

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK DID NOT ENSURE
THAT A MANAGED CARE
ORGANIZATION COMPLIED WITH
REQUIREMENTS FOR DENYING
PRIOR AUTHORIZATION
REQUESTS**

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**September 2023
A-02-21-01016**

Office of Inspector General

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Report in Brief

Date: September 2023
Report No. A-02-21-01016

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



Why OIG Did This Audit

OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid enrollees. The Senate Special Committee on Aging requested that OIG conduct a review of the Medicaid managed care organization (MCO) industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several news articles have highlighted concerns related to the Medicaid managed care program and its oversight.

Our objective was to determine whether New York's oversight of Centers Plan for Healthy Living (CPHL) ensured compliance with Federal and State requirements when CPHL denied access to requested services that required prior authorization.

How OIG Did This Audit

Our audit covered denials of prior authorization requests for CPHL long-term care services and dental services that were either overturned by New York or withdrawn by CPHL. For these requests submitted during the period from April 2018 through March 2020, CPHL reported 1,131 overturned denials and 19 withdrawn denials. We reviewed a judgmental sample of 70 denials to determine whether they complied with Federal and State requirements.

New York Did Not Ensure That a Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests

What OIG Found

For 35 of 70 sampled denials, New York's oversight of CPHL ensured that CPHL complied with Federal and State requirements when it initially denied prior authorization requests for services and items. These denials were overturned by the State Department of Financial Services or State Office of Temporary and Disability Assistance based on additional information provided during the appeal process. However, for the remaining 35 sampled denials, we determined that CPHL justified the denials by citing incorrect information in denial notices issued to the associated Medicaid enrollees. Ultimately, the enrollees' access to requested services associated with these sampled claims were delayed a median of 75 days and, in one case, as many as 282 days, which may have significantly impacted the health and safety of Medicaid enrollees.

We determined that New York's monitoring was not effective to ensure that CPHL complied with requirements for denying prior authorization requests. New York did not—and was not required to—regularly obtain and review information related to MCOs' initial denials and internal appeals of prior authorization requests. Rather, New York relied on its retrospective review of a sample of prior authorization denials during its biennial operational surveys and other data. Without obtaining and reviewing information related to MCOs' initial denials and internal appeals, New York had limited ability to conduct effective oversight of CPHL's prior authorization practices.

What OIG Recommends and New York's Comments

We recommend that New York: (1) use the finding in this report to determine whether CPHL was noncompliant and determine whether a corrective action plan or other sanctions are appropriate, (2) review CPHL's appeal process and ensure that CPHL makes any necessary changes to comply with requirements for denying services, and (3) implement procedures to obtain and review information related to MCOs' initial denials and internal appeals.

New York did not indicate concurrence or nonconcurrence with our findings or recommendations. However, it described actions it has taken or plans to take to address the findings, such as by means of a plan to conduct a focused survey of MCOs. We commend New York for its actions but note that its plans do not fully address our recommendations. We maintain that our recommendations should be fully implemented.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	2
Medicaid Program.....	2
New York’s Medicaid Managed Care Program.....	2
Centers Plan for Healthy Living.....	5
CPHL Prior Authorization Process.....	5
How We Conducted This Audit.....	6
FINDINGS.....	7
The State Agency’s Oversight Did Not Ensure That CPHL Complied With Requirements for Denying Prior Authorization Requests.....	8
Denials Overturned by CPHL on Internal Appeal.....	9
Denials Overturned by DFS on External Appeal.....	10
Denials Overturned by OTDA at Fair Hearing.....	11
State Agency Monitoring Did Not Adequately Address CPHL’s Appeal Process ..	12
RECOMMENDATIONS.....	12
STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	13
APPENDIX	
A: Audit Scope and Methodology.....	14
B: State Agency Comments.....	16

INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid enrollees. Medicaid managed care organizations (MCOs) provide Medicaid enrollees with coverage for a variety of health care services through networks of health care providers. Specifically, MCOs may cover medical (inpatient, outpatient, and laboratory), radiological, dental, and pharmaceutical services.

The Senate Special Committee on Aging requested that OIG conduct a review of the Medicaid MCO industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several news articles have highlighted concerns related to the Medicaid managed care program and its oversight. Specifically, these articles identified concerns related to patient neglect due to MCOs' denials of requests for medically necessary services and a lack of oversight by the Centers for Medicare & Medicaid Services (CMS).¹ This report is the second in a series of OIG reports that examine Medicaid MCO denials.²

For our audit of Medicaid MCO denials in New York, we selected denials made by one MCO for review. We selected Centers Plan for Healthy Living (CPHL) because it was among the Medicaid MCOs with the highest percentage of denials overturned by New York for services requested during the period from April 1, 2018, through March 31, 2020 (audit period).³

OBJECTIVE

Our objective was to determine whether the New York State Department of Health's (State agency's) oversight of CPHL ensured compliance with Federal and State requirements when CPHL denied access to requested services that required prior authorization.

