New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans

Medicaid Program
Department of Health

Report 2015-S-9 March 2016

Executive Summary

Purpose

To determine whether the Medicaid program made inappropriate capitation payments to Managed Long Term Care Partial Capitation plans for recipients who were no longer enrolled in these plans. The audit covered the period January 1, 2010 through January 31, 2015.

Background

Managed Long Term Care Partial Capitation plans (Plans) provide health and long-term care services to recipients who have a long-lasting health problem or disability. Generally, recipients enrolled in these Plans need home care, adult day health care, or other long-term care for more than 120 days; have both Medicaid and Medicare; and are age 21 or older. Medicaid pays Plans a monthly capitation payment for every Medicaid recipient enrolled in a Plan, and the Plan arranges for the provision of services its members require. For the period January 1, 2010 through January 31, 2015, Medicaid paid Plans $15 billion in capitation payments. The Department of Health (Department) can recover inappropriate capitation payments made to Plans. An inappropriate payment occurs when a capitation payment was made for a recipient who was later retroactively disenrolled from a Plan and the Plan was not "at risk" for the provision of services during the disenrollment period (i.e., the Plan did not pay for medical services for the recipient during the disenrollment period). Plans are required to void (repay) these inappropriate capitation payments when recipients are retroactively disenrolled.

Key Findings

- For the period January 1, 2010 through January 31, 2015, we determined Medicaid paid Plans 5,368 monthly capitation payments totaling about $21.4 million for recipients who were subsequently disenrolled and the Plans were not "at risk" (did not pay for medical services) during the disenrollment periods. By the end of our fieldwork, the Plans voided 1,522 of the 5,368 monthly capitation payments (totaling about $6.2 million). Additionally, the Office of the Medicaid Inspector General recovered another 800 payments (totaling more than $3.2 million) in response to our findings, leaving 3,046 capitation payments totaling about $12 million that still needed to be reviewed and recovered from the Plans.
- The Department does not have a system in place to identify capitation payments made for retroactively disenrolled recipients. As a result, the Department cannot properly monitor whether Plans are voiding the capitation payments. Also, the Department's managed long-term care contracts do not require Plans to void inappropriate capitation payments within a specified timeframe. Therefore, improper capitation payments for retroactively disenrolled recipients can remain outstanding for several years.
- If the Department revises its policy on the payment of capitation payments during disenrollment periods when Plans were "at risk" (provided medical services), the Medicaid program could realize significant savings. Specifically, if Medicaid paid for the cost of such health care services rather than capitation payments, we estimated that for the period January 1, 2010 through January 31, 2015, the Medicaid program could have saved approximately $3.1 million.

Key Recommendations

- Review the remaining $12 million in capitation payments we identified and recover overpayments as appropriate.
- Enhance Department oversight to identify and recover capitation payments for retroactively disenrolled recipients for periods that Plans were not "at risk" for providing medical services.
- Amend Plan contracts to specify a timeframe in which Plans are required to void inappropriate capitation payments for retroactively disenrolled recipients.
- Assess the impact of revising payment policies to reimburse Plans for the cost of medical services (as opposed to capitation payments) provided to retroactively disenrolled recipients.

Other Related Audits/Reports of Interest

Department of Health: Appropriateness of Medicaid Eligibility Determined by the New York State of Health System (2014-S-4)
Department of Health: Optimizing Medicaid Drug Rebates (2015-S-1)

State of New York
Office of the State Comptroller

Division of State Government Accountability

March 30, 2016

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for 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 *Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans*. This audit was performed pursuant to the State Comptroller's authority under 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,

Office of the State Comptroller
Division of State Government Accountability

Table of Contents

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Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2015, the New York State Medicaid program had approximately 7.1 million enrollees and Medicaid claim costs totaled about $53 billion. The federal government funded about 52.4 percent of New York's Medicaid claim costs, the State funded about 30.2 percent, and the localities (the City of New York and counties) funded the remaining 17.4 percent.

The New York State Medicaid program, administered by the Department of Health (Department), pays health care providers either directly through fee-for-service payments or through monthly capitation payments to managed care plans. Under the managed care method, Medicaid pays each managed care plan a monthly payment for each Medicaid recipient enrolled in the plan. The plans are then responsible for ensuring enrollees have access to a comprehensive range of health care services. Managed care plans typically have networks of participating providers that they reimburse directly for services provided to their enrollees. Managed care plans are also required to submit encounter claims to the Department's Medicaid claims processing system (eMedNY) to inform the Department about each medical service provided to recipients enrolled in managed care.

