Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK STATE IMPROPERLY CLAIMED MEDICAID REIMBURSEMENT FOR SOME MANAGED LONG-TERM CARE PAYMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Inspector General

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Office of Inspector General

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Report in Brief
September 2017
Report No. A-02-15-01026

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Review

Recent investigations of a New York Medicaid Managed Long-Term Care (MLTC) plan identified significant vulnerabilities in the MLTC program. In addition, OIG reviews of certain Medicaid services in New York identified this area as being at high risk for improper payments.

In New York, MLTC plans under contract with the State receive fixed monthly payments to provide services to Medicaid beneficiaries who are chronically ill or disabled and who wish to stay in their homes and communities. In return, the plans agree to the terms of New York's MLTC contract, which was approved by the Centers for Medicare & Medicaid Services (CMS). During State fiscal year (SFY) 2014, New York claimed Medicaid reimbursement totaling $4.8 billion ($2.4 billion Federal share) for its MLTC program.

Our objective was to determine whether New York's claims for Medicaid reimbursement for monthly payments made for enrolled beneficiaries to MLTC plans complied with certain Federal and State requirements.

How OIG Did This Review

We reviewed a random sample of 100 payments that New York made to MLTC plans during SFY 2014. We also consulted with CMS physicians to determine whether the beneficiaries associated with these payments received adequate service planning and care management.

New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments

What OIG Found

New York improperly claimed reimbursement for 36 of 100 payments made to MLTC plans. Specifically, New York did not ensure that MLTC plans documented eligibility assessments of program applicants and reassessments of those already in the program, and conducted these assessments in a timely manner. New York also did not ensure that the plans provided services to beneficiaries according to a written care plan. Further, New York did not ensure that the plans enrolled and retained only those beneficiaries who required community-based services, and disenrolled beneficiaries who requested disenrollment in a timely manner.

In addition, CMS physicians found that for 71 beneficiaries associated with the payments we reviewed, the beneficiaries' MLTC plans did not comply with New York's contract requirements for service planning and care management. As a result, there could have been health and safety risks to these beneficiaries. We provided New York with the physicians' findings related to the 71 beneficiaries.

What OIG Recommends and New York Comments

We recommend that New York develop procedures to monitor MLTC plans for compliance with Federal and State requirements detailed in its contract, including requirements for adequate service planning and care management. We also recommend that New York ensure that future contracts include provisions that allow it to recover payments when plans do not comply with contract requirements. This measure could have saved the Medicaid program $1.4 billion ($717 million Federal share) during our 1-year audit period.

New York did not indicate concurrence or nonconcurrence with our recommendations. However, New York described steps that it has taken to improve its monitoring of the MLTC plans and indicated that it is developing a new contract that will include enhancements to address our concerns. New York took exception to our statement that it could have achieved Medicaid cost savings because, during our audit period, New York was not required to include our recommended provisions in its MLTC contracts. We maintain that our recommendations are valid. Although the MLTC contracts did not contain provisions that would have allowed New York to recover premium payments when MLTC plans did not comply with contract requirements, we found that such provisions, if included in the contracts, could have achieved savings during our audit period.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/21501026.asp

TABLE OF CONTENTS

APPENDICES

INTRODUCTION

WHY WE DID THIS REVIEW

A recent Federal and State investigation of a New York Medicaid Managed Long-Term Care (MLTC) plan identified significant vulnerabilities in the MLTC program, including the enrollment of ineligible individuals and improper billings. In addition, Office of Inspector General reviews of Medicaid home- and community-based services in New York identified this program as being at high risk for improper payments. Therefore, we decided to review claims for Medicaid reimbursement for payments made to other MLTC plans throughout the State. Appendix A contains a list of related Office of Inspector General reports on Medicaid home- and community-based services in New York.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Medicaid reimbursement for monthly capitation payments, made for enrolled beneficiaries to MLTC plans, that complied with certain Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. In New York, the State agency administers the program.

New York's Medicaid Managed Long-Term Care Program

In August 2012, CMS approved the State agency's request to administer long-term care services through a managed care model. These services are provided to beneficiaries who are chronically ill or disabled and who wish to stay in their homes and communities. Under the managed care model, MLTC plans receive fixed monthly capitation payments to provide long-term care services.[1] In return, the plans agree to the terms of the State agency's CMS-approved managed care organization (MCO) contract.

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[1] MLTC plans under contract with the State agency receive a monthly capitation payment for each enrollee from the effective date of enrollment until the effective date of disenrollment of the enrollee or termination of the contract, whichever occurs first. During State fiscal year (SFY) 2014, the median capitation payment made to MLTC plans was $4,066.

The State's MLTC program provides eligible beneficiaries with community-based services, person-centered service planning,[2] care management,[3] and other long-term care services covered by the capitation payment.[4] Community-based services include home nursing, home health aide services, personal care services, and adult day health care.

The State agency's CMS-approved MCO contract requires MLTC plans to fulfill reporting requirements to ensure adequate capacity and access for the enrolled population and to demonstrate administrative and management arrangements satisfactory to the State agency. Reports include information on service availability, accessibility, and acceptability; enrollment; enrollee demographics; disenrollment; beneficiary health and functional status (including the assessment instrument); service utilization; encounter data; enrollee satisfaction; marketing; grievance and appeals; and fiscal data. The State agency's Office of Medicaid Inspector General (OMIG) has the right to audit and recover overpayments caused by the submission of misstated reports and encounter data.

During State fiscal year (SFY) 2014, New York claimed Medicaid reimbursement totaling $4.8 billion ($2.4 billion Federal share) for capitation payments made to MLTC plans for enrolled beneficiaries.

Requirements for Managed Long-Term Care Service Providers

States seeking Federal reimbursement for Medicaid services provided through a managed care model must receive prior approval from CMS for their contracts with MCOs. In New York, the "Special Terms and Conditions" of the State's section 1115(a) Medicaid demonstration waiver and the State agency's CMS-approved MCO contract establish the requirements for documenting and delivering MLTC services.