¹ Des Moines Register, "Care Denied: How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals," Jan. 16, 2018; Dallas Morning News, "[As patients suffer, companies profit](#)," June 3, 2018; Los Angeles Times, "[Coverage denied: Medicaid patients suffer as layers of private companies profit](#)," Dec. 19, 2018; and Pennsylvania Health Law Project News, "[Alert: Consumers Face Barriers Challenging Service Denials by Keystone First and AmeriHealth Caritas](#)," Feb. 28, 2020.

² The first report, *Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization* ([A-03-20-00201](#)), was issued Dec. 20, 2022.

³ Our audit period was based on the most recent data available at the start of our audit.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid enrollees. States contract with MCOs to make services available to Medicaid enrollees. Under a risk-based managed care plan, State Medicaid agencies pay MCOs a capitation payment, which is a fixed amount per month for each enrollee. A State Medicaid agency makes the payment regardless of whether or not the enrollee receives services during the period covered by the payment.

The contractual, risk-based arrangements between State Medicaid agencies and MCOs shift financial risk for the costs of Medicaid services from a State agency and the Federal Government to the MCO. If an MCO spends more on covered services than it receives in capitation payments, the MCO absorbs the loss; if it spends less, it keeps the gain. This financial risk gives MCOs a potential incentive to limit what they pay network providers by improperly denying enrollees' access to covered services, constraining payments to providers, or both.

Each State Medicaid agency is responsible for monitoring its Medicaid managed care program. A State's monitoring system must address all aspects of the managed care program, including the performance of each MCO's administration and management, appeal and grievance systems, and claims management (42 CFR §§ 438.66(a) and (b)). Each contract between a State and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of an enrollee (42 CFR § 438.210(a)(3)(ii)). Additionally, an MCO must have a grievance and appeal system in place for enrollees (42 CFR § 438.402(a)). An MCO must also ensure that individuals who decide on grievances and appeals are independent of any previous decisions, have the appropriate clinical expertise, if applicable, and take into account all documents, records, and other information submitted by enrollees (42 CFR § 438.406(b)(2)). As part of its monitoring process, a State must review an MCO's records of grievances and appeals (42 CFR § 438.416(a)).

New York's Medicaid Managed Care Program

More than 5 million Medicaid enrollees in New York receive services through managed care. During the audit period, the State agency contracted with 52 MCOs to offer different Medicaid MCO plans covering all age groups and various income levels. Most enrollees in MCO plans

receive comprehensive health care services through health maintenance organization plans or prepaid health services plans. However, Medicaid enrollees who are chronically ill or disabled and medically eligible for nursing home care but who wish to stay in their homes and communities may receive services through a managed long-term care (MLTC) plan.

To manage the benefits provided to Medicaid enrollees, MCOs in New York are generally required to conduct utilization reviews to determine the medical necessity of health care services. The MCOs may conduct prior authorization reviews before providing coverage for new or additional services. Services requiring prior authorization are included in MCO member handbooks.

