State of New York
Office of the State Comptroller
Division of Management Audit

DEPARTMENT OF HEALTH

PREFERRED PRIMARY CARE PROVIDER PROGRAM

REPORT 95-S-118

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit

Report 95-S-118

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Commissioner
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Dear Dr. DeBuono:

The following is our report on selected aspects of the Department of Health's Preferred Primary Care Provider Program.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit

August 8, 1996

Executive Summary

Department Of Health
Preferred Primary Care Provider Program

Scope of Audit

Primary health care includes family practice services, pediatrics, internal medicine, obstetrics/gynecology, radiology, pharmacy services and laboratory services, and is provided by individual physicians, hospital outpatient departments and freestanding clinics. To improve the health care provided to underserved populations in New York's Medicaid program, in 1990 the State Legislature created the Preferred Primary Care Provider Program, which is administered by the Department of Health (Department). In this program, primary care providers offer services in underserved areas, and in return these providers may be allowed to be paid on the basis of unique reimbursement rates and are exempt from Medicaid restrictions that limit the number of times services may be provided to patients.

In 1991, the State Legislature, in its ongoing efforts to improve the Medicaid program, passed legislation encouraging the development of managed care programs within New York's Medicaid program. In managed care programs, all the medical services needed by program participants are arranged for by a single provider. Department officials expect all the Preferred Providers to eventually be absorbed into managed care programs.

Our audit, which covered the period January 1, 1993 through February 29, 1996, focused on the 81 outpatient departments and freestanding clinics in the Preferred Primary Care Provider Program, and addressed the following questions about the Program:

- Has the Department adequately evaluated the performance of the Program against the goals established for the Program?

- Has the Department adequately monitored whether Preferred Providers comply with Program regulations?

Audit Observations and Conclusions

The legislation creating the Preferred Primary Care Provider Program established goals relating to improving access to health care, ensuring high quality health care, and controlling the cost of health care under the Medicaid program. We found that, even though the Program has been in

operation for more than five years, Department officials have not evaluated Program performance against these goals. As a result, Department officials do not know whether access to health care has improved, quality health care has been provided, or the cost of health care is better controlled in the Medicaid program. We also found that, because Program costs are not summarized by the Department, Department officials cannot evaluate whether the Program is cost-effective.

The Department is responsible for ensuring that Preferred Providers comply with Program regulations. To evaluate this compliance, Department staff visit Preferred Providers to review their records and observe their operations. However, we found that Department staff made such visits to only 25 of the 81 Preferred Providers. We believe this extent of monitoring provides inadequate assurance that the services offered by Preferred Providers are sufficiently accessible and otherwise in accordance with Program regulations. Moreover, in the visits that were made, Department staff identified deficiencies at eleven Preferred Providers. For example, at one Preferred Provider, the records did not indicate that nutritional assessments were done for the patients, as is required by Program regulations. Despite these deficiencies, the Department made follow-up visits to only one of the eleven Preferred Providers to ensure that the deficiencies were corrected.

We recommend improvements in Department procedures for evaluating Program performance and monitoring Program implementation; it is important that these improvements be applied to the managed care programs that will absorb the Preferred Primary Care Provider Program.

Comments of Department Officials

Department officials acknowledge that there is no one written policy stating that program performance be compared to program goals or that program compliance is monitored for all programs. However, they indicate their belief that existing policies, procedures and mechanisms provide adequate guidance to effectively achieve and measure programatic and administrative objectives. The officials also stated they will continue to assure that program performance is adequately monitored and evaluated through established processes and systems, and that they are prepared to issue a formal policy in support of these established procedures.

As indicated in this report, we found that the Department has not evaluated the performance of the Preferred Provider Program against the goals established for the Program. We also found that, while the Department has monitored the compliance of some Preferred Providers with Program Regulations, the extent of this monitoring has not been adequate. Therefore, we believe the Department needs to establish formal policies and procedures to track program costs and monitor performance against program goals.

Contents

Introduction

Background

Medicaid is a joint federal-state entitlement program intended to provide basic medical services for certain groups of low-income persons who are designated as eligible recipients. The Federal and state governments jointly finance the Medicaid program. Within broad Federal limits, states determine the medical services covered by the program and the rates to be paid to the medical providers, and normally make payments directly to the providers who render the services. During the year ended December 31, 1995, New York's Medicaid payments totaled about $22.2 billion, making New York's Medicaid program the nation's most expensive health care program.

