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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

July 22, 2004

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Managed Care Payments for Newborn Services
Report 2003-S-7

Dear Dr. Novello:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we audited the Department of Health's (Department) policies and procedures for ensuring the appropriateness of certain Medicaid payments made for services to newborn recipients enrolled in Managed Care Organizations (MCO) for the six-year period July 1, 1997 through June 30, 2003.

A. Background

The Department administers the State's Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the federal Social Security Act to provide medical assistance to needy people. The State is integrating managed care into Medicaid to help provide quality health care to low-income and disabled citizens in a more cost-effective manner. The Department's responsibilities include: certifying MCOs as qualified to participate in Medicaid managed care; overseeing MCO operations and quality of services; providing oversight and technical assistance to local district social services; evaluating managed care program performance; and developing and maintaining the necessary systems to operate and administer Medicaid and managed care. Local district social services work in partnership with the Department in administering the Medicaid managed care program.

The Department uses a fiscal agent, Computer Sciences Corporation, to operate the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and make payments to health care providers (providers) for services rendered to recipients. MMIS pays providers for these services by means of the fee-for-service method or the capitation method. With fee-for-service, MMIS pays the provider directly for

each Medicaid-eligible service rendered; with capitation, MMIS pays the MCO a monthly capitation fee for managing and providing all the enrolled recipient's health care services, regardless of the number or types of services actually received.

An infant born to an MCO-enrolled Medicaid recipient generally becomes a member of the mother's MCO. (Exceptions occur when infants are born significantly underweight and require extensive health care services.) Department policy requires hospitals to promptly notify the MCO of the infant's birth so the MCO can manage necessary services. Section 366-g of the Social Service Law (Law), effective July 1, 2000, also requires hospitals to notify the Department of the child's birth within five business days. The Department can then promptly enter the infant's name, birth date and MCO enrollment status on MMIS. If the infant is enrolled in an MCO, the MCO receives a monthly capitation payment for the infant from birth, as well as a Supplemental Newborn Capitation Payment (commonly called a kick payment). The kick payment is a one-time, fixed amount intended to reimburse the MCO for the cost of the newborn's hospital stay. Department policy states the MCO must pay the hospital's charges for newborn services before submitting a kick payment claim. MMIS paid 158,189 kick payments, totaling about $489 million, to 40 MCOs statewide during our 6-year audit period.

The MCO environment, which features all-inclusive monthly capitation fees, does not provide for reporting of specific types and frequency of services. Therefore, to monitor and evaluate MCO services to recipients, the Department developed the Medicaid Encounter Data System (MEDS) in 1996 to gather, process and report encounter data. An encounter is a professional face-to-face contact or transaction (such as an inpatient stay or a well-child visit) between an enrollee and a medical provider. The Department's Medicaid Managed Care Model Contract states that MCOs must submit encounter data monthly to the Department. The Department is responsible for maintaining MEDS, for analyzing encounter data and for ensuring MCOs comply with reporting requirements. The terms of New York State's mandatory Medicaid managed care program (the Partnership Plan), as approved by the federal Centers for Medicare and Medicaid Services (CMS), also require that MCOs provide complete, timely and accurate encounter data for all enrollees. According to CMS guidelines issued in July 1997, states can use encounter data to monitor managed care services by identifying underutilization of services, detecting fraud and abuse, and evaluating the quality and appropriateness of care provided.

In a prior audit (Report 2002-S-25, issued September 17, 2003), we examined kick payment claims to determine whether Medicaid paid twice for the same newborn services: once to the hospital on a fee-for-service basis, and again to the MCO in the form of a kick payment. The prior audit found Medicaid made duplicate payments because the Department did not enforce its requirement that MCOs must pay hospitals for newborn hospital stays before they can be reimbursed for these costs in the form of kick payments from Medicaid. Our current audit examines the extent to which Medicaid pays MCO kick payment claims without documentation that the child was born and was provided services through the MCO.

B. Audit Scope, Objective and Methodology

We audited the Department's policies and procedures for monitoring Medicaid reimbursement for managed care kick payments during the six-year period July 1, 1997 through June 30, 2003. The objective of our financial related audit was to determine if Medicaid made only appropriate kick payments to MCOs for newborn services. To accomplish our objective, we interviewed Department officials and reviewed applicable Medicaid policies, procedures, rules, laws, regulations and internal controls that pertain to newborn kick payment claims processing. We developed computer programs to match and identify all MCO kick payments made without date of birth information on MMIS and/or encounter data to support newborn services. To test the validity of the kick payment claims identified in this match, we reviewed claims from five judgmentally selected MCOs (four downstate MCOs and one upstate MCO). We selected these MCOs because our computer match showed the four downstate entities had submitted the greatest number of inadequately supported kick payment claims; we included the upstate entity to provide geographic diversity to this test of MCO kick claim payments statewide.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess the operations of the Department that are included in our audit scope. Further, these standards require that we understand the Department's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence that supports transactions recorded in the accounting and operating records and applying such other auditing procedures, as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