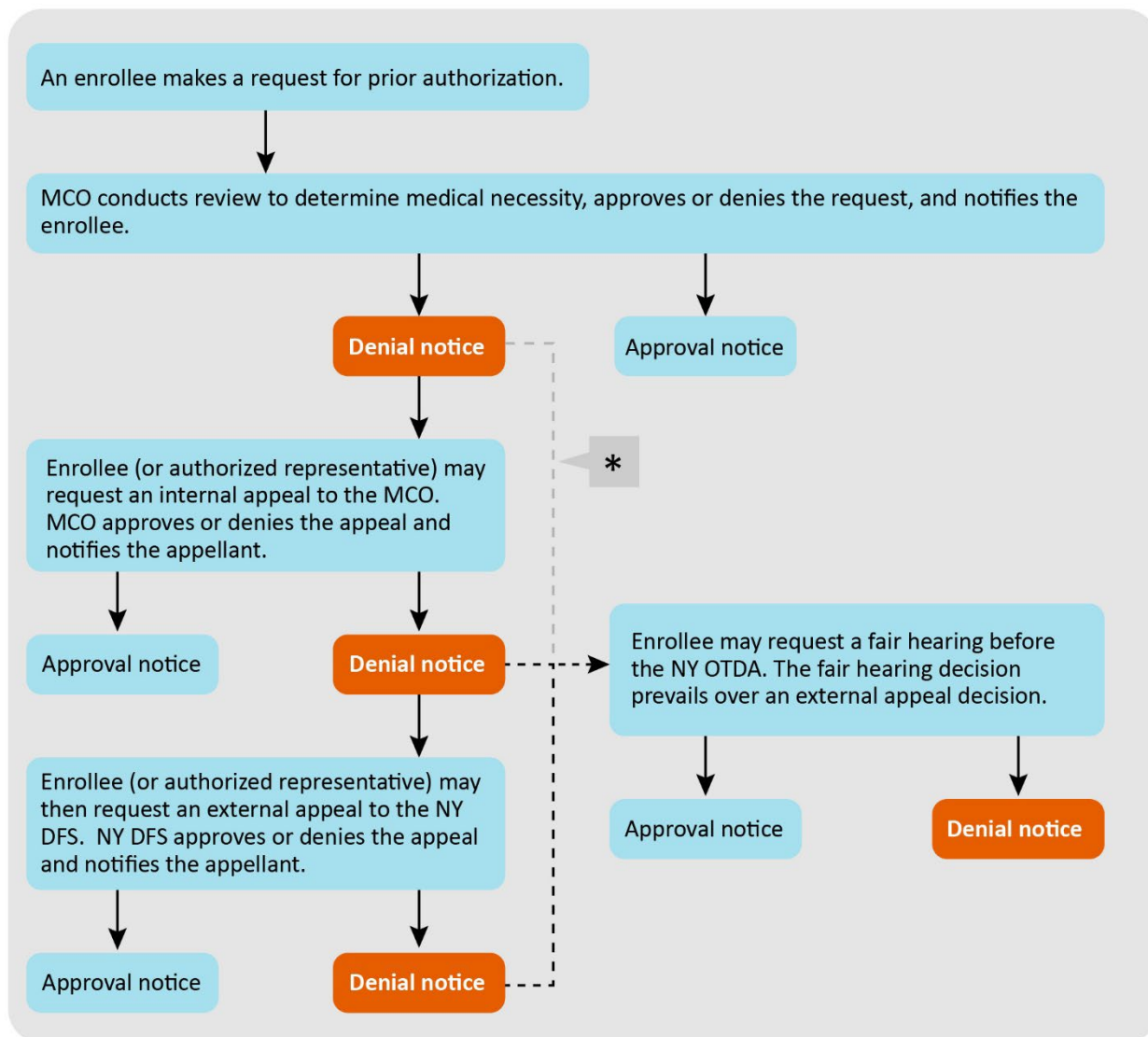
The MCO's prior authorization process begins when an enrollee, or a provider on the enrollee's behalf, submits a request for new or additional services and supporting documentation for the request. The MCO then determines the medical necessity of the prior authorization request based on an assessment of the enrollee's health status that may include consultation with the enrollee's provider. The MCOs must complete prior authorization reviews and provide notices of determination to enrollees within 3 business days of receiving the necessary information (Section 4903(2) of the New York Public Health Law (NYPBH)). A notice of adverse determination must include the reasons for the determination, instructions on how to initiate appeals, and notice of the availability, upon request, of the clinical review criteria for the determination. Such denial notices must also specify any additional information that must be provided for the appeal (NYPBH § 4903(5)).

An enrollee or authorized representative, such as the enrollee's provider, can request an internal appeal to the MCO (NYPBH § 4904(1)). If an internal appeal is denied (i.e., the MCO's determination is upheld), an enrollee may request an external appeal to the New York State Department of Financial Services (DFS) (NYPBH § 4910(2)). At any point after the internal appeal process, an enrollee may request a fair hearing before the New York State Office of Temporary and Disability Assistance (OTDA).⁴ A fair hearing determination prevails over an external appeal determination.⁵ Each MCO maintains its own records of service denials and internal appeals. Similarly, DFS and OTDA each maintain their own appellate records. All of these records are maintained in separate databases under different record numbers. See the figure on the following page for a flowchart of the MCO service denial and appeal process in New York.

⁴ Prior to May 1, 2018, an enrollee could request a fair hearing without first exhausting the MCO internal appeal process. On May 1, 2018, New York began requiring enrollees to receive an internal appeal denial from the MCO before requesting a fair hearing from OTDA in accordance with new requirements under 42 CFR §§ 438.402(c)(1)(i) and 438.408(f)(1). On Mar. 26, 2020, New York obtained a waiver from CMS effective Mar. 1, 2020, that allowed enrollees to request a fair hearing 1 day after requesting an internal appeal for the duration of the COVID-19 public health emergency.

⁵ Title 10 § 98-2.11(c) of the New York Compilation of Codes, Rules, & Regulations (NYCRR).

Figure: MCO Service Denial and Appeal Process in New York



* Prior to May 1, 2018, an enrollee could request a fair hearing without first exhausting an MCO’s internal appeal process. On May 1, 2018, New York began requiring each enrollee to receive an internal appeal denial from an MCO before requesting a fair hearing from OTDA. On March 26, 2020, New York obtained a waiver from CMS effective March 1, 2020, that allowed enrollees to request a fair hearing 1 day after requesting an internal appeal.

As part of its monitoring process, the State agency indicated that it conducts biennial operational surveys of MCOs during which it reviews random samples of MCO service denials for compliance with Federal and State requirements. During these surveys, the State agency also collects information on the rate of appeals overturned by DFS and OTDA. The State agency may also conduct focus surveys of MCOs to address specific concerns identified during operational surveys and through routine monitoring of complaints and MCO encounter data. If the State agency identifies noncompliance by an MCO, it requires the MCO to develop and implement a corrective action plan. In cases of egregious or repeat deficiencies, the State

agency may impose sanctions under Article IX of the MCO contract, which may include monetary penalties under 18 NYCRR Part 516 and 42 CFR Part 438, Subpart I.

