

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

**DEPARTMENTS OF HEALTH AND
SOCIAL SERVICES**

**MANAGED CARE RATE SETTING
AND PAYMENT PRACTICES**

REPORT 95-S-135



H. Carl McCall
Comptroller



State of New York Office of the State Comptroller

Division of Management Audit

Report 95-S-135

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Dear Dr. DeBuono and Mr. Wing:

The following is our report on practices of the Department of Health and the Department of Social Services relating to setting managed care provider payment rates and processing providers' monthly capitation premium claims.

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*

February 6, 1997

Executive Summary

Departments Of Health And Social Services Managed Care Rate Setting And Payment Practices

Scope of Audit

New York State's Medicaid program, which provides medical assistance to needy people, is administered by the Department of Health (Health) and the Department of Social Services (Social Services). The Medicaid Management Information System (MMIS) is a computerized payment and reporting system, which processes and pays claims for services to Medicaid recipients. MMIS pays providers' claims using the fee-for-service or the capitation method. Under fee-for-service, MMIS pays a claim for every Medicaid-eligible service delivered; under capitation, MMIS pays a managed care provider a monthly premium based on a negotiated payment rate, regardless of the number of services provided. Health is responsible for setting managed care payment rates. Health's policy establishes the managed care payment limit at 95 percent of the approximate fee-for-service cost for similar recipients. Social Services coordinates the activities of the State's 58 local social services districts, which include enrolling recipients in managed care plans. For the two-year period ended December 31, 1995, Medicaid paid premiums of about \$1.6 billion to managed care providers.

Our audit addressed the following questions about practices of Health and Social Services related to managed care rate setting and claims processing for the period January 1, 1990 through June 30, 1996:

- ! Have Health and Social Services established adequate controls over the development and use of managed care payment rates?
- ! Do Health and Social Services take the steps needed to ensure the accuracy of providers' monthly premium claims before MMIS pays the claims?

Audit Observations and Conclusions

We found that Health and Social Services have not established adequate controls over the managed care rate setting process to ensure that rates are economical, set according to uniform procedures and established in a timely manner. Further, we found that Health and Social Services need to activate certain MMIS edits to ensure the accuracy of managed care claims.

Health develops managed care rates based on a provider's geographic region, recipient demographic data, historical fee-for-service cost data and the information in detailed rate proposals submitted by managed care providers. After Health and the provider arrive at a mutually acceptable rate, it must be approved by Social Services, the Division of the Budget and the Federal

Health Care Financing Administration. We found that, although Health follows a routine rate setting process, management has not established adequate controls over the process to ensure that rates are accurately set according to uniform procedures and established in a timely manner. For example, we found that Health extended a provider's existing rates for six months without documenting management's approval of the extension. Since the subsequent rates were lower, this action allowed the provider to receive an estimated \$3.4 million over the payment limit. As these funds are not recoverable, Health officials should evaluate the financial impact before granting such extensions. Further, we found that Social Services developed unauthorized "transition rates" for recipients whose eligibility type had changed. These rates were set without the knowledge of Health's rate setters and were used by MMIS without approval. To improve the consistency of managed care rate setting, we recommend that Health develop a procedures manual and document exceptions to procedures. We also recommend that Health monitor the process of updating approved payment rates to MMIS to ensure this information is accurate. We identified three errors in rate information entered on MMIS, one of which allowed the provider to be overpaid about \$2.4 million. After we notified Social Services, staff corrected MMIS records and recovered the \$2.4 million. (See pp. 5-7)

We found that, in 1995, about 96 percent of the 2,440 managed care rates were recorded on MMIS an average of nine months after the rate's effective date. Because Health does not effectively track this process, we could not determine all the reasons why it took so long to set rates. We believe one reason why managed care rates were set late was that many providers do not comply with Health's requirement to submit proposals at least 90 days before the start of the rate period. Delays in using new rates can potentially result in lost interest income for the State or an interest cost for providers. To improve rate setting efficiency, we recommend that Health establish a means of monitoring the rate setting process, and evaluate imposing penalties on providers who submit proposals late. (See pp. 7-8)