Under the State agency's contract with MLTC plans, the plans are required to conduct an eligibility assessment of a program applicant within 30 days of first contact by the applicant or of being referred to the applicant by the State agency's enrollment broker.[5] These eligibility assessments must be performed by a registered nurse in the applicant's home. MLTC plans are

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[2] Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the beneficiary, as well as the beneficiary's functional level and support systems.

[3] Care management includes referral to and coordination of necessary medical, social, educational, financial, and other services that support the beneficiary's psychosocial needs.

[4] MLTC plans are required to provide medically necessary long-term care services (e.g., durable medical equipment, nonemergency transportation, dentistry, optometry, and audiology). The State agency reimburses providers for medical services not covered by the capitation payment (e.g., inpatient hospital services, physician services) on a fee-for-service basis.

[5] The State agency's enrollment broker during our audit period was New York Medicaid Choice, a private company under contract with the State agency to manage all enrollment into MLTC plans throughout the State.

required to conduct comprehensive reassessments of enrolled beneficiaries and person-centered service plan updates at least once every 6 months, or sooner, if the beneficiary's condition warrants. MLTC plans are allowed to enroll and retain only those beneficiaries who are assessed as requiring more than 120 days of community-based services. In addition, MLTC plans must disenroll beneficiaries who requested their disenrollment no later than the first day of the second month after the month in which they made their request. Finally, MLTC plans are required to provide beneficiaries with adequate person-centered service planning and care management.

For details on Federal and State requirements related to MLTC services, see Appendix B.

HOW WE CONDUCTED THIS REVIEW

Our review covered 1,020,954 monthly capitation payments totaling $3,954,148,274 ($1,979,003,231 Federal share) that the State agency made to 29 MLTC plans during SFY 2014 (April 1, 2013, through March 31, 2014).[6] We reviewed a random sample of 100 of these payments. This review included consulting with CMS physicians to determine whether the 100 beneficiaries associated with the sampled payments received adequate person-centered service planning and care management during SFY 2014.

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix C contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

FINDINGS

The State agency claimed Medicaid reimbursement for some monthly capitation payments made to MLTC plans that did not comply with certain Federal and State requirements stipulated in the State agency's CMS-approved MCO contract. Of the 100 payments in our random sample, 64 complied with the requirements, but 36 did not. On the basis of our sample results, we estimated that the State made monthly capitation payments totaling $1.4 billion ($717 million Federal share) to MLTC plans that did not comply with these requirements. In addition, the State agency did not ensure that MLTC plans provided adequate person-centered service planning and care management for 71 of the 100 beneficiaries associated with our sampled payments.

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[6] Our review excluded more than 224,000 payments totaling more than $821 million ($411 million Federal share) made during this period to 1 other MLTC plan that was under investigation.

PLANS DID NOT COMPLY WITH CONTRACT REQUIREMENTS

Of the 100 payments in our random sample, 36 did not comply with Federal and State requirements stipulated in the State agency's CMS-approved MCO contract. Of the 36 payments, 8 contained more than 1 deficiency. Specifically:

- For 19 payments, the MLTC plans did not conduct the associated beneficiary's eligibility assessment or reassessment in a timely manner, document the eligibility assessment, or document that it was performed by a registered nurse.
- For 14 payments, the MLTC plans did not provide a written care plan for the beneficiary that covered the payment period.
- For 10 payments, the MLTC plans did not provide the beneficiary with any community-based services during the payment period.
- For one payment, the associated beneficiary should have been disenrolled from the MLTC plan at least 1 month before the payment period.

The noncompliant payments occurred because the State agency did not adequately monitor MLTC plans for compliance with Federal and State requirements for (1) documenting initial eligibility assessments and reassessments and conducting them in a timely manner using a registered nurse, (2) providing services according to a written care plan, (3) enrolling and retaining only those beneficiaries who required more than 120 days of community-based services, and (4) disenrolling beneficiaries in a timely manner.

On the basis of our sample results, we estimated that the State made monthly capitation payments totaling $1,434,947,274 ($717,473,637 Federal share) to MLTC plans that did not comply with certain Federal and State requirements. (Appendix F contains a summary of deficiencies, if any, identified for each sampled payment.)

Initial Eligibility Assessment or Reassessment Not Documented or Not Conducted in a Timely Manner or by a Registered Nurse

Under the State agency's MCO contract with MLTC plans, the plans are required to conduct an eligibility assessment of a program applicant within 30 days of first contact by the applicant or of being referred to the applicant from the enrollment broker (Article V.B.1.B.i of the contract). MLTC plans are required to conduct a comprehensive reassessment of the beneficiary and a person-centered service plan update at least once every 6 months, or sooner, if the beneficiary's condition warrants (Article V.J.5 of the contract).

For 19 sampled payments, the MLTC plans either did not conduct the associated beneficiary's initial eligibility assessment or reassessment in a timely manner, document that the initial eligibility assessment was conducted, or document that the assessment was performed by a registered nurse. Specifically:

- For one payment, the MLTC plan did not conduct an eligibility assessment within 30 days of first contact with the applicant. More than 300 days elapsed before the plan conducted an assessment.

- For 15 payments, the MLTC plans did not conduct a reassessment within the prior 6 months of the payment period. Reassessments occurred between 30 and 218 days (median of 58 days) after they were due.

- For two payments, the MLTC plans did not document an initial eligibility assessment of the beneficiary.

- For one payment, the MLTC plan did not document that the beneficiary's initial eligibility assessment was performed by a registered nurse.

Care Plan Not Documented

MLTC plans are required to provide person-centered service planning and care management through the establishment and implementation of a written care plan and to assist beneficiaries with accessing services authorized under the care plan (Article V.J.1 of the contract). Service plan updates must be performed at least once every 6 months, or sooner, if the beneficiary's condition warrants (Article V.J.5 of the contract).

For 14 sampled payments, the MLTC plans did not provide a written care plan for the beneficiary.