In addition to being the State Auditor, the Comptroller performs other constitutionally and statutorily mandated duties as chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Managed Care Payments for Newborn Services

Medicaid should pay an MCO's kick payment claim only when there is documentation to show an infant was born to a Medicaid recipient, and the infant is enrolled in the MCO. To help ensure kick payments claims are appropriate, the Department can consult various information sources to corroborate the claim. These include the MMIS recipient eligibility files, which should reflect the infant's birth date and enrollment status, and encounter data on MEDS, which should provide additional evidence (e.g., well-child visits) that the MCO managed the infant's health care services. However, we found that the Department paid MCO kick payment claims without adequate

documentation of birth and/or subsequent health care services to corroborate the claim. As a result, some of the $32.2 million kick payments may be inappropriate.

The Department should verify the legitimacy of MCO kick payment claims before paying them by confirming the newborn's birth date and enrollment status to independent sources. Further, the Department could alternatively review the encounter data on MEDS for evidence that the MCO provided services (e.g., an initial well-child exam) to the newborn enrollee. To determine the extent to which the Department verifies the appropriateness of kick payments, we used computer-assisted audit techniques to identify kick payment claims paid during our six-year audit period that were not supported by either of the above forms of documentation. Our tests identified a total of 9,697 claims, representing Medicaid payments totaling $32.2 million, which the Department may have paid inappropriately because it lacked documentation of birth date and/or MCO services. Specifically, we found that Medicaid paid the following potentially improper claims:

- 6,974 claims ($24.8 million) with no date of birth on MMIS;
- 2,282 claims ($6.2 million) that were not supported by encounter data; and
- 441 claims ($1.2 million) that had neither date of birth nor encounter data.

For the 6,974 claims for which no birth date was indicated on the recipient eligibility file, MMIS paid MCOs $24.8 million for newborn hospital stays without any evidence the child was born, or that MCOs actually incurred the claimed hospital costs. One of the reasons Medicaid pays these potentially inappropriate claims is that hospitals sometimes delay in notifying the Department about Medicaid recipient births and the Department does not wish to hold up payments to the MCO.

The Department's contract with MCOs states that MCOs must submit encounter data monthly for entry on MEDS. Since MEDS contains records of each service and procedure provided to MCO enrollees, encounter entries constitute evidence that MCO providers delivered professional services (such as a well-child check-up). However, our test identified 2,282 kick payment claims, totaling $6.2 million, for the hospital stay costs of infants for whom MEDS had no encounter data for our audit period. Although birth date information existed for these 2,282 claims to confirm that infants were born, the lack of encounter data suggests these infants were not receiving health care services. Medicaid paid these potentially inappropriate claims because the Department does not enforce its contract requirement that MCOs submit monthly encounter data.

Without encounter data, the Department is certainly at higher risk of making inappropriate kick payments. However, since these 2,282 claims relate to infants who are, in fact, enrolled in MCOs, the absence of MEDS data in these instances indicates the Department did not track these recipients' health care services. This means that, for claims dated from the beginning of our audit period, the Department lacks almost six years of treatment information for such children. Department officials stated that they have taken steps to enforce the encounter data reporting requirements and they have monitored MCOs compliance with the contract. To obtain the information needed to monitor service delivery and to evaluate the quality of care MCOs provide, the Department should take vigorous steps to ensure MCOs comply with the contract requirement to report encounter data.

We also identified 441 kick payment claims, totaling about $1.2 million, for which the Department lacked both date of birth information and encounter data. These claims, in our opinion, were at highest risk of being inappropriately paid because the Department has no evidence that the infants were born or that their health care was managed by the MCO.

The need for such independent data to verify the claims was shown by our further review of 50 claims selected from 4,638 claims submitted by five MCOs. We selected claims from the four MCOs that received the largest amount of kick payments made without a date of birth or encounter data. The top four MCOs were all located in the downstate area so we selected a fifth MCO from the upstate area to provide geographic diversity. We selected our 50 claims from those that met established criteria. Principal among our criteria was that the claim's date was after 1999; the absence of a birth date on MMIS; and a lack of encounter data. Our test of 50 claims included: 13 claims from HIP Health Plan of New York; 12 claims from Metro Plus Health Plan; 11 claims from Neighborhood Health Providers; 10 claims from Healthfirst; and 4 claims from Capital District Physicians Health Plan. We sent copies of these claims to the relevant MCOs and requested documentation that showed the MCOs had in fact paid the hospital bill for the newborn services reimbursed by MMIS. The MCO is supposed to pay the hospital before it bills MMIS for the kick payment.