MMIS uses edits that check a provider's claim for reasonableness before it is paid. In reviewing 19 managed care edits, we found that four were inactive for New York City claims, and a fifth was set to ignore managed care claims. We estimate that Medicaid could save at least \$5 million a year if these edits were activated. We also found that some MMIS records lacked data (e.g., a recipient's date of birth) needed to verify a claim's reasonableness. We recommend that all MMIS managed care edits be activated to ensure appropriate payments, and that MMIS records be verified for completeness. (See pp. 13-15)

Comments of Officials

Health and Social Services officials agreed with our audit recommendations. Social Services officials investigated the downstate claims affected by the four inactive MMIS edits and identified \$3.8 million in potential overpayments which were referred for collection.

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Introduction

Background

New York State's Medical Assistance Plan (Medicaid), established under Title XIX of the Federal Social Security Act to provide medical assistance to needy people, is administered by the Department of Health (Health) and the Department of Social Services (Social Services). Social Services contracts with a fiscal agent to operate the Medicaid Management Information System (MMIS), a computerized payment and information reporting system. MMIS processes Medicaid claims and make payments to health care providers for services rendered to recipients.¹

There are two different methods to pay providers: fee-for-service and capitation. Under the fee-for-service method, MMIS pays a provider claim every time a recipient receives a Medicaid-eligible service. Under the capitation method, MMIS pays managed care providers a monthly fee based on an agreed upon capitation payment rate, regardless of the extent of services provided. In exchange for this monthly rate, managed care providers are responsible for delivering various medical services to the Medicaid recipients enrolled with them. Social Services coordinates the activities of the State's 58 local social services districts (local districts), which include enrolling individual recipients in managed care plans. Health is responsible for the Medicaid Managed Care program and sets the monthly capitation premiums called managed care payment rates. For the two-year period ended December 31, 1995, Medicaid paid about \$1.6 billion in capitation premiums to managed care providers.

Health's managed care payment rates vary according to both the characteristics of individual recipients and the geographic region the provider serves. Health has developed various actuarial groups based on recipient characteristics (such as age, sex and type of Medicaid eligibility); further, local districts authorize various provider reimbursement rates for residents who are Medicaid recipients. Because there are so many variables, a managed care provider can be paid on the basis of from six to more than 300 possible rates for various classes of recipients and geographic regions. Using information available from Social Services and Health about the Medicaid recipient population they will be expected to serve, a provider submits a detailed rate

¹ During our audit period, Social Services administered Medicaid and MMIS through its fiscal agent, Computer Sciences Corporation. After October 1, 1996, the Department of Health became responsible for administering Medicaid and MMIS.

proposal (proposal) which states, and provides a justification for, the monthly rates it is willing to accept to provide services to each class of recipient.

Health has a policy that limits a provider's managed care rates to 95 percent of the approximate fee-for-service cost for similar recipients in the provider's geographic region. To determine the fee-for-service cost for the rate period, Health applies several technical factors (based on historical cost trends within the Medicaid program) to fee-for-service information it obtains from MMIS. Health then uses this information, along with the proposal, to develop the rates it is willing to pay the provider. After Health and the provider arrive at mutually acceptable rates, the rates must be approved by Social Services, the Division of the Budget and the Federal Health Care Finance Administration. Health then submits the rate information to Social Services for MMIS to use in paying monthly premium claims.

Health used the above process to develop rates for managed care providers in all 58 local districts during the period covered by our audit. Health continues to use this rate setting process in 25 districts; however, effective April 1, 1996, Health began using competitive bidding procedures in 33 districts to set rates for managed care providers.

As of December 31, 1995, about 650,000 of about 3.6 million eligible Medicaid recipients were enrolled in managed care programs on a voluntary basis. Through an initiative called the Partnership Plan, Health and Social Services are trying to expand enrollment in managed care to about 2.8 million Medicaid recipients. However, Social Services and Health officials have requested a waiver from the Federal government to allow them to convert the State's voluntary enrollment into a mandatory system.