Centers Plan for Healthy Living

CPHL is one of 41 MCOs in New York offering MLTC plans for Medicaid enrollees who are chronically ill or have disabilities, and who need health care and long-term care services, such as home care or adult day care, in order to stay in their homes and communities.

Headquartered in Staten Island, New York, CPHL arranges and pays for services to enrollees throughout New York. Most enrollees enrolled in CPHL's MLTC plans receive services through a partially capitated plan that provides long-term care services but does not cover primary care or inpatient hospital services. During our audit period, CPHL's partially capitated MLTC plan served more than 35,000 Medicaid and dually eligible enrollees (i.e., Medicaid enrollees who are also enrolled in Medicare) and received more than \$4.2 billion from the State agency to cover these enrollees.

CPHL's partially capitated MLTC plan provides a comprehensive, long-term care benefit package of covered services through a network of providers. Each enrollee continues to receive primary care physician and other non-CPHL covered services through Medicare or Medicaid on a fee-for-service basis or a Medicare Advantage plan. An enrollee in the plan is assigned a care management team comprised of nurses, social workers, and service coordinators to help manage the enrollee's chronic health problems. The team works with the enrollee and the enrollee's physician to develop a plan of care and must re-evaluate the plan as needed or at least once every 6 months based on an assessment of the enrollee's health care needs. The team is also responsible for coordinating all medically necessary services covered by CPHL as well as needed Medicaid services not covered by CPHL.⁶ Also, CPHL must identify the service needs of all enrollees and ensure that medically necessary covered benefits are delivered in a timely manner.⁷

CPHL Prior Authorization Process

CPHL requires prior authorization for most covered services provided under its partially capitated MLTC plan.⁸ Some services also require a physician's order. When an enrollee or provider acting on the enrollee's behalf requests authorization of a new service or more of the same service currently authorized in the plan of care, CPHL must review the request and reassess the enrollee's needs. If the prior authorization request requires clinical review to

⁶ CPHL MLTC Partial Capitation Contract No. C033057, effective Jan. 1, 2017, through Dec. 31, 2021, Article V, Section J.

⁷ CPHL MLTC Partial Capitation Contract No. C033057, Appendix B, Section IV.C.

⁸ When prior authorization decisions are made by CPHL, enrollees are entitled to the same benefits and standards and to the same notice and procedural due process rights as if the prior authorization decision were made by the State agency (New York Social Service Law (NYSSL) § 365-a(8)).

determine medical necessity, CPHL obtains and submits all necessary documentation to its Medical Director for review. If CPHL determines that the requested service is medically necessary, it approves the request and updates the plan of care. If CPHL denies or limits the requested service, it provides the enrollee a notice that includes information on how the enrollee can request an appeal or a fair hearing.

HOW WE CONDUCTED THIS AUDIT

Our audit covered CPHL denials of prior authorization requests for long-term care services and dental services that were either overturned by DFS or OTDA, or withdrawn by CPHL during an internal appeal, external appeal, or fair hearing process. For our audit period (from April 1, 2018, through March 31, 2020), CPHL reported receiving 105,451 prior authorization requests for new long-term care services, of which 79,898 were fully approved, 3,353 were partially denied, and 22,200 were fully denied.⁹ Additionally, CPHL reported receiving 5,324 prior authorization requests for dental services, of which 2,955 were fully approved, 814 were partially denied, and 1,555 were fully denied. For the 110,775 prior authorization requests submitted during the audit period that resulted in 27,922 full or partial denials CPHL reported 1,131 denials overturned on internal appeal, or by DFS or OTDA, and 19 denials withdrawn by CPHL during OTDA's fair hearing processes.¹⁰

We reviewed a judgmental sample of 70 overturned or withdrawn denials (sampled denials) to determine whether CPHL's initial denials and internal appeal denials complied with Federal and State requirements.¹¹ We also reviewed records and supporting documentation maintained by the State agency, DFS, and OTDA for the 70 sampled denials to determine whether the State agency validated CPHL's records and identified any specific concerns at CPHL through its oversight activities. We also reviewed the State agency's most recently completed biennial operational survey of CPHL and other MCOs to determine whether the State agency had previously identified any operational deficiencies that required corrective actions.¹²

⁹ According to CPHL, the totals reported to OIG do not include authorizations made before an individual officially enrolled in CPHL's MLTC plan, extensions of previous authorizations, or authorizations related to requests for incontinence supplies (e.g., diapers).

¹⁰ Total prior authorization requests were comprised of 105,451 requests for long-term care services and 5,324 requests for dental services. Total denials were comprised of 3,353 partial denials for long-term care services, 22,200 full denials for long-term care services, 814 partial denials for dental services, and 1,555 full denials for dental services.