The Department of Health (Department) develops medical standards for New York's Medicaid program, monitors the quality of care provided to Medicaid recipients, and sets Medicaid reimbursement rates and fees. The Department is also responsible for developing new ways of providing medical services under the Medicaid program.

In recent years, New York's Medicaid program has increasingly emphasized comprehensive primary care services as a way to maintain or improve the health care provided by the program, while reducing program costs. Primary care services include family practice, pediatric, internal medicine, obstetrics/gynecology, radiology, pharmacy and laboratory services, and are provided by individual physicians, hospital outpatient departments (outpatient departments), and freestanding diagnostic and treatment centers (freestanding clinics). As part of this increased emphasis on primary care services, in 1990 the State Legislature established the Preferred Primary Care Provider Program (Preferred Provider Program) under section 2807(12) of the Public Health Law. This action was taken as part of a larger primary care initiative, the purpose of which was to improve the health care provided to medically underserved and medically indigent populations.

Under the Preferred Provider Program, outpatient departments and freestanding clinics that want to be designated as Preferred Providers must meet the requirements described in Part 85.44 of Title 10 of the New York State Health Code, Rules and Regulations (Regulations). According to the Regulations, Preferred Providers must provide high quality, accessible and comprehensive primary care services and must document the extent to which they reach medically underserved populations in the facility's service area. Preferred Providers are also required to meet many operational standards such as remaining open for at least five days a week for 40 hours during the week with eight additional hours during evenings or weekends, and maintaining 24-hour telephone access to clinical staff for emergencies. To encourage participation in the Program, certain kinds of Preferred Providers are allowed

to use an alternative Medicaid reimbursement methodology in which payment is based upon costs associated with the specific procedures and services performed rather than the facility's general operating costs, and all Preferred Providers are exempt from Medicaid restrictions that limit the number of times services may be provided to patients.

Our audit focused on the outpatient departments and freestanding clinics in the Preferred Provider Program. A total of 81 outpatient departments and freestanding clinics are designated as Preferred Providers. For the year ended December 31, 1995, these providers were paid about $273.1 million for outpatient services provided to Medicaid recipients. This amount includes both the Medicaid payments made under the Preferred Provider Program and Medicaid payments not made under the Program. (As described later in this report, Program costs are not summarized by the Department; consequently, the total amount of Medicaid payments made under the Program is not indicated by Department records.)

In 1991, the State Legislature, in its ongoing efforts to improve the Medicaid program, passed legislation encouraging the development of managed care programs within New York's Medicaid program. In managed care programs, all the medical services that are needed by program participants are arranged for by a single provider. Because such providers generally receive a flat fee for each program participant, rather than a fee for each service provided, they have an incentive to control costs. Due to the expansion of managed care programs in New York's Medicaid program, in 1995 the Department stopped processing new applications from clinics and outpatient departments to become Preferred Providers. The Department anticipates that Preferred Providers will eventually be absorbed into managed care programs.

Audit Scope, Objectives and Methodology

We audited selected aspects of the Preferred Provider Program for the period January 1, 1993 through February 29, 1996. Our audit objectives were to assess the adequacy of the Department's procedures for (1) evaluating the performance of the Preferred Provider Program against the goals established for the Program and (2) ensuring provider compliance with the Program's Regulations. Our audit did not address the individual physicians who were designated as Preferred Providers under a separate regulation, because physicians are normally paid set Medicaid fees for their services; our audit was concerned with Medicaid payments made on the basis of cost-based rates. To accomplish our audit objectives, we interviewed officials from the Department and reviewed Department records. We also reviewed applicable Medicaid payment policies, procedures, rules and regulations.

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 those 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 Department's operation included in our audit scope. An audit includes examining, on a test basis, evidence supporting 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 management's estimates, decisions and judgements. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Department Officials to Audit

Draft copies of this report were provided to Department officials for review and comment. Their comments have been considered in preparing this report and are included as Appendix B.

Within 90 days after 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 therefor.

The Effectiveness of the Preferred Provider Program

We found that the Department has not evaluated the performance of the Preferred Provider Program against the goals established for the Program. We also found that, while the Department has monitored the compliance of some Preferred Providers with Program Regulations, the extent of this monitoring has not been adequate. We recommend improvements in Department procedures for evaluating program performance and monitoring program implementation, and note it is important that these improvements be applied to the managed care programs that will absorb the Preferred Provider Program.