Audit Scope, Objectives and Methodology

We audited the policies and procedures of Health and Social Services for setting managed care payment rates and for processing providers' monthly premium claims for the period January 1, 1990 through June 30, 1996. The objectives of our performance audit were to assess whether Health and Social Services have established adequate controls over the development and use of managed care payment rates, and whether these agencies take the necessary steps to ensure the accuracy of the providers' monthly premium claims before MMIS pays the claims. Our audit did not address the establishment of rates for partially capitated managed care plans or for social health management organizations.

To accomplish our audit objectives, we interviewed officials from Health and Social Services and reviewed applicable Medicaid payment policies, procedures, rules, regulations, rate setting documentation and internal controls

that pertain to setting managed care provider payment rates and paying provider monthly capitation premium claims. We developed computer programs to extract, analyze and evaluate; (1) all managed care claims paid for the two years ended December 31, 1995, and (2) the managed care claims paid at the rate authorized for recipients under the age of one for the six years ended December 31, 1995.

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 Social Services and Health that are included in our audit scope. Further, these standards require that we understand the agencies' internal control structures and compliance with those laws, rules and regulations that are relevant to those agency operations 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 the estimates, judgments and decisions made by management. 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 Health and Social Services Officials to Audit

Draft copies of this report were provided to Health and Social Services officials. Their comments have been considered in preparing this report, and are included as Appendix B and Appendix C, respectively. In addition to the matters discussed in this report, we provided Health and Social Services officials with detailed comments concerning other matters. Although these matters are of lesser significance, our recommendations related to these matters should be implemented to improve operations.

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

Controls Over Development of Payment Rates for Managed Care Providers

Management is responsible for establishing and maintaining a system of controls to ensure that managed care rates are economical, accurately set according to uniform procedures and established in a timely manner. While Health generally follows a routine process to set Medicaid payment rates for managed care providers, we found that Health has not fully established adequate internal controls over the rate setting process.

Developing Managed Care Rates

Health develops managed care rates according to a process which, as described earlier in this report, uses recipient data from Social Services, fee-for-service cost data from MMIS and detailed rate proposals submitted by managed care providers. However, we found that Health does not have a procedures manual describing the steps that program analysts should follow in this rate setting process. Therefore, staff may not set rates in a uniform manner and some providers may be inappropriately paid.

We found that MMIS pays providers for some recipients according to unapproved “transition rates” that are developed outside Health’s rate-setting process. When a managed care provider enrolls a Medicaid recipient, the recipient has a Medicaid eligibility type that corresponds to a rate set by Health. However, the recipient’s eligibility type can change after enrollment, and Health has not set managed care rates for every type of Medicaid eligibility. Social Services allows a recipient who has changed eligibility type to stay in the managed care plan, even if Health has not set a corresponding managed care rate. Social Services staff select an existing rate they believe should correspond to the new eligibility type, and then record the rate on MMIS records. This “transition rate” allows the provider to be paid for such recipients. However, Social Services did not have documentation authorizing the development of “transition rates.” As a result, MMIS used managed care rates that were developed without the knowledge of Health’s rate setters, and were not approved, as required, by the Division of the Budget and the Federal Health Care Finance Administration.

During our audit period, Health sent approved managed care rates to Social Services, whose staff recorded the information on MMIS. Since these rates determine provider payments, any error in the information will cause MMIS to incorrectly pay managed care claims. We observed that neither Social Services nor Health had procedures to monitor this process to ensure that the correct information was entered on MMIS records. While comparing authorized managed care rates and transition rates, we identified three errors

(one for each of three providers) in the rate information that Social Services had entered on MMIS records. For one provider, Social Services incorrectly recorded the start date for the provider's rates. This error allowed the provider to receive \$2.4 million more than it should have from Medicaid. For the other two providers, Social Services had incorrectly recorded transition rates on MMIS resulting in minimal mispayments. After we notified Social Services of the three errors, staff corrected MMIS records and recovered the \$2.4 million.

