THOMAS P. DINAPOLI
STATE COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

August 31, 2021

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

Re: Improper Fee-for-Service Payments for Services Covered by Managed Long-Term Care Plans
Report 2021-F-4

Dear Dr. Zucker:

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 have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Improper Fee-for-Service Payments for Services Covered by Managed Long-Term Care Plans* (Report 2018-S-65).

Background, Scope, and Objective

The State's Medicaid program offers managed long-term care (MLTC) coverage to people who are chronically ill or disabled and who wish to stay in their homes and communities. Through December 31, 2019, the Medicaid program offered four different MLTC plan types: Partial Capitation, Program of All-Inclusive Care for the Elderly, Medicaid Advantage Plus, and Fully Integrated Duals Advantage (FIDA). As of December 31, 2020, FIDA plans are no longer available in New York. For the State fiscal year ended March 31, 2021, MLTC plans received $15.2 billion in premium payments on behalf of 330,936 Medicaid recipients.

MLTC plans offer a range of services, such as home health care, nursing home care, dentistry, vision care, and durable medical equipment. The Department of Health (Department) created model contracts for each of the four plan types, which identify the services that plans must cover and pay for (benefit package) in exchange for monthly premium payments for each member enrolled. However, some services are excluded (i.e., carved out) from benefit packages and may be paid separately by Medicaid fee-for-service (FFS). Medicaid FFS claims are subject to various payment controls that, for example, determine whether recipients are enrolled in a MLTC plan and will deny FFS claim payments unless the services are carved-out from the recipient's MLTC benefit package. The carved-out services are controlled by the scope of benefits information maintained in eMedNY (the Medicaid claims processing and payment system). The Medicaid program should not pay claims on a FFS basis for MLTC plan covered services.

We issued our initial audit report on January 17, 2020. The audit objective was to determine whether the Department made improper FFS payments for certain services covered by MLTC plans. The audit covered the period from January 1, 2014 through June 30, 2019. Our audit identified $16.4 million in improper Medicaid FFS payments for MLTC covered services. Of the $16.4 million in overpayments, $15.6 million was paid because the Department did not configure eMedNY system edits and MLTC benefit packages correctly, so eMedNY did not correctly identify certain services as the responsibility of the MLTC plan. The remaining $877,000 was improperly paid because, at the time eMedNY adjudicated the claim, the recipient was not enrolled in MLTC, but was retroactively enrolled at a later date.

The objective of our follow-up was to assess the extent of implementation, as of May 7, 2021 of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made some progress in addressing the problems we identified in the initial audit report; however, further actions are still needed. For instance, since the initial audit, we identified about $4.3 million in additional improper Medicaid FFS payments for MLTC covered services from July 1, 2019 through February 15, 2021. Of the initial report's three audit recommendations, two were partially implemented and one was not implemented.

Follow-Up Observations

Recommendation 1

Review the $16.4 million in improper Medicaid FFS payments and make recoveries, as appropriate.

Status – Partially Implemented

Agency Action – The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments of behalf of the Department. During the initial audit, we provided OMIG with a file containing the overpayments we identified. As of March 12, 2021, OMIG had only recovered $146,046 (less than 1%) of the $16.4 million in improper payments we identified. Another $94,531 was recovered through provider-initiated claim voids unrelated to OMIG efforts.

According to OMIG officials, all claims identified in the initial audit are being reviewed as part of OMIG projects and improper payments identified will be pursued. However, officials were unable to provide an expected completion date or supporting documentation to substantiate OMIG's review. Of the $16.1 million in unrecovered claims, OMIG may have already lost the opportunity to recover about $3.1 million (19%) due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the remaining improper payments to prevent further loss of recoveries.

Recommendation 2

Correct eMedNY MLTC benefit package information and system edits to prevent FFS payments for MLTC covered services.

Status – Partially Implemented

Agency Action – Each MLTC plan type is assigned a benefit package that includes all covered

services defined in the corresponding MLTC model contract. Certain information used to describe benefit package services (e.g., procedure code, specialty code, reimbursement rate code, claim type, category of service) is maintained in eMedNY and is associated with a Global Identification Number (Global ID), which is then used in conjunction with eMedNY system edits to prevent improper FFS payments for MLTC covered services.

Our initial audit determined the majority of overpayments occurred because the Department did not configure eMedNY system edits and MLTC benefit packages correctly. For example, the MLTC benefit package and mainstream managed care benefit package shared the same Global ID despite significant differences between the services covered by these different plans. Of the initial audit's $16.4 million in overpayments, $13.6 million (83%) was for clinic, nursing home, and home health claims on behalf of members enrolled in Partial Capitation MLTC plans. Since the initial audit, we identified over $4 million in additional improper Medicaid FFS payments for these services from July 1, 2019 through February 15, 2021.

In April 2020, the Department created a Global ID specific to MLTC plans, which allows the Department to apply system edits that are separate from mainstream managed care plans and specific to MLTC plans. For example, system edits have been added that deny certain FFS nursing home payments for clients in Partial Capitation MLTC plans. In addition, officials stated the Department is currently performing internal audits to address other scenarios, such as improper FFS payments for MLTC covered professional services performed in a diagnostic and treatment center. We urge the Department to complete these audits and implement system edits timely to prevent further overpayments.

Recommendation 3

Work with Local Districts to develop a process to identify and recover improper Medicaid FFS payments for MLTC services resulting from retroactive enrollments.

Status – Not Implemented

Agency Action – Retroactive enrollment occurs when recipients are enrolled in a MLTC plan with an effective date in the past. MLTC plans receive premium payments to cover the months of retroactive coverage. FFS payments made during a period covered by retroactive enrollment may be improper if it is determined the services should have been covered by the MLTC plan.

Our initial audit determined that Local Departments of Social Services (Local Districts) did not have a process to identify and recover improper FFS payments for MLTC covered services provided during retroactive enrollment periods. In response to our audit, the Department indicated it would work with Local Districts to develop such a process; however, officials were unable to provide evidence that changes have been made. Furthermore, we reviewed FFS claims paid between July 1, 2019 and February 15, 2021 and found an additional $270,413 in improper payments on 385 claims paid during a retroactive enrollment period. We encourage the Department to prioritize the development of a routine process to identify and recover these types of improper payments.

Major contributors to this report were Vicki Wilkins, Francesca Greaney, and Jennifer Kirby.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Mr. Robert Schmidt, Department of Health
Mr. Frank T. Walsh, Jr., Acting Medicaid Inspector General