Community-Based Services Not Provided

MLTC plans are allowed to enroll only applicants who are determined eligible using the State agency's assessment tool and are expected to require at least one community-based service for more than 120 days (Article IV.B.4 and 6 of the contract). The plans must initiate disenrollment of beneficiaries who are assessed as no longer requiring these services (Article V.D.4.f of the contract).

For 10 sampled payments, the MLTC plans did not provide the associated beneficiary with any community-based services. For five of the beneficiaries, the MLTC plans did not provide these services for nearly the entire audit period.[7] The remaining five beneficiaries were eventually disenrolled within 6 months of not receiving any community-based services from their MLTC plans – either voluntarily or involuntarily (i.e., the MLTC plan initiated disenrollment).

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[7] For four of these beneficiaries, the MLTC plans did not provide community-based services during all of SFY 2014. For the remaining beneficiary, the MLTC plan did not provide these services for 11 months of SFY 2014.

Disenrollment Not Conducted in a Timely Manner

Beneficiaries enrolled in an MLTC plan may voluntarily disenroll from the plan for any reason upon notifying the MLTC plan (Article V.D.2.a of the contract). The effective date of disenrollment must be no later than the first day of the second month after the month in which the beneficiary requested disenrollment (Article V.D.2.a of the contract).

For one sampled payment, the MLTC plan did not grant the beneficiary's request for voluntary disenrollment in a timely manner. The beneficiary notified the MLTC plan more than 2 months before the start of the month associated with the sampled payment.[8]

PLANS DID NOT PROVIDE ADEQUATE SERVICE PLANNING AND CARE MANAGEMENT

For 71 of the 100 beneficiaries associated with our sampled payments, CMS physicians found that the beneficiaries' MLTC plans did not comply with contract requirements for person-centered service planning and care management.

Under their contracts with the State agency, MLTC plans are required to provide person-centered service planning and care management through the establishment and implementation of a written care plan and assisting beneficiaries to access services authorized under the care plan. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the beneficiary, as well as the beneficiary's functional level and support system. Care management includes referral to and coordination of other necessary medical, social, educational, financial, and other services of the person-centered service plan that support the beneficiary's psychosocial needs irrespective of whether such services are covered by the MLTC plan (Article V.J.1 of the contract).

CMS physicians found that the MLTC plans did not provide 71 beneficiaries with either adequate person-centered service planning, care management, or both.[9] This occurred because the State agency did not adequately monitor MLTC plans to ensure the health and safety of beneficiaries. Specifically, the State agency did not ensure that MLTC plans (1) provided services according to a written care plan that was personalized and specifically addressed the unique medical and psychosocial needs of the beneficiaries and (2) actively coordinated the medical and social care of the beneficiaries. Failure to meet these contract requirements could have jeopardized the health and safety of a significant number of Medicaid

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[8] The beneficiary requested to be disenrolled from the plan on November 20, 2013, because she wished to be in a nursing home of her choice and no longer at her residence. The plan was required to disenroll the beneficiary no later than January 1, 2014. The sample payment date was February 1, 2014, which covered enrollment for the month of February 2014.

[9] A total of 65 beneficiaries did not receive adequate person-centered service planning, 60 did not receive adequate care management, and 54 did not receive either adequate person-centered or care management services.

beneficiaries. (Appendix G contains a summary of the beneficiaries who received either inadequate person-centered service planning, care management, or both.)

We provided the State agency with the CMS physicians' findings related to the 71 beneficiaries for whom the MLTC plans did not provide either adequate person-centered service planning or care management, or both.

Person-Centered Service Planning

For 65 beneficiaries, the MLTC plans did not establish and implement written care plans that adequately addressed the beneficiary's medical and psychosocial needs. Specifically, CMS physicians found that the care plans were not individualized, included only the most basic set of services (e.g., home health aide, personal care, transportation), and omitted covered services that would have benefited the beneficiary (e.g., physical therapy, podiatry, dentistry). In addition, the physicians found that the care plans did not include scheduled, structured, and routine medical appointments with the beneficiary's primary care physician and specialists to address the most serious medical diagnoses and active diseases, such as diabetes, hypertension, stroke, dementia, heart disease, and difficulty walking.

The CMS physicians found that for some of these beneficiaries, the MLTC plans did not conduct person-centered service planning to adequately address hospital discharge, mental illness, memory impairment, fall prevention, and unsanitary living conditions. Specifically:

- For eight beneficiaries, the plans did not provide post-hospitalization service planning to address the beneficiaries' health, safety, and psychosocial needs.

- For five beneficiaries, the plans did not provide service planning to address the beneficiaries' diagnosis of schizophrenia, bipolar disorder, or dementia; or being in need of a psychiatric evaluation.

- For three beneficiaries, the plans did not provide service planning to address and prevent the beneficiaries from falling in their homes.

- For one beneficiary, the plan did not provide service planning that considered the beneficiary's lack of social supports and unsanitary living conditions.

Care Management

For 60 beneficiaries, the MLTC plans did not provide adequate referrals and coordination of necessary medical services. Specifically, CMS physicians found that the MLTC plan documented the beneficiaries' need for covered and noncovered services (e.g., primary care, specialist) but did not follow through with making referrals and coordinating services.

The CMS physicians found that for some of these beneficiaries, the MLTC plans did not conduct care management activities to adequately address the needs of beneficiaries who required physical therapy, care coordination, referrals to support psychosocial needs, fall prevention, durable medical equipment, and primary care. Specifically:

- For seven beneficiaries diagnosed with having difficulty walking, the plans did not make a physical therapy referral.
- For six beneficiaries, the plans relied primarily on the beneficiaries and their families to coordinate the beneficiaries' care.
- For four beneficiaries who required either psychiatric evaluations, food stamps, housing, or social day care, the plans did not make appropriate referrals or coordinate care.
- For three beneficiaries who had experienced multiple falls in their homes, the plans did not make a fall assessment referral.
- For two beneficiaries diagnosed with paralysis or difficulty walking, the plans did not coordinate the repair or acquisition of a power wheelchair.
- For two beneficiaries who required a primary care physician, the plans did not make an appropriate referral.