Health normally sets annual rates for each provider. We reviewed the documentation that Health staff prepared for the development of payment rates for eight providers, who together accounted for about half of Medicaid's managed care expenditures in calendar years 1994 and 1995. We found that, after experiencing delays in setting one of the eight provider's rates, Health staff extended the provider's existing rates for six months without documentation of management approval of the extension. We estimate that this rate extension allowed the provider to receive an additional \$3.4 million from Medicaid because the rate's payment amount exceeded the State's managed care payment limit (95 percent of fee-for-service costs). Health officials responded that when they set the provider's new rate, which was lower, the Medicaid program saved over \$7 million when compared to fee-for-service costs. While we acknowledge the achievement of these savings, we contend that Medicaid could have saved more money if the provider's rates had been kept to the managed care payment limit during the six-month extension period. Therefore, the Medicaid program did not receive the full benefit of the lower rate. Health officials also stated that Health management had approved the extension; however, Health officials had no documentation of this approval, nor had they obtained the required approvals from the Division of the Budget and the Federal Health Care Finance Administration. We believe that documentation of such situations is essential to verify management's knowledge and approval of (1) a departure from established rate setting procedures, and (2) the financial impact of granting the extension. A procedures manual that identifies situations requiring management approval would provide greater control over the rate setting process.

In reviewing the rate setting documentation for the eight providers, we found little written evidence of the rate negotiation process between Health and the provider, and no evidence of supervisory review of the process. We observed that Health did not require the analysts to document significant provider contacts, both verbal and written, that occurred during rate negotiations. Without such documentation, management lacks assurance that staff obtained all the information necessary to assist in developing the provider's rates. However, we did observe that Health made improvements in its rate setting documentation. During 1995, analysts began developing documentation describing key points of the negotiation process, any additional steps undertaken or information considered to adjust the initial rates and the rationale used to justify the provider's final negotiated rates. However, Health has not formalized these additional documentation requirements, or the need for supervisory review, in written procedures.

We found that Health did not set managed care provider rates in a timely manner. We found that during calendar year 1995, about 96 percent of the 2,440 managed care rates were recorded on MMIS late, with the updating occurring an average of nine months after the rate's effective date. Therefore, MMIS made substantial payments without having the current rate information. In reviewing the rate setting for the eight large managed care providers noted earlier, we found that Health had set all their rates late. For seven of these providers, it took an average of 14 months after their rates' effective dates for the current rates to be recorded on MMIS. Only one of these seven providers had its rates recorded on MMIS within a year of their effective date. As previously mentioned, Health decided to extend the eighth provider's existing rates for an additional six months. Health extended the rates after analyzing the provider's rate proposal for eight months after the effective date. Even with the extension, it still took an additional year for the new rate information to be recorded on MMIS. Since Health lacks an effective monitoring process to track a provider's rate development, we were unable to identify all of the reasons why it took so long to set managed care payment rates.

We believe that one reason why managed care rates are set late is that providers do not send their rate proposals to Health in a timely manner. Health guidelines require that providers submit their rate proposals at least 90 days prior to the start of the rate period (effective date of the rate). However, Health has not developed procedures to foster provider compliance with its information submission guidelines; such as sending letters to managed care providers to remind them of the approaching deadline. For the eight providers reviewed, we found that only one provider submitted its rate proposal on time. However, this provider submitted inadequate information, which hindered Health's ability to analyze the rate proposal. Further, the potential exists for providers who anticipate receiving lower managed care

rates to delay submitting their proposals in order to continue to receive payments at the previous higher rates. The financial impact of these retroactive adjustments can be significant, resulting in the State or provider owing the other party millions in additional payments. For example, when the 1994 rates for one managed care provider were finally set in October 1995, the provider had to reimburse \$9.5 million to the State because the new rates were lower. This resulted in the State losing interest income on money it overpaid the provider and the provider having to repay the State a large amount of money.