Program Evaluation

The Preferred Provider Program was implemented with the intent of giving medically indigent persons in underserved areas greater access to comprehensive primary health care. The legislation creating the Program established the following six goals:

- Improve access for Medicaid eligible persons to ongoing, comprehensive primary health care and related services.
- Promote the delivery of recognized standards of primary care for Medicaid eligible patients of all ages, including child/teen health program services for children.
- Encourage the development of accessible primary care services in areas of high need and reduce the related morbidity and mortality in underserved areas.
- Stress healthy lifestyles and the prevention and early detection of illness, as well as intervention in illness.
- Improve continuity of care and coordination of primary health care services and reduce episodic, non-emergency use of hospital emergency departments.
- Control systemwide Medicaid costs through the promotion of primary care services and the development of models of service delivery that are cost-effective.

Government agencies managing social services such as health care programs need to gauge the success of different methods of delivering the services so that they can choose the methods that work best. Moreover, to ensure efficient and effective operation, the performance of health care programs should be analyzed periodically. Such an analysis should include measurements comparing the program's performance to the program's goals as well as measurements of the health status and satisfaction of patients.

We determined that the Department has not evaluated the performance of the Preferred Provider Program against the goals established for the Program, because the Department has no formal policy requiring such evaluations for any of its programs. As a result, even though the Preferred Provider Program has been in operation for more than five years, Department officials do not know whether underserved people's access to primary care services has improved, whether the quality of the medical services provided to underserved people has increased, whether the overall healthiness of underserved people has improved, whether the use of hospital emergency rooms for non-emergencies has declined, or whether other costly aspects of the Medicaid program have been at all affected by the Program.

We urge Department officials to establish a formal policy requiring program evaluations. With the expansion of Medicaid managed care programs, periodic evaluations will be needed to provide assurance that the programs are operating as intended and that anticipated savings are being realized.

One of the goals of the Preferred Provider Program is to develop models of service delivery that are cost-effective. However, we found that Program costs are not summarized by the Department. Since Department officials have not calculated Program cost, they cannot evaluate whether the Program has been cost-effective. We recommend that the Department track the cost of the Preferred Provider Program, as well as the cost of the managed care programs that will absorb the Preferred Provider Program.

Recommendations

1. Establish a formal policy requiring that program performance periodically be compared to program goals for all programs administered by the Department.

2. Track the cost of the Preferred Provider Program and the managed care programs.

Program Compliance

Outpatient departments and freestanding clinics must meet the standards described in the Regulations. For example, they must be open for a certain amount of time and must ensure continuity of care for patients by assigning a primary care practitioner or a team of practitioners to treat the patient during each visit. In return for meeting these standards, Preferred Providers are allowed the following benefits:

- Many Preferred Providers may use an alternative Medicaid reimbursement methodology in which they are paid a unique rate for each kind of patient visit. Usually Medicaid clinic providers are paid a general rate based on the costs historically incurred by each provider. A total of 40 of the 81 Preferred Providers are reimbursed through the alternative methodology.

- To ensure that Medicaid reimbursements are paid for necessary services only, certain services may not be reimbursed more than a certain number of times a year without special authorization. For example, for any given patient, no more than 14 physician visits per year may be reimbursed without special authorization. However, Preferred Providers are not subject to these restrictions in seeking reimbursement.

The Department is responsible for ensuring that Preferred Providers comply with the Regulations. To evaluate this compliance, Department staff visit the Preferred Providers to review their records and observe their operations. However, we found that Department staff had made such visits to only 25 of the 81 Preferred Providers. Moreover, these visits were made between January 1993 and November 1994; no Preferred Provider was visited after November 1994. We believe this extent of monitoring is not adequate and provides insufficient assurance that Preferred Providers maintain accessible office hours, ensure continuity of care for patients, or satisfy the other requirements in the Regulations.

Department officials told us they focused their monitoring efforts on the Preferred Providers that use the alternative reimbursement methodology (24

of the 25 visits were made to Preferred Providers using this methodology). However, we question the appropriateness of this focus, because during the year ended December 31, 1995, the Preferred Providers using the standard reimbursement methodology were paid a total of $221.3 million for all outpatient Medicaid services (as described earlier in this report, Preferred Provider Program costs were not separately summarized by the Department), while the Preferred Providers using the alternative reimbursement methodology were paid only $51.8 million for all outpatient Medicaid services.