RECOMMENDATIONS

We recommend that the State agency:

- develop procedures to monitor MLTC plans for compliance with Federal and State requirements detailed in its contracts with the plans, including (1) documenting initial eligibility assessments and reassessments and conducting them in a timely manner using a registered nurse, (2) providing services according to a written care plan, (3) enrolling and retaining only those beneficiaries who require more than 120 days of community-based services, (4) disenrolling beneficiaries in a timely manner, (5) providing services according to a written care plan that is personalized and specifically addresses beneficiaries' unique medical and psychosocial needs, and (6) actively coordinating beneficiaries' medical and psychosocial care and
- ensure that future contracts with MLTC plans include provisions that allow the State agency to recover payments when plans do not comply with contract requirements. This measure could have saved the Medicaid program approximately $1.4 billion ($717 million Federal share) during SFY 2014.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. However, the State agency described steps that it has taken to improve its monitoring of MLTC plans and indicated that it is developing a new MCO contract that will include enhancements to address our concerns.

Regarding our first recommendation, the State agency stated that in 2015, it created a unit within its Bureau of Managed Long-Term Care to monitor MLTC plans through focused surveys to determine compliance with Federal and State regulations, the terms of its MCO contracts, and other State agency guidance. The State agency also indicated that its OMIG has conducted and will continue to conduct audits of MLTC plans in areas such as enrollee eligibility, disenrollment, and lack of qualifying community-based long-term care services.

Regarding our second recommendation, the State agency stated that it is working with its OMIG to develop a new MCO contract for 2017 through 2021. The State agency plans for the new contract to include enhancements for care management requirements, community-based long-term care service utilization parameters, timely and appropriate disenrollments, premium recoupments, and fining mechanisms. However, the State agency took exception to our statement that implementing our recommendation could have resulted in cost savings to the Medicaid program. The State agency stated that it disagreed with the estimate of cost saving because, during our audit period, the State agency was not required to include our recommended provisions in its MLTC contracts.

The State agency's comments are included in their entirety as Appendix H.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our recommendations are valid. Although the MLTC contracts did not contain provisions that would have allowed the State agency to recover premium payments when MLTC plans did not comply with contract requirements, we found that such provisions could have achieved savings during SFY 2014. We recognize the State agency's efforts to improve its monitoring of the MLTC program and its initiative to develop a new MCO contract that addresses our audit findings and recommendations.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New York State Improperly Claimed Medicaid Reimbursement for Some Adult Day Health Care Services	A-02-13-01016	12/23/2015
New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Metropolitan Jewish Health System That Were Unallowable	A-02-12-01024	11/25/2015
New York Claimed Medicaid Reimbursement for Some Adult Day Health Care Services Provided by Center for Nursing and Rehabilitation That Were Unallowable	A-02-12-01015	11/25/2015

APPENDIX B: FEDERAL AND STATE REQUIREMENTS RELATED TO MANAGED LONG-TERM CARE SERVICES

All managed care plans are subject to Federal requirements, as implemented in 42 CFR part 438. States seeking Federal Medicaid reimbursement for services provided through a managed care model must receive prior approval from CMS for their MCO contracts (42 CFR § 438.806).

The Special Terms and Conditions for New York's Partnership Plan section 1115(a) Medicaid demonstration waiver (No. 11-W-00114/2) and the State agency's CMS-approved MCO contract establish the requirements for documenting and delivering MLTC services, including eligibility assessments, service planning, and care management.

Beneficiaries are eligible to enroll in an MLTC plan when they are expected to require at least one community-based service for more than 120 days (Article IV.B.6 of the contract). Community-based services are nursing services in the home, therapies in the home, home health aide services, personal care services in the home, adult day health care, private duty nursing, and consumer-directed personal assistance services. Beneficiaries are provided additional Medicaid services that are either covered services provided by the MLTC plan or available on a fee-for-service basis. MLTC enrollees must obtain inpatient hospital services on a fee-for-service basis.

MLTC plans are required to use the assessment instrument specified by the State agency to assess each applicant for eligibility for MLTC enrollment (Article V.B.1.B of the contract). The initial assessment for MLTC eligibility must be conducted within 30 days of first contact by an individual requesting enrollment or of receiving a referral from the enrollment broker or other source. This assessment must be performed by a registered nurse in the individual's home (Article V.B.1.B.i of the contract).

MLTC plans are allowed to enroll and retain only those individuals who are assessed as needing more than 120 days of community-based services (Article IV.B.6 and V.D.4.f of the contract). The MLTC plans must initiate disenrollment of any individuals who are assessed as no longer requiring community-based long-term care services (Article V.D.4.f of the contract).

MLTC plans are required to provide person-centered service planning and care management through the establishment and implementation of a written care plan and assisting enrollees to access services authorized under the care plan. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the enrollee, as well as the enrollee's functional level and support systems. Care management includes referral to and coordination of other necessary medical, social, educational, financial, and other services of the person-centered service plan that support the enrollee's psychosocial needs irrespective of whether such services are covered by the MLTC plan (Article V.J.1 of the contract).

A comprehensive reassessment of the enrollee and a person-centered service plan update must be performed as warranted by the enrollee's condition but in any event at least once every 6 months (Article V.J.5 of the contract).

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 1,020,954 monthly capitation payments totaling $3,954,148,274 ($1,979,003,231 Federal share) that the State agency made to 29 MLTC plans during SFY 2014 (April 1, 2013, through March 31, 2014). We reviewed a random sample of 100 of these payments. This included consulting with CMS physicians to determine whether the 100 beneficiaries associated with the sampled payments received adequate person-centered service planning and care management during SFY 2014.

Our review allowed us to establish reasonable assurance of the authenticity of the data obtained from the Medicaid Management Information System (MMIS) fiscal agent for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claim data in the MMIS to the State agency's claim for reimbursement through the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

The scope of our audit did not require us to perform a comprehensive medical review or an evaluation of medical necessity for eligibility and enrollment in the MLTC program. We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. We reviewed the MLTC plans' internal controls for documenting MLTC services provided to enrolled beneficiaries. We did not assess the appropriateness of MLTC payment rates.