¹¹ We judgmentally sampled denials based on the type of appeal (i.e., internal appeal, external appeal, and fair hearing) and the cost of the associated services requested. We selected the 69 denials with the highest associated cost and 1 denial that CPHL incorrectly reported as having been withdrawn during the fair hearing process but instead had been overturned by DFS.

¹² We note that the State agency did not conduct any focus surveys of CPHL during our audit period.

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 A contains the details of our audit scope and methodology.

FINDINGS

The State agency's oversight of CPHL did not ensure that CPHL complied with requirements for denying prior authorization requests. Specifically, the State agency's monitoring procedures did not include obtaining and reviewing information related to CPHL's initial denials and internal appeals prior to an external appeal or fair hearing process. For 35 of the 70 sampled denials, CPHL complied with Federal and State requirements when initially denying prior authorization requests for services and items. These denials were overturned by DFS or OTDA based on additional information provided to them during the appeal process. However, for the remaining 35 sampled denials, we determined that CPHL justified the denials by citing incorrect information in the denial notices issued to associated enrollees.¹³

We determined that 35 sampled denials overturned by CPHL on internal appeal, DFS or OTDA cited incorrect information in the denial notices issued by CPHL to enrollees. Specifically, we found that:

- for 2 denials overturned on internal appeal, CPHL had all the information it needed to approve the requests when it made the denials but incorrectly claimed that information was missing in the denial notices;
- for 17 denials overturned on external appeal, CPHL's denial notices contained incorrect information; and
- for 16 denials overturned by OTDA fair hearing judges, CPHL's denial notices contained incorrect information.

For a majority of our sampled denials, CPHL's initial denial notices cited missing documentation as the basis for the denials. Similarly, CPHL's denial notices for internal appeals cited missing documentation as a justification for not overturning the initial denials. However, based on information in the decision that overturned the denials, we determined that for these 35 sampled denials either the information identified as missing had been provided or the reasons given for the denials were contradicted by supporting documentation maintained by CPHL and

¹³ Specifically, 14 sampled denials cited incorrect information in CPHL's initial denial notices related to the associated prior authorization requests and 21 sampled denials cited incorrect information in CPHL's final denial notices related to associated internal appeals.

the State agency. CPHL explained that its denials were justified and that for each denial: (1) the associated enrollee's condition changed after the denial notice or (2) the associated enrollee provided new information during the appeal process.

We determined that the State agency's monitoring was not effective to ensure that CPHL complied with requirements for denying prior authorization requests. The State agency did not—and was not required to—regularly obtain and review information related to MCOs' initial denials and internal appeals of prior authorization requests. Rather, the State agency relied on its retrospective review of a sample of prior authorization denials during its biennial operational surveys and other data. Furthermore, the State agency relied on DFS and OTDA to maintain records associated with external appeals and fair hearings in separate databases, which made it difficult for the State agency to actively monitor MCOs for noncompliance with Federal and State requirements. Without obtaining and reviewing information related to MCOs' initial denials and internal appeals, the State agency had limited ability to conduct effective oversight of CPHL's prior authorization practices.

As a result of CPHL's denials, the Medicaid enrollees associated with the 35 sampled denials did not have access to requested services for a median of 75 days and, in 1 case, as many as 282 days.¹⁴ These delays may have significantly affected the health and safety of vulnerable Medicaid enrollees. Although the 35 sampled denials were ultimately overturned, they created an administrative burden for the enrollees and their providers as they had to appeal CPHL's denials. Enrollees who cannot wait for DFS or OTDA to overturn a CPHL denial may have to pay out-of-pocket for services that may be covered by Medicaid. Finally, CPHL's denials may be particularly harmful for enrollees who cannot afford to pay for services directly as well as for critically ill enrollees who may suffer negative health consequences due to delayed or denied care.

THE STATE AGENCY'S OVERSIGHT DID NOT ENSURE THAT CPHL COMPLIED WITH REQUIREMENTS FOR DENYING PRIOR AUTHORIZATION REQUESTS

According to its contract with the State agency, CPHL must identify the service needs of all enrollees and ensure that medically necessary covered benefits are delivered in a timely manner.¹⁵ Additionally, CPHL must include in its denial notices the reasons for the determination, instructions on how to initiate appeals, and notice of availability, upon request, of the clinical review criteria for the determination. A denial notice must also specify any

¹⁴ We calculated the delay for each of the sampled denials from the date CPHL denied the associated prior authorization request after receiving the required documentation to the date of CPHL's authorization of the requested service.

¹⁵ CPHL MLTC Partial Capitation Contract No. C033057, Appendix B, Section IV.C. According to Appendix J of the contract, "medically necessary services" are services necessary to prevent, diagnose, correct, or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee's capacity for normal activity, or threaten some significant handicap.

additional information that must be provided for an appeal.¹⁶ Furthermore, CPHL's internal appeal reviewers must take into account all information submitted by enrollees.¹⁷ For its part, State agency oversight (i.e., its monitoring system) must address all aspects of New York's managed care program including the performance of each MCO's administration and management, appeal and grievance systems, and claims management.¹⁸

Denials Overturned by CPHL on Internal Appeal

We determined that when making two denials that were later overturned on internal appeal, CPHL had all the information it needed to approve prior authorization but incorrectly claimed in the denial notices that the information was missing.

