NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

May 7, 2024

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 Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report, 2023-F-29 entitled," Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility."

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

cc: Frank Walsh
Amir Bassiri
Jacqueline McGovern
Amber Rohan
Brian Kiernan
Timothy Brown
James Dematteo
James Cataldo
Michael Atwood
Melissa Fiore
OHIP Audit
DOH Audit

Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2023-F-29 entitled, "Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility" (Report 2020-S-52)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2023-F-29 entitled, **"**Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility" (Report 2020-S-52).

Recommendation #1:

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

Status – Partially Implemented

Agency Action – Our initial audit found $701 million in improper MLTC premium payments on behalf of 52,397 recipients who were no longer eligible for MLTC. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. We shared the details of our findings with OMIG at the conclusion of our initial audit. In response. OMIG officials stated they continuously perform audits of MLTC Plans adherence to applicable laws, regulations, and policies governing the Medicaid program. However, at the time of our follow-up, only $32.8 million (or nearly 5%) of the $701 million had been recovered. We note that OMIG may have already lost the opportunity to recover over $259 million of payments due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the improper payments we identified to prevent further loss of recoveries.

Response #1:

OMIG has recovered $33,440,835 of the OSC-identified overpayments. Additionally, there are 3,551 OSC-identified payments totaling $14,352,833, which OMIG has identified for audit but have not yet been recovered. There are 30,453 claims totaling $126,097,680 which are no longer able to be audited and recovered due to the statute of limitations.

OMIG continues to conduct audits of managed long-term care (MLTC) Plans where there are no community-based long-term care (CBLTC) services occurring. As part of its audits, OMIG reviews plan members who are receiving few or no services in a particular scope period.

Additionally, OMIG routinely conducts audits to identify capitation payments paid to Medicaid Managed Care Plans for enrollees after their month of death. Staff detect these inappropriate capitation payments by matching Vital Statistics data to capitation payments on the Medicaid Data Warehouse (MDW) and supplement that data by identifying individuals who have a claim status indicating a death occurred, or a date of death listed in their demographic data, prior to a date of service on the capitation payment.

OMIG continues to review the program areas identified by OSC within its scope of review for potential additional recoveries. For any OSC findings after March 2020, OMIG will utilize guidance issued by Federal and State entities as to the appropriateness of the claims during the COVID-19 public health emergency (PHE).

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 [Assisted Living Program] facility*
- *Not eligible based on assessments*

Status – Partially Implemented

Agency Action – Our initial audit found that the Department had not developed adequate oversight to ensure MLTC plans timely identified enrollees who were ineligible for MLTC. During the COVID-19 public health emergency (PHE), members could only be disenrolled from their MLTC plan for limited reasons, such as those who were determined to be deceased. In November 2020, the Centers for Medicare & Medicaid Services allowed states to resume some involuntary disenrollments as long as comparable coverage was maintained. In response, in October 2021, January 2022, and July 2022, the Department resumed involuntary MLTC disenrollments for select reasons. Additionally, in October 2023, the Department notified MLTC plans to, effective November 1, 2023, resume involuntary disenrollments of MLTC enrollees per the MLTC model contract requirements. In addition to the notification, the Department provided detailed policy instructions. According to Department officials, issuing the policy instructions was a necessary first step that will allow them to focus on developing surveys to monitor MLTC actions. We encourage the Department to implement a process to ensure timely disenrollment of MLTC enrollees who no longer meet program requirements.

Response #2:

The Department was restricted at the onset of the PHE in March 2020 from involuntarily disenrolling MLTC members except for reasons of death and moves out of state. During the PHE and once the Centers for Medicare & Medicaid Services allowed states to resume involuntary disenrollments under limited circumstances, the Department worked carefully to release guidance and communicate to MLTC plans which involuntary disenrollment reasons were resumed, when those reasons were effectuated, and that OMIG could begin audit and recoupment activities for those resumed reasons.

The five MLTC involuntary disenrollment reasons resumed during the PHE effective October 1, 2021, January 1, 2022, and July 1, 2022, can be found under Other Guidance and Resumption of MLTC Involuntary Disenrollments[1].

These resumed reasons included:

1) not in aligned Medicare Advantage Program,
2) no longer resides in plan's service area,

[1] https://www.health.ny.gov/health_care/medicaid/covid19/guidance/

3) enrollee or family member engages in behavior that impacts plan's ability to furnish services,
4) enrollee has been absent from the plan's service area for more than 30 days, and
5) enrollee is not in receipt of Community Based Long Term Services and Supports (CBLTSS) in the previous calendar month.

Members who are determined to be deceased by the Local District of Social Services (LDSS) or moved out of New York State, are disenrolled once the LDSS closes the member's Medicaid eligibility.

Subsequently, at the conclusion of the PHE, the Department prepared and issued new MLTC Policy 23.03 on October 18, 2023, which resumed almost all involuntary disenrollments. The policy included clear guidance on member outreach and education requirements, member notices, as well as the updated Involuntary Disenrollment Request Form, and the workflow preparation and required supporting evidence for New York Medicaid Choice (NYMC) to process such involuntary disenrollments for MLTC members for each resumed reason. MLTC Policy 23.03[2] is posted under 2023.