Setting the Upper Payment Limit

Health has a policy which sets an upper payment limit for a provider's managed care rates at 95 percent of the approximate fee-for-service costs for similar recipients in the provider's geographic region. As noted earlier, Health calculates this upper payment limit by applying certain claim payment adjustment factors (based on historical trends within Medicaid) to these fee-for-service costs. Since errors in either the cost data or the adjustment factors affect the calculation of the upper payment limit, they may cause Health to set inappropriate rates.

During our audit period, the annual file of historical Medicaid recipient cost data, which was produced from MMIS by the Medicaid fiscal agent, was used by numerous individuals within Social Services and Health to evaluate the Medicaid program. We found that a Social Services official instructed the fiscal agent to change the file's format and make all payment amounts positive numbers, including negative payment amounts associated with adjusted and voided claims. This change could have caused Health to set inflated managed care rates based on an overstated fee-for-service upper payment limit. After we informed Health officials about this format change, they were able to obtain the annual file in the proper format, averting any potential overpayments. However, since Health's managed care rate setters are not notified of changes to this file, this situation may recur.

We believe that Health could maintain more accurate cost records, and reduce the risk of unanticipated format changes, by streamlining the process of calculating the upper payment limit. We found that during our audit period, Health followed a cumbersome process to obtain and manipulate the recipient annual claims payment file. The Medicaid fiscal agent produced the recipient annual claims payment file, which was sent to Health. At Health, officials use numerous mainframe computer programs to separate the recipients into local district actuarial groupings, while other computer programs manipulate the fee-for-service data to include the costs for recipients who might enroll with a managed care provider. We believe that Health should use the fiscal agent's computer to manipulate the fee-for-service data used to generate the required

annual file, thereby making this process more efficient and less susceptible to error.

We also found that Health should improve controls over the calculation of the claim payment adjustment factors to ensure that these factors are uniformly determined and accurately applied. Health applies the claims payment adjustment factors to historical fee-for-service information to arrive at the upper payment limit. One of the claim adjustment factors trends the historical Medicaid payment data to the period covered by the managed care rate. For this trend factor, Health uses a regression analysis to determine changes in both recipient cost and service utilization in Medicaid. Health has to enter the results of the regression analysis into a computer program which evaluates these Medicaid trends for a two, three or four-year period.

Staff determine what kind of analysis (i.e., for two, three or four years) results in the most appropriate trend factor for setting the 95 percent fee-for-service limit. The difference in data can significantly affect the limit. For example, if the four-year, rather than the three-year trend were used for recipients with Home Relief eligibility, the fee-for-service limit would have been reduced by about 10 percent. Typically, Health uses the trend factor for the three-year period because staff believe that it appears to be the most reasonable. However, Health lacks written policies and procedures to guide staff in their review and analysis of trend factors. Without such guidance, management lacks assurance that the appropriate trend factors are chosen. While staff involved indicated that they check one another's work, we did not find evidence of supervisory review of the application of trend factors to the fee-for-service data. We also noted that Health incorrectly entered one of the regression analysis factors in the computer program, which resulted in an overstatement of the trend factor for Home Relief recipients. Health officials estimate that, as a result, providers may have been overpaid about \$50,000 for 1995 managed care rates.

Social Services and the Office of the State Comptroller regularly perform Medicaid audits which identify millions of dollars in overpayments made to fee-for-service providers. However, when Health officials set managed care payment rates, they do not reduce Medicaid's historical fee-for-service cost data by the amount of overpayments identified by such audits. Therefore, the data Health is using for its trend analyses is overstated by the amount of these identified overpayments. To ensure more accurate cost data, we believe that Health should develop an adjustment factor that reduces historical fee-for-service cost data by the overpayments identified by these audits.