In the visits that were made, Department staff identified deficiencies at eleven Preferred Providers. For example, Program Regulations require that patients treated by Preferred Providers receive nutritional assessments and psycho/social assessments. Further, when patient problems are identified during these assessments, the providers are required to make appropriate referrals for counseling.

However, for one provider Department staff found no evidence of nutritional assessments for seven of 24 patient records examined and no evidence of psycho/social assessments for four of 24 records examined. Also, there was no evidence of an appropriate counseling referral for three of four patients having problems that were identified during the psycho/social assessments. One of the patients who did not receive a nutritional assessment suffered from diabetes, and one patient who claimed during the psycho/social visit that she had been sexually abused did not receive a referral for counseling. Despite these types of deficiencies, the Department made follow-up visits to only one of the eleven Preferred Providers to ensure that the deficiencies were corrected. Considering the extent to which both initial visits and follow-up visits were not made, we conclude that Department monitoring efforts provide inadequate assurance that Preferred Providers are complying with Program Regulations.

Department officials told us that an independent contractor also evaluated the extent to which Preferred Providers complied with Program Regulations. However, we determined that this evaluation, which was part of a larger evaluation of services provided to certain Medicaid recipients, addressed only 23 Preferred Providers and only some of the Program Regulations. As a result, we maintain that the Preferred Provider Program has not been adequately monitored.

We note the Department does not have a policy requiring that program compliance be monitored. We believe such a policy would provide better assurance that the programs administered by the Department are adequately monitored. In particular, we note the need to monitor compliance with the regulations governing the managed care programs that will absorb the Preferred Provider Program.

Recommendation

3. Establish a policy requiring that program compliance be monitored for all programs administered by the Department.

Major Contributors to This Report

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July 18, 1996

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RE: OSC Draft Audit 95-S-118 Preferred
Primary Care Provider Program

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit 95-S-118 entitled, "Preferred Primary Care Provider Program".

Thank you for the opportunity to provide comments.

Sincerely,

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

enclosure

Appendix B

Department of Health Comments on the Office of the State Comptroller's Audit Report "Preferred Primary Care Provider Program" (95-S-118)

The Department of Health has reviewed the draft audit "Preferred Primary Care Provider Program" and has the following comments on the recommendations:

Recommendation # 1 - Establish a formal policy requiring that program performance periodically be compared to program goals for all programs administered by the department.

Recommendation # 3 - Establish a policy requiring that program compliance be monitored for all programs administered by the Department.

Response - The Department agrees that there is no one written policy stating that program performance be compared to the program goals or that program compliance is monitored for all programs. However, in the Department's decentralized organizational structure, individual program managers are held accountable to provide assurance that programs are operating in an economical, effective and efficient manner. Due to the complexity of the Department's programs, standardized approaches to program monitoring and/or evaluation may not be appropriate. As such, many policies, procedures and mechanisms have been established for program managers that provide guidance to effectively achieve and measure programmatic and administrative objectives.

Managers employ a number of mechanisms - internal and external - to assure that program performance is consistent with program goals. Monitoring strategies vary depending on the type of program and funding source. The reviews can include use of external experts such as Island Peer Review Organization to conduct utilization reviews, accounting firms to conduct reviews of Federal and select State grants and other governmental audit agencies. The internal reviews include monitoring of program performance and compliance through site visits and comparative analysis of program achievements (status reports, budget statements, etc.) to the established goals (work plan). In addition, renewal or continued grant funding is dependent upon review and approval of the contractor's final report that details program achievements.

The Department remains committed to targeting its limited resources to achieve its goals. It will continue to assure that program performance is adequately monitored and evaluated through its established processes and systems such as: self assessment through the annual internal control program, project management reviews, annual surveys and/or reviews of health care providers. While this system provides adequate assurance that program performance and compliance is effectively monitored, the Department is prepared to issue a formal policy in support of these established procedures.

Recommendation #3 - Track the cost of the Preferred Provider Program and the managed care programs.

Response - The Department of Health agrees to track the cost of the preferred provider program and the managed care programs. The department will issue a notice to its managers that highlights these responsibilities and will consider offering training courses to improve management skills in performance measurement and monitoring.