The updated populations excluded and exempt from MLTC enrollment (including ALP) are available in the *Overview of Managed Long Term Care*[3].

In 2024, the Department will conduct a focused survey of case reviews of MLTC member reassessments to ensure case records document continued MLTC eligibility status.

The Department will continue activities to ensure the MLTC program is operating effectively to serve members who are documented to be eligible and in need of long-term care services and supports.

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.

Status – Implemented

Agency Action – Our initial audit found that a Department directive required MLTC plans to make 10 attempts to contact a member within a 90-day period prior to requesting Maximus to process an involuntary disenrollment, and this likely contributed to improper premium payments for recipients who did not receive any CBLTC services. According to MLTC officials, one reason this occurs is because certain auto-enrolled members are difficult to contact. Beginning July 1, 2022, the Department resumed the involuntary disenrollment of members who were not in receipt of CBLTC for the previous calendar month. In addition, the Department updated its policy so that the involuntary disenrollment process can now occur after 30 days and five failed attempts to contact the member. As such, members who are not receiving CBLTC services can

[2] https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

[3] https://www.health.ny.gov/health_care/managed_care/mltc/mltc_overview.htm

be removed from MLTC more timely. Lastly, the Department evaluated the feasibility of processing retroactive disenrollments and stated it does not currently have the authority to retroactively seek involuntary disenrollments. (We note that, with the policy change to 30 days the materiality of this portion of the recommendation and the need for retroactive disenrollments was significantly reduced.)

Response #3:

The Department agrees with this recommendation status.

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.

Status – Not Implemented

Agency Action – Medicaid enrollees must be assessed as needing CBLTC services for more than 120 days to be eligible for MLTC. During our initial audit, Maximus was responsible for the initial assessment of voluntary enrolled MLTC recipients, and MLTC plans were responsible for performing the semi-annual assessment of their own members thereafter. Our initial audit found that, of the more than 3 million total assessments we reviewed, 97% concluded that the members were in need of CBLTC services for more than 120 days. However, we also found that, although the vast majority of assessments resulted in the continuation of MLTC coverage, over $2.8 billion in premium payments were made on behalf of members who received 60 days or less of CPLTC services in the 6 months following assessment.

MLTC plan reassessments were put on hold with the onset of the PHE, but resumed in July 2021 on a rolling catch-up schedule. On May 16, 2022, the New York Independent Assessor (NYIA [Maximus]) took over responsibility for all initial assessments for MLTC care. The NYIA is also expected to take over the reassessment process from MLTC plans in the future. According to Department officials, they are developing a process to monitor the current reassessment process with MLTC plans and are implementing the NYIA's role to ensure that the takeover of reassessments is done in a timely and appropriate manner and that members who are determined to be ineligible are disenrolled. Department officials also stated that, prior to the NYIA taking over the reassessments, they plan to conduct focused surveys to review case plans in order to ensure the appropriateness of eligibility. Despite its stated plans, the Department was unable to provide us with evidence of how it will monitor the process to ensure members are properly assessed and receiving the appropriate level of care.

Response #4:

The Department does not agree that this recommendation has not been implemented. The following is a summary of steps the Department, working with OMIG, has taken to implement this recommendation.

Members no longer in receipt of CBLTSS were to be disenrolled per Department guidance[4] issued April 7, 2022, effective July 1,2022. MLTC Policy 23.03[5] issued October 18, 2023 reiterates this same reason for involuntary disenrollment.

The Department issued MLTC Policy 22.01[6] on April 27, 2022. On May 16, 2022, the NYIA Program took over the initial assessments of Medicaid enrollees seeking community based long term care services and supports. If found eligible, the NYIA Program refers the Medicaid enrollee for enrollment in a MLTC plan of their choice, or to be auto assigned if they do not choose.

The Department issued guidance[7,8] directing MLTC plans to resume and continue eligibility reassessments of their current enrollees via face-to-face or telehealth on a rolling catch-up schedule.

In 2024, the Department will conduct a focused survey of case reviews of MLTC member's reassessments to ensure case records document continued MLTC eligibility status.

The Department will continue activities to ensure the MLTC program is operating effectively to serve members who are documented to be eligible and in need of long-term care services and support.

In support of the Department's monitoring activities, OMIG continues to conduct audits of MLTC Plans where there are no CBLTCS occurring. As part of its audits, OMIG reviews enrollees who are receiving few or no services in a particular scope period.

Additionally, OMIG routinely conducts audits to identify capitation payments paid to Medicaid Managed Care Plans for enrollees after their month of death. Staff detect these inappropriate capitation payments by matching Vital Statistics data to capitation payments on the MDW and supplement that data by identifying individuals who have a claim status indicating a death occurred, or a date of death listed in their demographic data, prior to a date of service on the capitation payment.

[4] https://health.ny.gov/health_care/medicaid/covid19/guidance/index.htm - see Other Guidance menu option and Resumption of MLTC Involuntary Disenrollments)
[5] https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm
[6] https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm
[7] COVID–19 https://health.ny.gov/health_care/medicaid/covid19/2020-03-18_guide_authorize_cb_lt_services.htmGuidance for Medicaid Providers (ny.gov)
[8] https://health.ny.gov/health_care/medicaid/covid19/guidance/ (see Other Guidance menu option)