We received a response to our request in 50 cases. The responses provided by the MCOs demonstrated to us that in 7 cases the full hospital bill was paid and only partial payments were made in 11 cases. However, for the vast majority of the 50 cases, the MCOs were not able to demonstrate that they had paid the hospital for the delivery of the infant. Therefore, in 32 (64 percent) of the claims we tested, the MCOs appear to have unduly profited from the kick payment because they had not paid the hospital for the services the hospital had rendered. A key requirement of this kick payment program is that the MCOs must pay the hospital before submitting a claim for the kick payment. This key requirement was the subject of a prior audit, Report 2002-S-25, Multiple Medicaid Payments for Newborn Services.

Recommendations

1. *Investigate and assess the appropriateness of the MCO kick payments identified in this report. Identify and recover any inappropriate payments.*

2. *Ensure hospitals comply with the requirement to report the birth of children to Medicaid recipients within five business days of the birth.*

3. *Improve monitoring of MCOs' compliance with contractual requirements for submitting encounter data, and use MEDS to monitor the quality of care delivered by MCOs.*

We provided draft copies of this report to Department officials for their review and comment. We considered their comments in preparing this report. Department officials generally agreed with the report's recommendations and identified actions planned or taken to implement them. However, with respect to recommendation number three, Department officials stated that they will continue to focus on using data collected, but did not address any new steps to improve the MCO's encounter data submission efforts. We urge officials to develop plans to improve compliance with the requirement that MCO's submit encounter data. A complete copy of the Department's response is included in Appendix A.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller and leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Major contributors to the report include Ken Shulman, Bill Clynes, Don Paupini, Sally Wojeski, Julie DeRubertis, Claudia Christodoulou and Nancy Varley.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Steven E. Sossei
Audit Director

cc: Robert Barnes, Division of the Budget

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 11, 2004

Steven E. Sossei
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2003-S-7) entitled "Managed Care Payments for Newborn Services."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Howe
Ms. Kuhmerker
Ms. Kutel
Ms. Pettinato
Mr. Reed
Mr. Seward
Ms. Shure
Mr. Van Slyke

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2003-S-7
Entitled "Managed Care Payments for Newborn Services"

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2003-S-7) entitled "Managed Care Payments for Newborn Services."

Recommendation #1

Investigate and assess the appropriateness of the MCO kick payments identified in this report. Identify and recover any inappropriate payments.

Response #1

The Department agrees with OSC's recommendation to seek recovery for kick payments associated with "no supporting encounter data reported" and "neither date of birth on record nor reported supporting encounter data". A review of kick payments associated with "no date of birth on record", is currently being completed and recoveries will be made where appropriate. It should be noted that a kick payment is appropriate to be paid to a plan if the newborn is enrolled (enrollment of the mother at time of birth is equivalent to newborn enrollment) and the plan has paid the hospital for the newborn stay.

Recommendation #2

Ensure hospitals comply with the requirement to report the birth of children to Medicaid recipients within five business days of the birth.

Response #2

The Department will follow up with this information to determine the best means of improving compliance with the requirements for reporting newborns for enrollment changes to WMS/MMIS in a timely manner. Please provide the list of hospitals identified in your audit report for review.

Recommendation #3

Improve monitoring of MCOs' compliance with contractual requirements for submitting encounter data, and use MEDS to monitor the quality of care delivered by MCOs.

Response #3

Since the inception of the Medicaid Encounter Data System (MEDS) in 1996, the Department has focused on using MEDS data for monitoring service utilization, continuity of care, access to care and quality of care delivered to managed care enrollees. To this end, systems were developed to monitor the volume and quality of data submitted to the Department.

- Minimum thresholds were established by encounter type.
- Feedback reports were created and shared monthly with MCOs.
- Information systems audits have been performed and medical record review validation studies have been conducted.
- Measures of timeliness of data submission (80% of records submitted within 3 months of service and 95% of records accepted monthly) were established.
- Patterns of service utilization, by plan and category of service are reviewed monthly.
- Targeted studies in areas of underreporting of MEDS (mental health and dental services) have been performed, and
- Statements of Deficiency's have been issued when MCO's fail to meet specified thresholds for encounter data reporting.

The Department of Health is a national leader in the use of Medicaid encounter data for monitoring quality of care. Four measures in the Quality Assurance Reporting Requirements (QARR) use encounter data as the data source. QARR is the annual performance measurement system that is used for an annual report on managed care performance and Medicaid consumer guides. All administrative measures (measures that use data from claims and encounters, not medical chart review) from QARR have been produced by plan, and by plan and county using MEDS for quality improvement purposes. Three QARR measures that measure well care of children and adults are included in an algorithm to reward high quality performing plans with increased premiums up to one percent. In mandatory managed care areas of the state, they are used to assigned members who have not chosen an MCO into higher performing plans. MEDS data has been used for many focused studies performed by our external quality review agent, IPRO, to define populations with specific conditions or diseases (asthma, diabetes, prenatal care). MEDS data has been used, and will continue to be used, to research condition-specific issues, perform small-area analyses, and evaluate patterns of care.