Example: Denial Overturned on Internal Appeal

On April 24, 2018, the physician for a 77-year-old, partially paralyzed enrollee submitted a prior authorization request for a stair lift to replace one that stopped working and could not be repaired. Supporting documentation for the request included: (1) a physician's order, (2) physician records, (3) a CPHL assessment on April 11, 2018, that indicated that the enrollee lived on the second floor of a home and required a stair lift to transfer between floors, and (4) an assessment of the enrollee's home by a durable medical equipment provider.

The physician faxed CPHL an additional letter on May 7, 2018, summarizing the purpose of the stair lift. That same day, CPHL denied the request and incorrectly claimed in the denial notice that CPHL had not received the result of an assessment of the enrollee's home. Also, CPHL incorrectly claimed that CPHL had not been informed that the enrollee used the second floor of the home.

On June 19, 2018, the enrollee's family appealed CPHL's denial and cited documentation previously submitted with the prior authorization request. On June 20, 2018, CPHL's internal appeal reviewer overturned CPHL's initial denial. We determined that CPHL's denial partly resulted in the enrollee not having access to the requested service for 44 days. During our audit, CPHL asserted that the physician's letter on May 7, 2018, had been new information that was received after CPHL rendered its determination. However, we noted that the letter had

¹⁶ NYPBH § 4903(5).

¹⁷ 42 CFR § 438.406(b)(2)(iii).

¹⁸ 42 CFR §§ 438.66(a) and (b).

repeated information previously submitted to CPHL and had not been cited as a missing document in CPHL's denial notice to the enrollee.

Denials Overturned by DFS on External Appeal

We determined that CPHL's denial notices contained incorrect information for 17 denials overturned on external appeal.¹⁹

Example: Denial Overturned on External Appeal

On October 9, 2019, an 89-year-old bedbound enrollee and the enrollee's daughter requested that the enrollee's personal care services be increased from 8 hours per day to 12 hours per day (84 hours per week) because the enrollee's wife had suffered a stroke and could no longer provide care. Supporting documentation for the prior authorization request included a September 2019 CPHL assessment and physician's records that indicated the enrollee needed additional assistance because of a decline in health since CPHL's assessment in May 2019 and that recommended a repositioning every 2 hours to prevent pressure sores. On October 14, 2019, CPHL denied the request and incorrectly claimed in its denial notice that the enrollee had no unscheduled daytime or nighttime needs.

On October 21, 2019, the enrollee and the enrollee's daughter appealed the denial to CPHL and cited the enrollee's diabetic condition, mobility limits, and nighttime diaper needs. The next day, CPHL's internal appeal reviewer upheld CPHL's denial and claimed in the denial notice that most of the enrollee's abilities to perform physical functions had not changed since CPHL's May 2019 assessment.

On February 20, 2020, the enrollee's lawyer appealed the CPHL denial to DFS. On March 20, 2020, an external reviewer contracted by DFS overturned CPHL's denial and identified incorrect information in CPHL's denial notices for the original prior authorization request and internal appeal. Specifically, the external reviewer noted that the enrollee had unscheduled daytime and nighttime needs that were not addressed by CPHL and caused multiple pressure sores to develop. The external reviewer also noted that the enrollee needed more than the originally requested 84 hours per week of personal care services. We determined

¹⁹ For 14 of the 17 denials, we noted that external reviewers concluded that CPHL did not act reasonably with sound medical judgment in the best interest of the enrollees. For the remaining three denials, the external reviewers did not comment on CPHL's conduct.

that, in part, CPHL's denial resulted in the enrollee not having access to the requested services for 164 days.

Denials Overturned by OTDA at Fair Hearing

We determined that CPHL's denial notices contained incorrect information for 16 denials overturned by OTDA.²⁰

Example: Denial Overturned at Fair Hearing

On October 26, 2018, the physician for a 61-year-old, morbidly obese enrollee submitted a prior authorization request for a motorized wheelchair. The enrollee weighed more than 500 pounds and could not be pushed in a manual wheelchair. Supporting documentation for the prior authorization request included an August 2018 CPHL assessment and physician's records that indicated that the enrollee needed weight-bearing support and a rollator (a type of mobility aid) for ambulation. On November 5, 2018, CPHL denied the request and claimed in its denial notice that no problem had been noted after a physical exam and that the enrollee had walked with an assistance device.

On December 12, 2018, the enrollee's care coordinator appealed the denial to CPHL and submitted additional documentation that included a physician's letter and updated physician records. The physician's letter cited additional conditions including coronary heart disease, diabetes, shortness of breath, polio-related residual left leg atrophy, right knee osteoarthritis, spinal deformities, and lower back pain in order to support the enrollee's need for a motorized wheelchair. On January 4, 2019, CPHL's internal appeal reviewer upheld CPHL's initial denial and claimed in the denial notice that the enrollee could walk with a rollator. (We note that the physician's letter indicated that the enrollee could walk only a few steps with a rollator.)

