollment from MLTC.

Members in Assisted Living Programs

Many MLTC-covered services are duplicative of those provided by Assisted Living Programs (ALPs). As such, the Partial Capitation Model Contract states that residents in ALPs cannot receive MLTC benefits.

Our audit found MLTC premium payments of over \$1 million on behalf of 152 recipients who were residing in ALP facilities during the same month the premium payments were made. For one member, who was admitted to an ALP on June 4, 2019, Department officials stated that, due to human error, when the Local Department of Social Services reported the person had entered an ALP, Mainstream Managed Care disenrollment was applied rather than MLTC disenrollment. Subsequently, the member was disenrolled from MLTC effective August 1, 2019. However, there was no attempt to recover premium payments made during the time from when the member was no longer eligible for MLTC to when the disenrollment process was finalized.

Lack of Oversight Over Premiums for Members Who Received Limited CBLTC Services

Medicaid enrollees must be assessed as needing CBLTC services for more than 120 days to be eligible for MLTC. During our audit scope, Maximus was responsible for the initial assessment for all voluntarily enrolled MLTC recipients, and then MLTC plans were responsible for performing the semi-annual assessments of their own members thereafter to determine whether they should remain in their plan.

From January 1, 2015 to March 31, 2021, 97% of the over 3 million total assessments in UAS-NY concluded that the members were in need of CBLTC services for more than 120 days. We found this to be an unusually high rate. One possible explanation is that MLTC plans were responsible for doing assessments of their own members, allowing MLTC plans to employ assessors. According to Department officials, this apparent conflict of interest should be addressed when a New York Independent Assessor (Maximus) begins handling all assessments, including eligibility reassessments, which will be required annually rather than semi-annually. At the conclusion of our audit fieldwork, the date the new process was scheduled to begin was still being determined.

Although the vast majority of recipient assessments result in the continuation of MLTC coverage, we determined that over \$2.8 billion in premium payments were made on behalf of members who received 60 days or less of CBLTC services in the 6 months following assessment (see Table 3). For example, one member was reassessed six times as requiring CBLTC services during a time when the member resided outside the MLTC plan’s service area. This member was enrolled in MLTC for the entire audit scope but received fewer than 28 days of CBLTC services during each 6-month period. Premium payments for this member totaled \$268,724. Meanwhile, the MLTC plan made encounter payments for CBLTC services totaling \$13,907 for the same period.

Table 3 – Less Than 60 Days of CBLTC Services in a 6-Month Period

| Days of CBLTC Services | Number of Premium Payments | Premium Payment Amount | Number of Members | Total MLTC Plan Encounter Payments for All Services |
|------------------------|----------------------------|------------------------|-------------------|---|
| Between 1 and 30 days | 194,699 | \$871,748,000 | 22,048 | \$103,214,816 |
| Between 31 and 60 days | 431,736 | 1,993,198,272 | 37,732 | 423,154,291 |
| Totals | 626,435 | \$2,864,946,272 | 59,780* | \$526,369,107 |

*51,947 distinct members.

The Department does not perform reviews to identify instances where MLTC members remain in MLTC but receive few services during their enrollment period. (Note: assessments for 3,605 members, or 7% of the 51,947 members from Table 3, did not indicate MLTC was needed.) The Department should consider a process to determine the reasons such limited services were received, and ensure members are receiving the required level of care as well as determine if members were properly assessed. Since the new independent assessor referred to by the Department will be required to perform assessments annually rather than semi-annually, it is of particular importance for the Department to better monitor recipients in MLTC in order to take timely corrective actions.

Recommendations

1. Review the \$701 million in improper premium payments identified in this report and recover, as appropriate.
2. Develop a process to ensure timely MLTC disenrollment of members who are no longer eligible due to the reasons listed below; such a process should include the Department's identification of these members and monitoring whether they are removed timely from MLTC.
 - Not in receipt of any CBLTC services
 - Deceased
 - In an inpatient setting for more than 45 days
 - Not Medicaid eligible or an eligibility status incompatible with MLTC
 - Residing in an ALP facility
 - Not eligible based on assessments
3. Reassess the process of allowing 90 days to elapse before involuntarily disenrolling members. Evaluate the feasibility of processing such disenrollments retroactively to allow for premium recoveries.
4. Monitor MLTC enrollees to ensure they are properly assessed and are receiving the appropriate level of care. Take appropriate action for members who are determined to be ineligible for MLTC or who are not receiving needed CBLTC services.