In January 2011, the New York State Governor's Office established the Medicaid Redesign Team to reduce Medicaid costs and improve the delivery of health services. As a result of the initiative, the Medicaid Redesign Team and 2011 budget legislation required mandatory enrollment of certain Medicaid recipients into Managed Long Term Care (MLTC) plans. MLTC plans provide a range of health and long-term care services that include, but are not limited to, home care, social day care, and nursing home care.

Enrollment in an MLTC plan is mandatory for Medicaid recipients who have both Medicaid and Medicare, are age 21 or older, and need community-based long-term care services for more than 120 days. Community-based long-term care includes services such as Personal Care and Nursing Services provided in the home, Home Health Care such as therapy and home health aide services, and Adult Day Health Care. Certain other Medicaid recipients can voluntarily enroll in an MLTC plan if they meet certain age requirements, are nursing home eligible, and meet other eligibility requirements.

There are three types of MLTC plans: Partial Capitation plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and Medicaid Advantage Plus (MAP) plans. All three plans provide community-based long-term care services, nursing home care, and ancillary and support services, including individualized care management. Additionally, PACE and MAP plans include benefits covered by Medicare. Partial Capitation plan benefit packages are solely covered by Medicaid. Accordingly, Partial Capitation plans provide long-term care services through Medicaid capitation payments, while other services (such as primary care services, emergency transportation, and hospital services) are reimbursed on a fee-for-service basis by Medicaid and/or Medicare.

The Department contracts with MLTC Partial Capitation plans (herein referred to as Plans) to arrange and pay for the health and long-term care services their members require. The Department compiles and distributes a monthly roster to each Plan listing every Medicaid recipient who is eligible for enrollment in the Plan for the upcoming month. The Plans use these monthly rosters to bill Medicaid for the enrollees' monthly capitation payments. For the period January 1, 2010 through January 31, 2015, Medicaid paid Plans $15 billion in monthly capitation payments.

Medicaid recipients who are enrolled in a Plan are retroactively disenrolled when the recipient loses eligibility or the recipient has requested to be removed from the Plan. According to the MLTC contract, the Department has the right to recover capitation payments made to Plans when the recipient was inappropriately enrolled in the Plan either for a portion of the enrollment period retroactive to the effective disenrollment date or for the entire enrollment period, in which case the entire enrollment period is retroactively deleted. However, the contract states the Department may only recover capitation payments if the Department determines that the Plan was not "at risk" for the provision of medical services during any portion of the payment period. The Plan is considered to have been "at risk" if the Plan paid for medical services provided to recipients during the month covered by the capitation payment.

Audit Findings and Recommendations

For the period January 1, 2010 through January 31, 2015, Medicaid made 5,368 capitation payments totaling about $21.4 million for recipients who were subsequently disenrolled retroactively from a Plan and did not receive medical services during the disenrollment period. The Plans should have voided these capitation payments when the recipients were disenrolled retroactively. As of July 2015, the Plans had voided 1,522 of the 5,368 monthly capitation payments (which totaled about $6.2 million). Additionally, the Office of the Medicaid Inspector General recovered another 800 payments (totaling more than $3.2 million) in response to our findings, leaving about $12 million in capitation payments that still needed to be voided and/or recovered. We determined the Department does not have a process in place to identify capitation payments made for recipients who were disenrolled retroactively. As a result, the Department cannot properly monitor these payments to ensure they are properly voided. Further, the Department's contracts with Plans do not stipulate a required timeframe for Plans to void inappropriate capitation payments. We made recommendations to the Department to recover the inappropriate Medicaid payments, enhance Department oversight, and implement repayment deadlines.

Overpayments for Recipients Who Were Disenrolled Retroactively

For the five-year period ended January 31, 2015, Medicaid made 5,368 capitation payments totaling about $21.4 million for recipients who were subsequently disenrolled retroactively from a Plan, and the Plan was not "at risk" during the disenrollment period (i.e., the Plan did not incur medical expenses for members). As of July 2015, the Plans voided 1,522 of the 5,368 capitation payments (totaling about $6.2 million). Additionally, on behalf of the Department, the Office of the Medicaid Inspector General recovered another 800 payments (totaling more than $3.2 million), leaving 3,046 capitation payments totaling about $12 million that still needed to be voided and/or recovered.

As illustrated in the following table, in most instances, the Plans received one month of inappropriate capitation payments for recipients who were disenrolled retroactively. These payments totaled about $11.5 million. However, we also found instances where Plans received multiple months of improper capitation payments prior to a recipient's disenrollment. For example, Medicaid made 16 months of capitation payments, totaling $70,159, to a Plan from September 2013 through December 2014 for a recipient who was disenrolled retroactively. However, according to the Department's eMedNY enrollment information, the recipient was not enrolled in the Plan during this period. Additionally, the Plan had not voided any of these improper payments. (Note: In the table, we only reported $65,774 of the total $70,159 because during one of the 16 months the Plan was "at risk" and paid a provider for services rendered to the recipient.)