On April 2, 2019, the enrollee's care coordinator submitted a fair hearing request to OTDA and provided only documentation previously submitted to CPHL. On August 28, 2019, the fair hearing judge overturned CPHL's denial based on the physician's letter submitted with the internal appeal request. The fair hearing judge identified incorrect information in CPHL's denial notice for the internal appeal but noted that the original prior authorization denial was correct because of missing information.

²⁰ We note that fair hearing judges noted in opinions related to 3 of the 16 denials that, contrary to CPHL's position, an enrollee's family member cannot be required to contribute to the care of an enrollee. For these three cases, CPHL noted family members were available and claimed additional personal care services were not needed.

Specifically, the fair hearing judge noted that the physician’s letter included with the enrollee’s internal appeal request had indicated that the enrollee could walk only a few steps with a rollator. We determined that, in part, CPHL’s denial resulted in the enrollee not having access to the requested service for 252 days.

State Agency Monitoring Did Not Adequately Address CPHL’s Appeal Process

We determined that the State agency’s monitoring was not effective to ensure that CPHL complied with requirements for denying prior authorization requests. The State agency did not—and was not required to—regularly obtain and review information related to MCOs’ initial denials and internal appeals of prior authorization requests. Rather, the State agency relied on its retrospective review of a sample of prior authorization denials during its biennial operational surveys and other data. Furthermore, the State agency relied on DFS and OTDA to maintain records associated with external appeals and fair hearings in separate databases, which made it difficult for the State agency to actively monitor MCOs for noncompliance with Federal and State requirements. Without obtaining and reviewing information related to MCOs’ initial denials and internal appeals, the State agency had limited ability to conduct effective oversight of CPHL’s prior authorization practices. For example, to thoroughly review an MCO’s denials, the State agency would need to separately obtain information related to denials and internal appeals from the MCO, external appeals data from DFS, and fair hearings data from OTDA. The State agency would then have to combine and reconcile the records before an effective review could be performed.²¹

By developing procedures to obtain and review data on MCOs’ initial denials and internal appeals, the State agency could more effectively detect trends or outliers among its MCOs to determine whether additional oversight is needed and whether an MCO should be subject to a corrective action plan or sanctions.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- use the findings in this report to determine whether CPHL was noncompliant and determine whether a corrective action plan or other sanctions are appropriate,
- review CPHL’s appeal process and ensure that CPHL makes any necessary changes to comply with requirements for denying services, and
- implement procedures to obtain and review information related to MCOs’ initial denials and internal appeals.

²¹ We note that the high number of Medicaid enrollees and MCO plans in New York further increases the challenge of monitoring MCO denials maintained in separate databases by different parties.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our findings or recommendations. However, it described actions that it has taken or plans to take to address the findings. Specifically, the State agency stated that it conducted a focused survey during 2021 and 2022 on the internal appeal and fair hearing management practices of Partial Capitation and Medicaid Advantage Plus MCOs that included CPHL. The State agency indicated that it issued statements of deficiency to MCOs that lacked required timeframe information or did not follow policies and procedures. Also, the State agency indicated that it plans to conduct a focused survey in late 2023 and 2024 to assess MCOs' compliance with prior authorization requests and supporting documentation requirements that will include CPHL.

We commend the State agency for the actions it has taken and those it plans to take to address the findings identified in our draft report. However, we note that the State agency's plans do not fully address our recommendation to implement procedures to obtain and review information related to MCOs' initial denials and internal appeals. Therefore, we continue to recommend that the State agency implement procedures to obtain and review information related to MCOs' initial denials and internal appeals.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered CPHL denials of prior authorization requests for long-term care services and dental services that were either overturned by DFS or OTDA, or withdrawn by CPHL during the internal appeal, external appeal, or fair hearing process. For the audit period from April 1, 2018, through March 31, 2020, CPHL reported receiving 105,451 prior authorization requests for new long-term care services, of which 79,898 were fully approved, 3,353 were partially denied, and 22,200 were fully denied.²² Additionally, CPHL reported receiving 5,324 prior authorization requests for dental services, of which 2,955 were fully approved, 814 were partially denied, and 1,555 were fully denied. For the 110,775 prior authorization requests submitted during the audit period that resulted in 27,922 full or partial denials, CPHL reported 1,131 denials were overturned by CPHL, DFS, or OTDA, and 19 denials were withdrawn by CPHL during the fair hearing process. We reviewed a judgmental sample of 70 overturned or withdrawn denials to determine whether the associated initial denials and internal appeal denials complied with Federal and State requirements.²³

We did not assess the State agency's overall internal control structure. Rather, we limited our review of the State agency's internal controls to those applicable to our objective. This included reviewing the State agency's policies and procedures for ensuring that CPHL and other MCOs comply with Federal and State requirements for denying access to requested services that require prior authorization. We also reviewed CPHL's policies and procedures for denying access to requested services that require prior authorization.

