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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 13, 2024

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Oversight of Managed Long-Term Care Member Eligibility
Report 2023-F-29

Dear Dr. McDonald:

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 (Department) to implement the recommendations contained in our initial audit report, *Medicaid Program: Oversight of Managed Long-Term Care Member Eligibility* (Report 2020-S-52).

Background, Scope, and Objective

The Department administers New York's Medicaid program. Many of the State's Medicaid recipients are enrolled in managed long-term care (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, 2022, Medicaid paid MLTC plans $15.7 billion in premiums for 338,186 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) 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 their members when it is determined they are no longer MLTC eligible (e.g., enrollees who did not receive any CBLTC services in a month or deceased recipients), and Maximus is responsible for processing the disenrollments. The Department can recover premium payments made to MLTC plans for ineligible enrollees.

The objective of our initial audit, issued on August 5, 2022, was to determine whether the Department made improper Medicaid MLTC premium payments on behalf of ineligible enrollees. The audit covered the period from January 2015 through March 2021. The audit identified $701 million in improper Medicaid MLTC premiums on behalf of 52,397 recipients who were no longer

eligible for MLTC. Additionally, we determined Medicaid paid $2.8 billion in MLTC premium payments on behalf of 51,947 recipients who received a limited number of CBLTC services, and the Department did not have a process to monitor that enrollees were properly assessed or had access to the care they needed.

The objective of our follow-up was to assess the extent of implementation, as of December 5, 2023, of the four 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, additional actions are still needed. For example, less than 5% of the $701 million in improper MLTC payments had been recovered. Furthermore, the Department needs to develop a process to identify and monitor ineligible enrollees in between assessments. Of the initial report's four audit recommendations, one was implemented, two were partially implemented, and one was not implemented.

Follow-Up Observations

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 plan 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 in payments due to federal lookback provisions. We encourage the Department and OMIG to take prompt action on the improper payments we identified to prevent further loss of recoveries.

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.

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 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.)

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 voluntarily enrolled MLTC recipients, and then 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 CBLTC 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.

Major contributors to this report were Thomas Sunkel, Emily Proulx, and Benjamin Buyer.

Department officials are requested, but not required, to provide information about any actions planned to address the unresolved issues discussed in this follow-up within 30 days of the report's issuance. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this follow-up.

Sincerely,

Christopher Morris
Audit Manager

cc: Melissa Fiore, Department of Health
Frank T. Walsh, Jr., Office of the Medicaid Inspector General