Number of Months of Improper Capitation Payments	Number of Recipients	Percent of Total Recipients	Improper Capitation Payments	Percent of Total Improper Capitation Payments
1	2,895	77.61%	$11,513,665	53.91%
2	465	12.47%	3,678,470	17.22%
3	181	4.85%	2,206,168	10.33%
4	87	2.33%	1,392,943	6.52%
5	40	1.07%	809,226	3.79%
6	31	0.83%	736,242	3.45%
7	7	0.19%	178,020	0.83%
8	11	0.30%	324,959	1.52%
9	8	0.21%	288,148	1.35%
10	2	0.05%	76,871	0.36%
11	2	0.06%	87,071	0.41%
15	1	0.03%	65,774	0.31%
Totals	**3,730**	**100%**	**$21,357,557**	**100%**

To verify the payments' impropriety, we provided the Department with a judgmental sample of 20 capitation payments totaling $83,326 for Plan recipients who, according to eMedNY enrollment information, were disenrolled retroactively. Department officials reviewed the payments and determined that 18 of the 20 payments totaling $75,051 were improper. Officials based their assessment on enrollment information from the State's Welfare Management System (WMS). The WMS maintains and processes eligibility and enrollment information for individuals who are eligible for benefits under public assistance programs for which the State's Local Departments of Social Services (LDSS) are responsible for administering. This includes Medicaid recipients enrolled in Plans. Eligibility information in WMS is ultimately communicated to the Department's eMedNY system. For the 18 improper payments, WMS showed either the recipient's entire enrollment period was rescinded or the recipient was disenrolled retroactively for a portion of the enrollment period. The remaining two capitation payments were appropriate because one recipient's enrollment information was updated after we selected our sample, and for a second recipient, a LDSS case worker data-entered the disenrollment date incorrectly.

According to Department officials, some capitation payments may appear to be improper; however, delays in the recipient enrollment recertification process can cause Plans to be at risk for the provision of medical services. Most Medicaid recipients are required to recertify their eligibility annually. However, recertification delays can occur, and the Plans may provide services in good faith for recipients who do not recertify on time. While these recertification delays may occur, our findings only include capitation payments for months in which Plans did not provide medical services to the recipients (i.e., the Plans were not "at risk"). Therefore, the delays in recertification, as cited by the Department, had no impact on the improper payments we identified.

As previously mentioned, LDSS case workers disenroll recipients retroactively when the recipient loses eligibility or the recipient has requested to be removed from a Plan. The LDSS case worker processes the disenrollment transaction through WMS. According to Department officials, the LDSS is responsible for notifying Plans when a recipient is disenrolled retroactively. The Plan is then responsible for voiding any capitation payments subsequent to the disenrollment date as long as the Plan was not "at risk" for providing services. However, we determined that the Department's MLTC contracts with Plans do not require Plans to void improper capitation payments within a specified timeframe. Therefore, improper capitation payments for recipients who are disenrolled retroactively can be outstanding for several years.

Further, the Department does not have a process in place to identify and monitor outstanding capitation payments that still need to be voided for recipients who are disenrolled retroactively. According to Department officials, they are developing an internal report that will identify recipients who have been disenrolled retroactively and will use this report to identify improper capitation payments. However, Department officials could not tell us when such a report would be available for this purpose.

Recommendations

1. Review the remaining $12 million in capitation payments we identified and recover overpayments as appropriate.

2. Amend Plan contracts to specify a timeframe in which Plans are required to void inappropriate capitation payments for recipients who are disenrolled retroactively.

3. Enhance Department oversight to identify, monitor, and recover capitation payments for recipients who are disenrolled retroactively for the periods that Plans were not "at risk" for providing medical services.

Department Policy on Recovery of Capitation Payments

Current Department policy considers capitation payments appropriate during periods of recipient disenrollment if the Plans were "at risk" and paid for medical services provided to recipients during the disenrollment periods. However, we found that if the Department revises its policy and paid the cost of medical expenses incurred by Plans for services provided to recipients during disenrollment periods rather than capitation payments, Medicaid could realize savings.