We performed our fieldwork at the State agency's offices in Albany, New York, and at MLTC plans' offices located throughout New York State from January 2015 through February 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

- met with CMS financial and program management officials to gain an understanding of and to obtain information on New York's MLTC program;

- met with State agency officials to discuss the State agency's administration and monitoring of the MLTC program;

- interviewed MLTC plan officials associated with the sampled payments regarding their MLTC program policies and procedures, including procedures for conducting initial eligibility assessments and enrolling beneficiaries, preparing written care plans and conducting reassessments, disenrollments, and documenting MLTC services;

- obtained from New York's MMIS a sampling frame of 1,020,954 monthly capitation payments made to 29 MLTC plans totaling $3,954,148,274 ($1,979,003,231 Federal share) for which the State agency claimed Medicaid reimbursement for enrolled beneficiaries during SFY 2014;[10]

- selected from our sampling frame a simple random sample of 100 capitation payments[11] and for each capitation payment determined whether:

    - the beneficiary was Medicaid eligible;

    - the beneficiary was enrolled in the MLTC program;

    - the initial eligibility assessment or reassessment of the beneficiary was conducted within the required timeframe and performed by a registered nurse using an eligibility assessment tool designated by the State agency;

    - the beneficiary received MLTC services according to a written care plan;

    - the beneficiary was assessed as requiring at least one community-based service for more than 120 days during the applicable 6-month timeframe; and

    - the beneficiary requested disenrollment or was assessed to be no longer eligible for MLTC services and, if applicable, was disenrolled in a timely manner;

- estimated the potential Medicaid program savings in the sampling frame of 1,020,954 capitation payments;

- consulted with two CMS physicians who reviewed the case histories of the beneficiaries associated with our sampled payments to determine whether the beneficiaries received adequate person-centered service planning and care management during SFY 2014;[12] and

- discussed the results of review with State agency officials.

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[10] The original data file contained 1,245,215 capitation payments made to 30 MLTC plans totaling $4,775,780,348 ($2,390,003,617 Federal share) for which the State agency claimed Medicaid reimbursement for enrolled beneficiaries during SFY 2014. From this file, we removed 224,261 capitation payments totaling $821,632,074 ($411,000,386 Federal share) for 1 MLTC plan that was under investigation.

[11] The random sample consisted of payments made to 16 MLTC plans for 100 unique beneficiaries.

[12] Specifically, the physicians reviewed the beneficiaries' health records maintained by the MLTC plans, including beneficiary assessments, service planning documents, and care managers' notes.

Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of capitation payments made to MLTC plans for enrolled beneficiaries during SFY 2014 for which the State agency claimed Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was an Access file containing 1,020,954 capitation payments made to 29 MLTC plans for enrolled beneficiaries totaling $3,954,148,274 ($1,979,003,231 Federal share) for which the State agency claimed Medicaid reimbursement during SFY 2014. The sampling frame did not include 224,261 capitation payments totaling $821,632,074 ($411,000,386 Federal share) made to 1 MLTC plan that was under investigation. The data for capitation payments were extracted from the New York MMIS.

SAMPLE UNIT

The sample unit was a capitation payment.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 capitation payments.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample items in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the overpayment associated with the noncompliant payments for both the total Medicaid dollars and Federal share using the point estimate. We also used the program to calculate the lower and upper limits for a 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results for Noncompliant Payments (Medicaid Dollars)

Capitation Payments in Frame	Value of Frame (Medicaid Dollars)	Sample Size	Value of Sample (Medicaid Dollars)	No. of Noncompliant Payments	Value of Noncompliant Payments (Medicaid Dollars)
1,020,954	$3,954,148,274	100	$381,200	36	$140,550

Table 2: Estimated Value of Noncompliant Payments (Medicaid Dollars)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$1,434,947,274
Lower limit	1,112,989,040
Upper limit	1,756,905,508

Table 3: Sample Details and Results for Noncompliant Payments (Federal Share)

Capitation Payments in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Noncompliant Payments	Value of Noncompliant Payments (Federal Share)
1,020,954	$1,979,003,231	100	$190,600	36	$70,275

Table 4: Estimated Value of Noncompliant Payments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$717,473,637
Lower limit	556,494,520
Upper limit	878,452,754

APPENDIX F: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED PAYMENT

Legend

Deficiency	Description
1	Initial eligibility assessment or reassessment not documented or not conducted in a timely manner by a registered nurse
2	Care plan not documented
3	Community-based services not provided
4	Disenrollment not conducted in a timely manner

Table 5: Office of Inspector General Review Determinations for the 100 Sampled Payments

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
1					
2					
3					
4					
5					
6					
7					
8					
9	X				1
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21	X	X			2
22		X			1
23					
24					
25			X		1

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
26	X	X			2
27		X			1
28	X				1
29					
30					
31				X	1
32	X				1
33	X				1
34					
35		X			1
36					
37					
38					
39			X		1
40					
41					
42					
43					
44					
45					
46	X				1
47	X				1
48					
49		X	X		2
50					
51			X		1
52					
53		X			1
54					
55					
56	X	X			2
57					
58					
59		X			1
60					
61					

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
62					
63					
64					
65					
66					
67					
68	X				1
69			X		1
70					
71	X				1
72					
73					
74	X	X			2
75		X	X		2
76	X				1
77					
78					
79					
80	X	X			2
81					
82			X		1
83					
84					
85					
86					
87	X				1
88			X		1
89	X				1
90					
91					
92					
93					
94	X				1
95		X			1
96					
97			X		1

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
98	X				1
99			X		1
100	X	X			2
Category Totals	**19**	**14**	**10**	**1**	**44**
36 Noncompliant Payments[13]					

[13] Eight payments contained more than one deficiency.

