NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

January 2, 2023

Honorable Andrea Inman
Audit Director
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236
ainman@osc.ny.gov

Dear Ms. Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2020-S-52 entitled, "Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility."

Please feel free to contact Mischa Sogut, Office of Governmental Affairs, at (518) 473-1124 or mischa.sout@health.ny.gov, with any questions.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Mischa Sogut

Department of Health Comments to Final 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 Final 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:

MLTC

The Office of the Medicaid Inspector General (OMIG) currently conducts audits of MLTC Plans where there are no CBLTC services occurring. As part of its audits, OMIG reviews Plan members who are receiving little or no services in a particular scope period. OMIG commenced audits prior to the OSC audit and has finalized 18 audits that overlap or are within OSC's audit scope period. These audits reviewed almost 5,600 Plan members, and resulted in more than $35 million in recoveries, of which more than $25.5 million were included in OSC's identified overpayments. There are an additional 16 audits in progress that include 4,800 members, with the potential to recover more than $23 million of the OSC identified overpayments.

OMIG continues to review the program areas identified by OSC for additional potential recoveries within OSC's review scope. 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).

Deceased Beneficiaries

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 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.

Regarding the specific claims identified in OSC's report, OMIG's most recent deceased recipient review identified over $3.1 million in claims. Nearly $1 million has already been identified and recovered in prior OMIG reviews, with the remainder to be collected via audits to be issued in the next year. OMIG's detailed review of OSC's findings discovered that 645 claims totaling $2,902,627 were associated with members who were determined to be alive during the month in question, and disenrollment would have left the member without health coverage. Plans have also already voided over $350,000 in claims identified by OSC.

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 2023 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 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 expects to resume this involuntary disenrollment reason in 2023 and will re-emphasize plan contractual requirements at that time.

- Not Medicaid eligible or an eligibility status incompatible with MLTC;

- 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 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.