Recommendations

To Health:

1. Enhance the internal controls over the development of payment rates for managed care providers by:
 - a) developing a managed care rate setting procedures manual to guide staff and to help ensure that all rates are consistently developed;
 - b) ensuring that all managed care rates, especially transition rates, are documented and approved;
 - c) establishing a monitoring process to ensure that managed care rates are properly recorded on MMIS for use in paying providers' claims; and
 - d) formalizing rate setting documentation requirements (including requirements for evidence of supervisory review, management approval of unique situations and progress of the rate negotiation process).
2. Develop an effective system of internal controls to help ensure the timely setting of payment rates for managed care providers.
3. Establish procedures to foster the timely submission of rate proposals by managed care providers. In developing the procedures, evaluate the feasibility of establishing penalties for providers who do not submit rate information within Health Department time frames.
4. Investigate the feasibility of having the fiscal agent develop new MMIS programs which could consolidate Health's existing computer programs with those used to create the annual file.
5. Investigate the error in the regression analysis factor used to trend costs for Home Relief recipients; recover any overpayments.
6. Consider including an audit adjustment factor when determining the fee-for-service costs for the managed care rate to arrive at the 95 percent upper payment limit.

Processing Managed Care Claims

Managed care providers submit monthly claims to receive their capitation premiums. MMIS has computer programs, which include edits, that check providers' claims against preestablished criteria to ensure that the claims are reasonable and appropriate before they are paid. MMIS is designed to allow officials to set an edit's status to deny the claim or to hold it for manual review by staff. Also, officials can set an edit to ignore (bypass) the claim and allow the claim to continue through the payment process. The edits can also be focused on claims for New York City recipients or claims from recipients in the rest of the State (upstate). We reviewed 19 MMIS managed care edits and found that four edits were set to deny certain managed care claims for upstate recipients, but not for New York City recipients. The four edits help ensure that managed care providers are paid only for recipients enrolled in their plan, and that the claimed service dates are appropriate when compared to the date of a recipient's enrollment in the managed care plan. By bypassing the managed care claims for New York City recipients, MMIS may have paid invalid claims. To assess the potential impact of these four inactive edits on claims payment, we reviewed MMIS reports of claims for upstate recipients that were denied by the four edits. We determined that, during State fiscal year 1995-96, the four edits denied about \$4.9 million in inappropriate managed care claims for upstate recipients. Upstate recipients represent less than half of all the Medicaid recipients enrolled in managed care plans. Therefore, if the four edits had been applied to managed care claims from New York City during this period and had achieved similar results, the Medicaid program would have saved at least an additional \$4.9 million. We have no reason to believe that using these edits in processing New York City managed care claims will not produce similar Medicaid savings annually.

Social Services officials stated that when the four edits were implemented, the necessary reference files for New York City recipients were not available. However, we determined that the reference files have been available for several years. After our inquiries, Social Services took steps to begin using the four edits to review managed care claims for New York City recipients and reported in response to our draft report that they identified \$3.8 million in potential overpayments which were referred for collection.

We also found that another edit, which is intended to ensure that providers are paid at the proper rate, is set to bypass managed care claims. Health determines the appropriate rates providers are supposed to use in billing claims for monthly managed care premiums. In paying these claims, MMIS matches the stated rate on the claim against certain recipient characteristics

(age, sex and type of Medicaid eligibility) to determine the appropriate rate. MMIS has an edit which denies the claim when the system is unable to determine the appropriate rate. However, this edit is set to ignore managed care claims, and allow the claims to continue through the payment process. Therefore, MMIS reimburses the provider according to the rate information as stated by the provider without verifying its accuracy.

For example, during the six-year period ended December 31, 1995, we found that MMIS potentially overpaid approximately \$139,000 to managed care providers who used the “one year and under” rate code (one of the highest paying payment rates) for recipients who were well over the age of one, including one recipient who was 64 years old. These providers received incorrect payments because MMIS did not verify the accuracy of the claims information. (We provided Social Services with reports of these overpayments.)