APPENDIX G: SUMMARY OF DEFICIENCIES FOR PERSON-CENTERED SERVICE PLANNING AND CARE MANAGEMENT

Legend

Deficiency	Description
1	Adequate person-centered service planning not provided
2	Adequate care management not provided

Table 6: Office of Inspector General Review Determinations for the 100 Beneficiaries Associated With the Sampled Payments

Beneficiary	Deficiency 1	Deficiency 2	No. of Deficiencies
1	X	X	2
2			
3	X	X	2
4			
5	X		1
6	X		1
7			
8	X	X	2
9		X	1
10			
11	X	X	2
12			
13	X	X	2
14			
15			
16			
17	X	X	2
18	X	X	2
19	X	X	2
20			
21	X		1
22			
23	X	X	2
24	X	X	2
25			
26	X		1

Beneficiary	Deficiency 1	Deficiency 2	No. of Deficiencies
27			
28	X	X	2
29			
30			
31	X	X	2
32	X	X	2
33	X		1
34		X	1
35	X	X	2
36	X		1
37	X	X	2
38	X		1
39	X	X	2
40	X		1
41	X	X	2
42			
43	X	X	2
44	X	X	2
45	X	X	2
46	X	X	2
47	X	X	2
48			
49	X	X	2
50			
51			
52	X	X	2
53	X	X	2
54		X	1
55	X	X	2
56	X		1
57	X		1
58		X	1
59	X	X	2
60			
61	X	X	2
62	X	X	2

Beneficiary	Deficiency 1	Deficiency 2	No. of Deficiencies
63			
64	X	X	2
65			
66			
67	X	X	2
68	X	X	2
69		X	1
70	X	X	2
71	X	X	2
72	X	X	2
73			
74	X		1
75	X	X	2
76	X	X	2
77			
78	X	X	2
79			
80	X	X	2
81	X	X	2
82	X	X	2
83			
84	X	X	2
85	X	X	2
86			
87	X	X	2
88	X	X	2
89		X	1
90	X	X	2
91			
92	X	X	2
93	X	X	2
94			
95	X	X	2
96	X	X	2
97	X	X	2
98	X	X	2

Beneficiary	Deficiency 1	Deficiency 2	No. of Deficiencies
99	X	X	2
100	X	X	2
Category Totals	**65**	**60**	**125**
A total of 71 beneficiaries did not receive either adequate person-centered service planning, care management, or both.[14]			

[14] Of the 71 beneficiaries, 54 did not receive either adequate person-centered service planning or care management.

APPENDIX H: STATE 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

June 27, 2017

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-15-01026

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-15-01026 entitled, "New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
Dennis Rosen
Erin Ives
James Dematteo
James Cataldo
Brian Kiernan
Elizabeth Misa
Geza Hrazdina
Jeffrey Hammond
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Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-15-01026 entitled
"New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-15-01026 entitled, "New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments."

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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1:

Develop procedures to monitor MLTC plans for compliance with Federal and State requirements detailed in its contracts with the plans, including (1) documenting initial eligibility assessments and reassessments and conducting them timely using a registered nurse, (2) providing services according to a written care plan, (3) enrolling and retaining only those beneficiaries who require more than 120 days of community-based services, (4) timely disenrolling beneficiaries, (5) providing services according to a written care plan that is personalized and specifically addresses beneficiaries' unique medical and psychosocial needs, and (6) actively coordinating beneficiaries' medical and psychosocial care.

Response #1

The Department created a Surveillance unit within its Bureau of Managed Long Term Care (MLTC) in September 2015. Staffing began immediately which included the onboarding of Registered Nurses to conduct the clinical aspects of the reviews. The primary function of the Surveillance Unit is to monitor the MLTC plans through full operational and focused surveys to determine compliance with Federal and State regulations, the terms of the Medicaid contracts, and other written guidance issued by the Department.

The surveys are conducted in phases, and begin by sending an initial letter to the MLTC plan. This letter advises the plan that the Department will be conducting a survey and identifies the materials the plan should provide to the Department in advance.

The Surveillance Unit, along with other applicable units within the Department, review the materials provided by the plan for compliance. An entrance interview is then conducted to further evaluate the MLTC's compliance and to address any questions raised by the materials submitted by the plan. The Department provides the MLTC with a general agenda to ensure the appropriate staff are present for the interview.

Following the entrance interview, the Surveillance Unit conducts a desk audit of specific care management records of members who are currently enrolled in the MLTC plan, or who have recently been disenrolled. The MLTC plan is provided with a list of names and Client Identification Numbers of members, and is instructed to provide documentation for each record. At a minimum, the following information is currently requested: enrollment, consent and release, initial and current Uniform Assessment System (UAS), and initial and current person centered service plan (PCSP). As the scope of the survey process continues to expand and evolve to accommodate for a changing long term care landscape, additional information that will be requested includes advance directives, Consumer Directed Personal Assistance Services (CDPAS), and backup plan.

The MLTC is also asked to submit care management notes, ancillary evaluations, and all discharge summaries, as well as any correspondence sent to the member, including but not limited to spenddown letters/invoices, grievance and grievance appeals notices, notice of action, action appeal, adverse determinations, service requests, and disenrollments for the identified timeframe.

Metrics and tools were created and continue to be revised to measure, through the review of the care management records, timely assessments, services provided according to the plan of care, eligibility for the program, timely disenrollment, and use of PCSP. We also utilize internal data to inform our survey process and check against plan submissions. Many of the survey metrics are included in the current protocols with the anticipation that they will continue expanding to include additional metrics. The Department implemented procedures dedicated to strengthening the MLTC plan's compliance with Federal and State guidance.

Additionally, OMIG has conducted and will continue to conduct audits of MLTC plans, in areas such as enrollee eligibility, disenrollment, and lack of qualifying community based long term care services, in accordance with the Model Contract.

Recommendation #2:

Ensure that future contracts with MLTC plans include provisions that allow the State agency to recover payments when plans do not comply with contract requirements. This measure could have saved the Medicaid program approximately $1.4 billion ($717 million Federal share) during SFY 2014.

