NEW YORK STATE OF OPPORTUNITY. Department of Health

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Commissioner

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

November 2, 2017

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 Follow-Up Audit Report 2017-F-10 entitled, "Improper Payments for Recipients No Longer Enrolled in Managed Long-Term Care Partial Capitation Plans." (Report 2015-S-9)

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
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Department of Health
Comments on the Office of the State Comptroller's Follow-Up Audit Report 2017-F-10 entitled, Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans (Report 2015-S-9)

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 2017-F-10 entitled, "Improper Payments for Recipients No Longer Enrolled in Managed Long-Term Care Partial Capitation Plans." (Report 2015-S-9)

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

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 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1

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

Status – Partially Implemented

Agency Action – The OMIG investigates and recovers improper Medicaid payments on behalf of the Department. As of May 9, 2017, the OMIG recovered $3.4 million in improper capitation payments, while $8.6 million still needed to be recovered. The OMIG stated that it will continue to recover the remaining improper payments through its normal audit process. We note, however, that of the $3.4 million recovered, $3.2 million of the capitation payments (94 percent) were from calendar years 2013 through 2015. We estimate that over $920,000 of the $8.6 million still to be recovered are capitation claims from the fourth quarter of 2011 and calendar year 2012, which will soon age beyond the period recoverable as allowed by the federal look-back provisions. We encourage the Department to take prompt action on these claims to prevent further loss of recoveries.

Response #1

In addition to the $3.4 million, OMIG has recovered another $ 2.5 million for a total recovery of $5.9 million of the $12 million. OMIG will continue to examine payments and pursue recoveries that are determined to be inappropriate.

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.

Status – Partially Implemented

Agency Action – According to Department officials, the Managed Long Term Care Partial Capitation Contract is currently in revision and language will be added to reflect language already contained in Appendix H of the Mainstream Medicaid Managed Care Model Contract. Officials stated the following proposed language will be added to the Managed Long Term Care Partial Capitation Contract:

"In all cases of retroactive Disenrollment, including Disenrollment effective the first day of the current month, the Enrollment Broker or LDSS is responsible for sending notice to the Contractor at the time of Disenrollment, of the Contractor's responsibility to submit to the SDOH's Fiscal Agent voided premium claims within thirty (30) business days of notification from the Enrollment Broker or LDSS for any full months of retroactive Disenrollment."

(Note: The State's Local Departments of Social Services, or LDSS, take part in the enrollment and disenrollment of Medicaid recipients into Plans.)

Response #2

The Department has added the following language to Article VI, F.4 to our contract revisions. The language reads: "In all cases of retroactive Disenrollment, including Disenrollments effective the first day of the current month, the entity designated by the State or Local Department of Social Services (LDSS) is responsible for sending notice to the Contractor at the time of Disenrollment, of the Contractor's responsibility to submit to the State Department of Health's Fiscal Agent voided premium claims within thirty (30) business days of notification from the entity designated by the State or LDSS for any full months of retroactive Disenrollment."

Pursuant to a Department of Health Memorandum of Understanding with OMIG and the Medicaid Fraud Control Unit (MFCU), managed care contract language related to program integrity is discussed and commented upon by each; revisions will then be discussed with the Trade Associations. The Centers for Medicare and Medicaid Services, must approve the final contract prior to Plans' execution. Signed contracts are then forwarded to the State Attorney General's office and OSC for approval. The Department anticipates implementation by December 2018.

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.

Status – Implemented

Agency Action – The OMIG has worked with the Department's Division of Long Term Care to improve their identification and recovery of capitation payments for individuals who have been retroactively disenrolled from the MLTC plans. This has led to the development of additional

reason codes for MLTC retroactive disenrollment scenarios in the eligibility and enrollment system, and the creation of a PowerPoint designed to assist the LDSS in identifying and recovering capitation payments for individuals retroactively disenrolled from the MLTC plans.

Response #3

The Department confirms our agreement with this report.

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.

Status – Implemented

Agency Action – As reported in the May 2017 Medicaid Update (the Department's official publication for Medicaid providers), the Department and the OMIG developed a new process to recover overpaid capitation payments and reimburse the Plans for the cost of health care services. The OMIG will identify and recover all inappropriately paid capitation payments, including those months when services were provided, consistent with State laws, regulations, and the Plan contracts. The Department will subsequently reimburse the Plans for costs incurred during the recovered capitation months if certain conditions are met.

Response #4

The Department confirms our agreement with this report.