We performed the audit work from May 2021 through June 2023.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State laws, regulations, contracts, and guidance related to Medicaid MCO denials in New York;
- met with State agency, DFS, and OTDA officials to gain an understanding of and obtain information on the oversight of Medicaid MCO denials and the remedies available to

²² According to CPHL, the totals reported to OIG did not include authorizations made before an individual officially enrolled in CPHL's MLTC plan, extensions of previous authorizations, or authorizations related to requests for incontinence supplies (e.g., diapers).

²³ We judgmentally sampled denials based on the type of appeal (i.e., internal appeal, external appeal, or fair hearing) and the cost of the associated services requested. We selected 69 denials with the highest associated costs and 1 denial that CPHL incorrectly reported as having been withdrawn during the fair hearing process but instead had been overturned by DFS.

enrollees including internal appeals, external appeals, and fair hearings;

- obtained and analyzed external appeals and fair hearings data maintained by the State agency, DFS, and OTDA to identify MCO(s) with high numbers of overturned denials, and selected CPHL for review;
- obtained and reviewed the State agency's most recently completed biennial operational survey of CPHL and other MCOs to determine whether the State agency had previously identified any operational deficiencies that required corrective actions;
- met with CPHL representatives to gain an understanding of and obtain information on the processes for MCO denials of prior authorization and internal appeals;
- obtained and assessed the reliability of prior authorization denials and internal appeals data maintained by CPHL by: (1) performing electronic testing, (2) reviewing existing information about these data and the system that produced the data, and (3) interviewing CPHL representatives and State agency officials knowledgeable about the data;
- determined that the data obtained were sufficiently reliable for the purpose of responding to our audit objective and selected for review a judgmental sample of 70 CPHL prior authorization denials that were overturned or withdrawn during the internal appeal, external appeal, or fair hearing process;
- obtained and reviewed supporting documentation for the sampled CPHL denials and related internal appeals, external appeals, and fair hearings to identify the reasons for the overturned or withdrawn denials, and determined whether CPHL complied with Federal and State requirements;
- obtained and reviewed records and supporting documentation maintained by the State agency, DFS, and OTDA for the 70 sampled denials to determine whether the State agency validated CPHL's records and, during its oversight activities (e.g., biennial operational surveys), identified any issues at CPHL; and
- discussed the results of our audit with State agency officials.

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 B: STATE AGENCY COMMENTS



**Department
of Health**

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

July 17, 2023

Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-21-01016

Dear Brenda Tierney:

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-02-21-01016 entitled, "New York Did Not Ensure That a Managed Care Organization Complied with Requirements for Denying Prior Authorization Requests."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Amir Bassiri
Jacqueline McGovern
Andrea Martin
Timothy Brown
Amber Rohan
Brian Kiernan
James DeMatteo
James Cataldo
Michael Atwood
OHIP Audit
DOH Audit

**New York State Department of Health
Comments to Draft Audit Report A-02-21-01016 entitled,
“New York Did Not Ensure That A Managed Care Organization Complied
With Requirements for Denying Prior Authorization Requests” by the
Department of Health and Human Services Office of Inspector General**

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report A-02-21-01016 entitled, “New York Did Not Ensure That A Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests” by the Department of Health and Human Services, Office of Inspector General (OIG).

Recommendation #1:

Use the findings in this report to determine whether CPHL was noncompliant and determine whether a corrective action plan or other sanctions are appropriate.

Response #1:

The Department conducted a focused survey during 2021-2022, on Partial Capitation and Medicaid Advantage Plus (MAP) plans’ internal Appeal and Fair Hearing management practices for the first quarter of 2021 which included CPHL. Policies and procedures were reviewed along with a sample size of Fair Hearing cases for each plan. Statements of Deficiency were issued to the plans that lacked the required timeframe information, or where policies and procedures were not followed. The Department will conduct an additional focused survey to assess plan compliance with prior authorization requests which will include CPHL.

Recommendation #2:

Review CPHL’s appeal process and ensure that CPHL makes any necessary changes to comply with requirements for denying services.

Response #2:

The Department conducted a focused survey during 2021-2022, on Partial Capitation and MAP plans’ internal Appeal and Fair Hearing management practices for the first quarter of 2021 which included CPHL. Policies and procedures were reviewed along with a sample size of Fair Hearing cases for each plan. Statements of Deficiency were issued to the plans that lacked the required timeframe information, or where policies and procedures were not followed. The Department will conduct an additional focused survey to assess plan compliance with prior authorization requests which will include CPHL.

Recommendation #3:

Implement procedures to obtain and review information related to MCOs’ initial denials and internal appeals.

Response #3:

The Department will conduct a focused survey in late 2023-2024 to assess Partial Capitation and Medicaid Advantage Plus (MAP) plan compliance with prior authorization requests and supporting documentation which will include CPHL.