Response #2

All MLTC model contracts were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) before being used. Prior to this audit, there was no requirement that this type of language, or significant care management requirements, be included in the MLTC contracts. The Department disagrees with the portion of Recommendation #2 stating that this measure could have resulted in fiscal savings. The claim of potential fiscal impact stemming from provisions that were not required to be included in the contracts is gratuitous. Provisions that allow the Department to recover payments when plans do not comply with contract requirements have since been added to the MLTC model contracts.

Since the audit period of April 1, 2013 through March 31, 2014 the Department's Division of Long Term Care (DLTC) has taken numerous steps to enhance MLTC plan operational requirements, and particularly in the areas of care management, UAS requirements, and assessment protocols. The DLTC has provided a listing, by topic, of the MLTC Policy Guidance Documents and Email Blast Reminders that have been issued to the MLTC plans since the beginning of this audit period (see attached).

In addition, since the beginning of this audit period there have been two contract amendments issued by DLTC. The first was issued during April 2013 and required MLTC plans to conform with the 1115 Standard Terms and Conditions to implement Mandatory Managed Long Term Care. Prior to the release of that contract amendment plans had the benefit of guidance and education provided by the Department and the Enrollment Broker. The second amendment was issued to plans during July 2016. It further enhanced requirements in the areas of care management and program integrity, and incorporated, by reference, adherence with Department-issued policy guidance. Please note that although this second amendment period is January 1, 2015 through December 31, 2016, its issuance was delayed by a lengthy review at CMS. A new Model Contract for the period January 1, 2017 through December 31, 2021 is currently under development by the Department and OMIG and numerous enhancements are planned, including care management requirements, Community Based Long Term Care service utilization parameters, timely and appropriate disenrollments, premium recoupments, and fining mechanisms. We are now strategically positioned to strengthen the Model Contract appropriately in response to the audit concerns.

Attachment

MLTC Policies 4/1/13-Present	Date of Issuance
MLTC Policy 13.09: Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York	April 26, 2013
MLTC Policy 13.09(a): Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York	September 24, 2013
MLTC Policy 13.09(b): Frequently Asked Questions on Uniform Assessment System for New York	December 10, 2013
MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care	May 8, 2013
MLTC Policy 13.11: Social Day Care Services Question and Answers	May 8, 2013
Letter from State Medicaid Director Helgerson to MLTC Plans on SADC	May 8, 2013
MLTC Policy 13.12: REVISION Personal Care Contracting Policy	May 10, 2013
MLTC Policy 13.13: Continuity of Care and Payment Requirements of MLTC Plans to LTHHCP Agencies Providing Care During the 90 Day Transition Period	May 30, 2013
MLTC Policy 13.14: Questions Regarding Managed Long Term Care (MLTC) Eligibility	May 30, 2013
MLTC Policy 13.15: Refining the Definition of Community Based Long Term Care Services	June 10, 2013
MLTC Policy 13.17: Care Management Administrative Services (CMAS) Agreement Guidance	June 14, 2013
MLTC Policy 13.17 REVISED: Care Management Protocol Guidelines - applicable to Partial MLTC and MAP plans	October 18, 2013
MLTC Policy 13.17A - Q&A Related to 13.17 REVISION: Care Management Protocol Guidelines - applicable to Partial MLTC and MAP plans	June 11, 2013
MLTC Policy 13.18: MLTC Guidance on Hospice Coverage	June 25, 2013
MLTC Policy 13.18(a): Update MLTC Guidance on Hospice Coverage	August 24, 2015
MLTC Policy 13.18(b): MLTC Guidance on Hospice Coverage Update	December 31, 2015
MLTC Policy 13.18(b): Hospice and MLTC FAQ	December 31, 2015
MLTC Policy 13.19: Medicare/Medicaid Coordination of Benefits	July 15, 2013

MLTC Policy 13.20: Provision of DME Supplies through Pharmacy	August 9, 2013
MLTC Policy 13.20 REVISED: Provision of DME Supplies through Pharmacy Reconsidered	October 23, 2013
MLTC Policy 13.21: Process Issues Involving the Definition of Community Based Long Term Care Services	August 12, 2013
MLTC Policy 13.22: Personal Care Contracting Policy - Rates	August 27, 2013
MLTC Policy 13.22(a): Personal Care Contracting Policy - Rates	December 5, 2013
MLTC Policy 13.23: Coverage of Telehealth Services in Managed Long Term Care Plans	September 4, 2013
MLTC Policy 13.24: Authorization for Release of Protected Health Information - Applicable to Partial MLTC, MAP, and PACE Plans	November 9, 2013
MLTC Policy 14.01: Transfers from Medicaid Managed Care to Managed Long Term Care	January 13, 2014
MLTC Policy 14.02: Receipt and Disbursement of Health Recruitment and Retention (HR&R) Funding	February 20, 2014
MLTC Policy 14.03: Consumer Directed Personal Assistance Service (CDPAS) and Program of All Inclusive Care for the Elderly (PACE)	March 14, 2014
MLTC Policy 14.04: MLTCP Potential Enrollee Assessments	May 22, 2014
MLTC Policy 14.05: Aid-Continuing to be provided without regard to the expiration of prior service authorization	August 6, 2014
MLTC Policy 14.05(a): Proper Handling of Enrollees´ Requests for Internal Appeals	August 20, 2014
MLTC Policy 14.06: Implementation of the Conflict-Free Evaluation and Enrollment Center (CFEEC)	September 30, 2014
MLTC Policy 14.07: Adult Day Health Care and Managed Long Term Care: Revisions to 10 NYCRR Part 425	October 16, 2014
MLTC Policy 14.08: Paying for Live-In 24 Hour Care for Personal Care Services and Consumer Directed Personal Assistance Services	November 24, 2014
MLTC Policy 15.01: Social Adult Day Care and MLTC: Implementation of New Social Adult Day Care Certification Process	May 8, 2015
MLTC Policy 15.01 (a): Social Adult Day Care and Managed Long Term Care: Implementation of New Social Adult Day Care Certification Process - UPDATE	May 21, 2015
Social Adult Day Care Certification Process FAQ	May 29, 2015

