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October 6, 2017

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

Re: Improper Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans
Report 2017-F-10

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 Payments for Recipients No Longer Enrolled in Managed Long Term Care Partial Capitation Plans* (Report 2015-S-9).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Medicaid pays health care providers either directly through fee-for-service payments or through monthly capitation payments to managed care plans. Under managed care, the Department contracts with managed care organizations (MCOs) to provide services to Medicaid recipients. The Department pays MCOs a monthly premium for each enrolled Medicaid recipient. In turn, MCOs are responsible for ensuring enrollees have access to a comprehensive range of health care services.

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. Enrollment in a 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. The Partial

Capitation Plan (Plan), one of the three types of MLTC plans, provides long-term care services through Medicaid capitation payments (i.e., monthly premium 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.

Medicaid recipients who are enrolled in a Plan can be 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 months covered by the capitation payments.

We issued our initial audit report on March 30, 2016. The audit objective was to determine whether Medicaid 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. Our initial audit determined that 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, some of the capitation payments had been recouped and 3,046 capitation payments totaling about $12 million still needed to be reviewed and recovered from the Plans. Our audit determined the Department did not have a system in place to identify capitation payments made for retroactively disenrolled recipients and therefore the Department could not monitor these payments to ensure Plans properly voided them. Further, the Department's contracts with Plans did not stipulate a required timeframe for Plans to void inappropriate capitation payments, leaving the inappropriate payments outstanding for several years. We also determined that if the Department revised its policy on the payment of capitation payments during disenrollment periods when Plans were "at risk" (recipients were 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.

We recommended the Department review the remaining $12 million in capitation payments we identified and recover overpayments as appropriate. We also recommended the Department enhance its oversight to identify and recover capitation payments for retroactively disenrolled recipients for periods that Plans were not "at risk" for providing medical services. We recommended the Department amend the Plan contracts to specify a timeframe in which Plans are required to void inappropriate capitation payments for recipients who are disenrolled retroactively. Lastly, we recommended the Department assess the impact of paying the cost of Plans' medical expenses rather than paying capitation amounts during periods when recipients were disenrolled retroactively and Plans were "at risk," and to consider revising the Department's

policy and amending MLTC contract language to reflect this change.

The objective of our follow-up was to assess the extent of implementation, as of May 31, 2017, of the four recommendations included in our audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made significant progress in addressing the problems we identified in the initial audit report. The Department has worked with the Office of the Medicaid Inspector General (OMIG) to enhance its ability to identify and recover capitation payments for retroactively disenrolled recipients for periods that Plans were not "at risk," and developed a new process to recover overpaid capitation payments and reimburse the Plans for the cost of services when the Plans were "at risk." The Department is also in the process of amending Plan contracts that will require Plans to void inappropriate capitation payments within 30 days of being notified of a recipient's retroactive disenrollment. However, further actions are still needed as only $3.4 million of the $12 million in improper capitation payments we identified have been recovered.

Of the initial report's four audit recommendations, two were implemented and two were partially implemented.

Follow-Up Observations

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.

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.)

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.

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.

Major contributors to this report were Sal D'Amato, Mostafa Kamal, and Misty Daiyan.

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: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General