From January 1, 2010 through January 31, 2015, we identified 1,423 capitation payments totaling more than $5.5 million for retroactively disenrolled recipients in which the Plans were "at risk." For this period, Plans collectively reported payments totaling about $2.4 million to providers for medical services rendered to Medicaid recipients during the disenrollment periods. If the Department had revised its policy (and the corresponding MLTC contract language) to reimburse Plans for the cost of medical services instead of the capitation amounts, Medicaid could have saved approximately $3.1 million ($5.5 million - $2.4 million).

For example, we found Medicaid paid a Plan $5,009 for a recipient's June 2014 monthly capitation. Subsequently, the LDSS retroactively disenrolled the recipient. The Plan reported medical expenses totaling $77 for the recipient during this month. In this instance, if the MLTC contract had been revised to pay the cost of the medical service rather than the capitation, Medicaid would have saved $4,932 ($5,009 - $77).

Recommendation

4. Assess the impact of revising the Department's policy on paying capitation amounts versus the cost of Plans' medical expenses during periods when recipients were disenrolled retroactively and Plans were "at risk." Based on the results of the assessment, consider revising the Department's corresponding policy and amending MLTC contract language.

Audit Scope and Methodology

The objective of our audit was to determine whether Medicaid made inappropriate capitation payments to Managed Long Term Care Partial Capitation plans (Plans) for recipients who were no longer enrolled. The scope of our audit was from January 1, 2010 through January 31, 2015.

To accomplish our audit objective and assess internal controls, we reviewed applicable sections of State laws and regulations, examined the Department's contracts with Plans, and analyzed Medicaid claim and encounter data in eMedNY. To assess the accuracy of pertinent eMedNY data, as well as the propriety of capitation payments made to the Plans, we reviewed a judgmental sample of 20 capitation payments selected from an audit population of 5,368 capitation payments. Our sample included payments that were selected based on disenrollment code, service year, and Plan. We also interviewed officials from local districts and the Department about the retroactive disenrollment process.

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. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

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.

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 it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them.

Within 90 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.

Contributors to This Report

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Vision

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 25, 2016

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 2015-S-9 entitled, "Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-9 entitled,
Improper Payments for Recipients No Longer Enrolled in
Managed Long Term Care Partial Capitation Plans

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2015-S-9 entitled, "Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans."

Background

New York State is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

General Comments

The Department agrees with the recovery of improper payments for recipients no longer enrolled in a managed long term care plan; however, reconciliation strategies designed to identify and recover inappropriate payments must incorporate the potential for Local Departments of Social Services (LDSS) errors when identifying this population. In performing a sample review of the cases identified for capitation returns, a LDSS error was noted on the date of death in a client's file. The client died in March 2013; the disenrollment was entered for March 2012. Capitation payments were correctly paid throughout 2012 and for the first three months of 2013. The Plan did not bill beyond the month of death. This is noted because "at risk" and reconciliation strategies designed to identify and recover inappropriate payments will result in immediate cost reductions to the State in the short run. However, policies developed to enforce these strategies must be done carefully to ensure that Plans are not penalized inaccurately. Managed long term care plans are not required to purchase reinsurance to provide a margin of safety for high cost cases, nor does New York State require a cap on the expenditures for an individual member enrolled in a Plan. We need to construct policies that reclaim inappropriate payments, while working to ensure that Plans are not put in a position of financial risk because of LDSS errors.

Recommendation #1

Review the remaining $12 million in capitation payments we identified and recover overpayments as appropriate.

Response #1

OMIG has recovered $1.2 million of the $12 million, and will continue to recover any inappropriate payments that were identified.

Recommendation #2

Amend Plan contracts to specify a timeframe in which Plans are required to void inappropriate capitation payments for recipients who are disenrolled retroactively.

Response #2

In 2016, the Department will be amending plan contracts. The contracts may be amended to mirror Medicaid Managed Care (MMC). For example, MMC contract Appendix H indicates that there is a 30 day timeframe to void payments--30 days from the date the plan is notified.

Recommendation #3

Enhance Department oversight to identify, monitor, and recover capitation payments for recipients who are disenrolled retroactively for the periods that Plans were not “at risk” for providing medical services.

Response #3

OMIG will continue to recover capitation payments for recipients who are disenrolled retroactively for the periods that Plans were not “at risk” for providing medical services.

Recommendation #4

Assess the impact of revising the Department’s policy on paying capitation amounts versus the cost of Plans’ medical expenses during periods when recipients were disenrolled retroactively and Plans were “at risk.” Based on the results of the assessment, consider revising the Department’s corresponding policy and amending MLTC contract language.

Response # 4

MMC and Managed Long Term Care have engaged in a workgroup with OMIG to develop best strategies to address “at risk” and reconciliation strategies. Policy and potential contract changes would then be made accordingly.