For MMIS edits to work properly, MMIS uses reference files to pay managed care providers based on the recipient's age, sex and type of Medicaid eligibility. MMIS determines a recipient's age by comparing the recipient's date of birth from its reference files to the date of service on the managed care claim. However, on June 30, 1996, we found that approximately 75,000 Medicaid eligible recipients had no date of birth on the MMIS reference file. About 40 percent of these recipients had been Medicaid-eligible for over one year, and several of the recipients had been eligible for at least two years. Both Health and Social Services lack procedures to identify these recipients and take steps to determine their date of birth. If such a recipient is enrolled in managed care, MMIS cannot determine the person's age based on its reference files, but must rely on the information provided by the managed care provider. Social Services' Quality Assurance and Audit unit has identified managed care providers that were paid monthly premiums for recipients who were not yet born. We believe that these erroneous payments occurred because MMIS reference files do not contain the correct date of birth for all recipients.

We tested 25 recipients from one upstate county for whom the MMIS recipient reference files did not have a date of birth. Using Health's vital statistics file, which contains birth certificate information such as date of birth, sex and parent information, we were able to identify the date of birth for 9 of the 25 recipients. Currently, Social Services does computer matches with Health's vital statistics file to identify deceased recipients. We believe that this match should be expanded to ascertain the date of birth of Medicaid recipients enrolled in managed care plans.

Recommendations

To Health and Social Services:

7. Periodically review all MMIS managed care edits and evaluate the appropriateness of their settings; activate the four identified managed care edits for New York City recipients.
8. Investigate and recover overpayments for all managed care claims which should have been denied by existing MMIS edits.
9. Modify MMIS to select the appropriate managed care payment rate in all instances.
10. Develop procedures to identify Medicaid recipients who lack date of birth information and then record this information on MMIS by:
 - a) verifying the accuracy of the recipient's date of birth through computer matching with Health's vital statistics file; and
 - b) developing controls to ensure that a recipient's date of birth cannot remain "unknown" on MMIS reference files for longer than six months.

Major Contributors to This Report

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January 10, 1997

Mr. Kevin McClune
Audit Director
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Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 95-S-135 entitled, "Managed Care Rate Setting and Payment Practices".

Thank you for the opportunity to comment.

Very truly yours,

A handwritten signature in cursive script that reads "Barbara DeBuono".

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

enclosure

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 95-S-135 Entitled
"Managed Care Rate Setting and Payment Practices"

Recommendation 1: Enhance the internal controls over the development of payment rates for managed care providers by:

- a. developing a managed care rate setting procedures manual to guide staff and to help ensure that all rates are consistently developed;
- b. ensuring that all managed care rates, especially transition rates, are documented and approved;
- c. establishing a monitoring process to ensure that managed care rates are properly recorded on MMIS for use in paying providers' claims; and
- d. formalizing rate setting documentation requirements (including requirements for evidence of supervisory review, management approval of unique situations and progress of the rate negotiation process).

Response 1: We agree with the above recommendations and have already begun to implement several of the recommendations. A plan will be undertaken to develop procedure manuals and document all rate approvals.

Recommendation 2: Develop an effective system of internal controls to help ensure the timely setting of payment rates for managed care providers.

Response 2: We agree that timely setting of payment rates is important. Use of a bidding process, as under the recent Partnership Plan RFP, should ensure a timely rate process. A system of internal controls will also be developed to ensure compliance under the negotiated rate process.

Recommendation 3: Establish procedures to foster the timely submission of rate proposals by managed care providers. In developing the procedures, evaluate the feasibility of establishing penalties for providers who do not submit the information within Health Department time frames.

Response 3: The Department agrees to establish procedures for the timely submission of rate proposals by managed care providers. The new contract under the Partnership Plan provides for imposition of fines for providers which do not submit timely information.

Recommendation 4: Investigate the feasibility of having the fiscal agent develop new MMIS programs which could consolidate Health's existing computer programs with those used to create the annual file.

Response 4: We will investigate this recommendation as part of the MMIS systems redesign RFP process.

Recommendation 5: Investigate the error in the regression analysis factor used to trend costs for Home Relief recipients; recover any overpayments.