MLTC Policy 15.02: Transition of Medicaid Managed Care Enrollees to Managed Long Term Care	June 15, 2015
MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees	July 2, 2015
MLTC Policy 15.04: Interim Guidance for MLTC Partial Capitation Appeal Notices	August 10, 2015
MLTC Policy 15.05: Clarification on Requirements for Consumer Directed Personal Assistance Service (CDPAS) Fiscal Intermediaries	August 14, 2015
MLTC Policy 15.05(a): Clarification on Requirements for Consumer Directed Personal Assistance Service (CDPAS) Fiscal Intermediaries.	November 4, 2015
MLTC Policy 15.06: Nursing Home Transition - Conflict-Free Evaluation and Enrollment Center (CFEEC) and Uniform Assessment System (UAS) Requirements	November 24, 2015
MLTC Policy 15.07: Potential Security Exposure with the UAS-NY	December 1, 2015
MLTC Policy 15.08: Conflict Free Evaluation and Enrollment Center (CFEEC) Dispute Resolution Policy	December 29, 2015
MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), effective December 23, 2015.	December 30, 2015
MLTC Policy 16.01: UAS-NY Assessment Requirements	March 15, 2016
MLTC Policy 16.02: Statutory Changes for Consumer Directed Personal Assistance Services (CDPAS)	March 29, 2016
MLTC Policy 16.03: CFEEC Dispute Resolution Update	June 1, 2016
MLTC Policy 16.04: Additional Supports Available through Money Follows the Person (MFP)	September 21, 2016
MLTC Policy 16.05: Non-Emergent Medical Transportation Benefit in MLTC	October 17, 2016
MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services	November 17, 2016
MLTC Policy 16.07: Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services	November 17, 2016
MLTC Policy 16.08: Conflict Free Evaluation and Enrollment Center (CFEEC) Update to Expiration of Evaluations	December 16, 2016

Name of Document (email blasts, letters, guidelines) **4/1/13-Present**	**Date of Issuance**
Systemic Problems with Mandatory MLTC Implementation	April 1, 2013
Partnership Plan and F-SHRP Amendment Letter	April 1, 2013
Social Day Care Letter to MLTC Plans	April 26, 2013
Data Collection Requirements	May 3, 2013
REMINDER: Appeals and Grievances Requirements	May 3, 2013
Guidelines for the Provision of Personal Care Services in Medicaid Managed Care	May 31, 2013
Data Reporting - 30 Day Assessments	July 11, 2013
Follow-up to SADC Network Review Email	July 24, 2013
SADC Network Review	July 24, 2013
SADC Continued Network Review	August 8, 2013
SADC Disenrollments and MLTC Participation	August 16, 2013
Care Management Administrative Services Contract for MLTC Plans	October 18, 2013
Home Health Services in Managed Care	January 24, 2014
Conflict-Free Evaluation and Enrollment Center (CFEEC) Fact Sheet	September 29, 2014
Conflict-Free Evaluation and Enrollment Center (CFEEC) Frequently Asked Questions (FAQs)	September 29, 2014
MLTC Plan Reminder: Last SAAM Submission	October 23, 2013
MLTC Quarterly Reporting Instructions-Revised	November 6, 2013
Mandatory Compliance Program Reminder	November 19, 2013
DOH Rate codes 3479 and 3480	December 2, 2013
MLTC Partial Plan Additional Rate Codes Letter	December 5, 2013
MLTC Partial Plan Additional Rate Codes Letter	December 9, 2013
Important Plan Direction Re: Davis Lawsuit Federal District Court Decision	December 10, 2013
REMINDER Re: MLTC Policy 13.17 REVISED: Care Management Protocol Guidelines	December 10, 2013
Alert to All MLTC Plans: Winter Weather Storm Emergency Preparedness Disaster Plans	January 3, 2014
MLTC Partial Plan Additional Rate Codes Letter	August 11, 2014
MLTC Rate Code 3479 and 3480	August 13, 2014
OTDA Fair Hearings Plan Representatives	September 2, 2014
Conflict-Free Evaluation and Enrollment Center (CFEEC) Fact Sheet	September 29, 2014
SDC Network Review	October 10, 2014
Managed Long Term Care - NYC Transportation Vendor Requirements	November 25, 2014
Managed Long Term Care - NYC Transportation Vendor Requirements	November 25, 2014

Email Blast: NH Transition - Plan Designated Contact	January 27, 2015
Emergency Preparedness and Disaster Preparedness policy and procedures	February 26, 2015
MLTC Model Notice Announcement	March 24, 2015
Conflict-Free Evaluation and Enrollment Center (CFEEC) Frequently Asked Questions (FAQs)	March 27, 2015
New York State Department Of Health Standard Clauses For Managed Care Provider/IPA Contracts REVISED	May 1, 2015
SADC Certification Webinar	May 19, 2015
Partial Capitation Model Action Notices Frequently Asked Questions (FAQs)	May 29, 2015
MLTC Model Action Notice FAQ and Citation Table	August 12, 2015
MLTC Plan re IC-10 coding	September 22, 2015
Emergency Preparedness	January 22, 2016
MAP Application	February 2, 2016
Updated: FLSA State Share Payments	February 4, 2016
PACE Model Expansion RFI	February 18, 2016
PACE Model Expansion Questionnaire	February 18, 2016
NHTD/TBI Waiver Transition Update	February 18, 2016
Statewide Administrative Health Home Services Agreement Between Managed Long Term Care Plan and Health Homes	February 2, 2016
Guidance for Providing Care Coordination and Management to Medicaid Members Enrolled in MLTC Plans and Health Homes	February 2016
State Administrative Health Home Service Agreement (ASA) Letter	March 8, 2016
MLTC and MMC Letter to Non-Dual Population Letter	May 9, 2016