Audit Scope, Objective, and Methodology

The objective of this audit was to determine whether the Department made improper Medicaid MLTC premium payments on behalf of ineligible enrollees. The audit covered premium payments made from January 2015 to March 2021.

To accomplish our audit objective and assess related internal controls, we interviewed officials and gathered information from the Department and the individual MLTC plans, examined the Department's relevant Medicaid policies and procedures, and reviewed applicable federal and State laws, rules, and regulations. We interviewed OMIG officials to gain an understanding of their audit efforts related to our audit objective. We used data from the Medicaid Data Warehouse and eMedNY to identify ineligible premiums paid on behalf of MLTC enrollees. We also identified questionable claims for members who received less than 60 days of services in a 6-month period. Based on our audit work, we believe the data obtained was sufficiently reliable for the purposes of this audit.

To confirm our findings, we provided samples of members to the Department, including the Department's Division of Long-Term Care, and the individual MLTC plans. These members (whose premium payments totaled \$1,022,425) were judgmentally selected based on numerous factors for each of the identified risk areas, such as members with recent dates of service and members with a high number of questionable premium payments. Because the samples were judgmentally selected, the results cannot be projected to the population as a whole. 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 may 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 recipient eligibility in managed long-term care plans.

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

Within 180 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.

Agency Comments and State Comptroller's Comment



KATHY HOCHUL
Governor

Department
of Health

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 13, 2022

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

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report **2020-S-52** entitled, "**Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility.**"

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Frank Walsh
Amir Bassiri
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Rohan
Michael Atwood
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**Department of Health Comments to
Draft Audit Report 2020-S-52 entitled, “Medicaid Program: Oversight
of Managed Long-Term Care Member Eligibility” 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 2020-S-52 entitled, “Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility” by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the \$701 million in improper premium payments identified in this report and recover, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) continuously performs audits of Managed Long-Term Care (MLTC) plan adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid program. OSC’s scope period for the audit bridged two different contracts that were approved by the Centers for Medicare & Medicaid Services (CMS). The 2015 MLTC Contract states the following, Article VI, Section F (1): “...the Department **may recover premiums in all cases where no services are provided** during the applicable period, unless the Contractor demonstrates that it was at risk for provision of medical services for any portion of the payment period for an applicable payment month...”. The 2017 MLTC Contract states the following, Article VI, Section F (1)(a)(xi): “...The Department shall have the right to recover capitation payments made to the Contractor for an Enrollee when, for the entire applicable payment month(s), the Department determines that the Enrollee was or is... Residing in the community and **not in receipt of any CBLTCS** because providers in fact refused or failed to render any services.”

OMIG is currently working with the Department, which in turn is working with CMS, to determine whether any changes are necessary to enhance its ability to recoup payments consistent with OSC’s recommendations. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider’s right to due process.

For any OSC findings after March 2020, OMIG will utilize guidance issued by the Department as to the ability of Plans to render services or disenroll during the COVID-19 Public Health Emergency (PHE).

State Comptroller’s Comment – As explained on page 8 of our report, the criteria from the two Contracts referenced by OMIG were appropriately applied to the audit findings. As such, the audit findings identified are recoverable based on the applicable Contract. In addition, we spoke to OMIG officials and reviewed OMIG MLTC audit reports completed during our audit period and found OMIG’s audit scope was not as comprehensive as our audit’s scope. Therefore, we encourage the Department and OMIG to review the \$701 million in audit findings and take prompt actions to recover all improper premium payments. Lastly, as also stated on page 8 of our report, we only included findings related to deceased individuals for the period after the onset of the

COVID-19 Public Health Emergency in March 2020, which are recoverable.

Recommendation #2:

Develop a process to ensure timely MLTC disenrollment of members who are no longer eligible due to the reasons listed below; such a process should include the Department's identification of these members and monitoring whether they are removed timely from MLTC.