Response 5: The error in the analysis has been investigated and discussed with auditors. We believe that the amount of any potential rate adjustment is immaterial and also believe that we do not have the ability to recover potential overpayments based on the contractual agreement in place.

Recommendation 6: Consider including an audit adjustment factor when determining the fee for service costs for the managed care rate to arrive at the 95 percent upper payment limit.

Response 6: We will explore the potential for such an adjustment.

Recommendation 7: Periodically review all MMIS managed care edits and evaluate the appropriateness of their settings; activate the four identified managed care edits for New York City recipients.

Response 7: We agree that managed care edits should be periodically reviewed. The four NYC edits have been activated, as indicated in the audit.

Recommendation 8: Investigate and recover overpayments for all managed care claims which should have been denied by existing MMIS edits.

Response 8: The audit report specifically refers to the four NYC edits which would have ensured that a managed care provider is paid only for recipients enrolled in its plan for the time period covered by the capitation payment. We agree that any payment made for recipients now enrolled in the plan for the period for which the payment is applicable should be recouped, once it is verified that the plan did not provide services for such recipient for that time period.

Recommendation 9: Modify MMIS to select the appropriate managed care payment rate in all instances.

Response 9: As described in the audit report, MMIS relies on managed care plan information to select the appropriate payment only when information is missing from the State's own MMIS reference file. We agree that such missing information should be remedied, and that additional follow-up of local social services offices, who are responsible for providing such information, should be initiated.

Recommendation 10: Develop procedures to identify Medicaid recipients who lack date of birth information and then record this information on MMIS by:

- a. verifying the accuracy of the recipient's date of birth through computer matching with Health's vital statistics file; and
- b. developing controls to ensure that a recipients's date of birth cannot remain "unknown" on MMIS reference files for longer than six months.

Response 10: We agree that procedures should be instituted to attain missing data of birthing information on MMIS. We believe that computer matching to the Health Department vital statistics file does not provide adequate results; however, we agree that the recipient date of birth should be verified and input within 6 months, and will work with the plans and local districts to ensure compliance.

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

BRIAN J. WING
Acting Commissioner



DAVID P. AVENIUS
Deputy Commissioner
Management Support and
Quality Improvement

January 13, 1997

Mr. Kevin M. McClune
Director of State Audits
Office of the State Comptroller
A.E. Smith State Office Building
Albany, New York 12236

Re: OSC Draft Report: DSS-DOH Managed
Care Rate Setting and Payment
Practices 95-S-135 (96-032)

Dear Mr. McClune:

We have reviewed the referenced draft report and the following are our comments to those recommendations that are relative to this Department.

Recommendation: Investigate and recover overpayments for all managed care claims which should have been denied by existing MMIS edits.

Response: The Department's Office of Quality Assurance and Audit (QA&A) has investigated the downstate claims effected by the four MMIS edits (609, 695, 694 and 697) and identified \$3.8 million in potential overpayments which were referred for collection. It should be noted that the \$3.8 million identified by QA&A was less than the report's purported savings of \$4.9 million. In addition, QA&A is currently reviewing the auditors' report involving possible inappropriate rate code payments as a result of not having MMIS edit 716 activated and will take whatever appropriate action is deemed necessary.

Recommendation: Periodically review all MMIS managed care edits and evaluate the appropriateness of their settings, activate the four identified managed care edits for New York City recipients.

Recommendation: Modify MMIS to select the appropriate managed care payment rate in all instances.

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Recommendation: Develop procedures to identify Medicaid recipients who lack date of birth information and then record this information on MMIS by:

- o verifying the accuracy of the recipient's date of birth through computer matching with Health's vital statistics file; and
- o developing controls to ensure that a recipient's date of birth cannot remain "unknown" on MMIS reference files for longer than six months.

Response: The Department will work with the Department of Health to effect any necessary changes to assure that accurate and up-to-date information is recorded on the MMIS on behalf of eligible recipients.

Thank you for sharing this report with us and we trust our comments are responsive to the issues raised.

Sincerely,



David P. Avenius
Deputy Commissioner
Management Support and
Quality Improvement