- Not in receipt of any CBLTC services
- Deceased
- In an inpatient setting for more than 45 days
- Not Medicaid eligible or an eligibility status incompatible with MLTC
- Residing in an ALP facility
- Not eligible based on assessments

Response #2:

In 2021 and 2022, the Department reviewed its MLTC disenrollment processes to strengthen and improve the timely identification of members for disenrollment. Planning activities to implement these improvements began in 2019 and were impacted in March 2020 with the onset of the PHE and, specifically, enactment of Section 6008 of the Families First Coronavirus Response Act, which precluded the State from involuntarily disenrolling members, except for very limited circumstances. In 2021 and 2022, the Department resumed five of the eleven involuntary disenrollment reasons on the existing 2014 Involuntary Disenrollment Form per CMS guidance. The remaining six reasons are under review, along with the pending updates needed to the involuntary disenrollment form to align to updated contractual requirements. The Department expects to resume the remaining contractually obligated involuntary disenrollment reasons in 2022 and is updating the form and guidance accordingly. As these involuntary disenrollments have resumed for the five reasons, the Department has issued guidance to plans and the enrollment broker. Specific details for each disenrollment reason are below:

- Not in receipt of any Community-Based Long-Term Care (CBLTC) services;
 - The Department reinitiated the resumption of the involuntary disenrollment reason for members that are not in receipt of CBLTC for the previous calendar month to align with contractual requirements, effective for involuntary disenrollments as of July 1, 2022, and thereafter. The Department provided instructions and a webinar to MLTC plans in April and May 2022.
- Deceased;
 - Disenrollment continued for deceased members during the PHE. The Department reminded MLTC plans to continue processing disenrollments for deceased members in guidance issued between August 2021 and May 2022.
- In an inpatient setting for more than 45 days;
 - Disenrollment for this reason is currently suspended during the PHE. The Department will resume this involuntary disenrollment reason in 2022 and will re-emphasize plan contractual requirements at that time.
- Not Medicaid eligible or an eligibility status incompatible with MLTC;

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- The Department is developing additional policies and procedures to assess coverage codes for members that temporarily or permanently lose Medicaid eligibility but continue to need CBLTC. Currently, CMS requires states to continue Medicaid eligibility without redetermination during the PHE.
 - Residing in an Assisted Living Program (ALP) facility;
 - The Department is reviewing the MLTC policies and procedures related to disenrollment of members who move to an ALP and will re-emphasize with the plans, Local Departments of Social Services and enrollment broker.
 - Not eligible based on assessments;
 - During the PHE, the requirements for semi-annual reassessments were suspended for MLTC plans unless the member's condition changed or the member requested a reassessment. The Department instructed Plans to resume routine reassessments in July 2021. In addition, personal care and consumer directed personal assistance regulatory changes made in November 2021 revised the cadence of routine reassessments from semi-annual to annual.
 - Effective May 16, 2022, the Department implemented the New York Independent Assessor (NYIA). In this first phase, the NYIA will conduct conflict-free initial assessments for all individuals seeking personal care services, consumer directed personal assistance services and/or MLTC enrollment for the first time. The Department is working with the NYIA to develop the timeframe and procedures for conducting conflict-free annual and non-routine reassessments as they take over this responsibility from the plans. In addition to revamping the MLTC assessment and reassessment procedures, the NYIA reduces plan disincentives related to plan disenrollment.

Recommendation #3:

Reassess the process of allowing 90 days to elapse before involuntarily disenrolling members. Evaluate the feasibility of processing such disenrollments retroactively to allow for premium recoveries.

Response #3:

The Department reinitiated the resumption of the involuntary disenrollment reason for members that are not in receipt of CBLTC for the previous calendar month to align with contractual requirements, effective for involuntary disenrollments as of July 1, 2022, and thereafter. The Department provided instructions and a webinar to MLTC plans in April and May 2022.

Recommendation #4:

Monitor MLTC enrollees to ensure they are properly assessed and are receiving the appropriate level of care. Take appropriate action for members who are determined to be ineligible for MLTC or who are not receiving needed CBLTC services.

Response #4:

Since October 1, 2021, the Department has resumed five MLTC involuntary disenrollment reasons including initiating the involuntarily disenrollment reason for members who are not receiving CBLTC in the previous calendar month with an effective date of July 1, 2022, and thereafter. As discussed in response to Recommendation #2, the Department is developing a process to monitor the current reassessment process with the plans and implementing the NYIA's role to ensure the takeover of reassessments are being done in a timely and appropriate manner and that members who are determined to be ineligible for MLTC are disenrolled.

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