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

DEPARTMENT OF HEALTH AND DEPARTMENT OF SOCIAL SERVICES

CONTROLS OVER CERTAIN MEDICAID PAYMENTS TO MANAGED CARE PROVIDERS

REPORT 96-S-67

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit

Report 96-S-67

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Dear Dr. DeBuono and Mr. Wing:

The following is our report on the Department of Health's and the Department of Social Services' practices for paying managed care providers for certain Medicaid recipients.

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

April 4, 1997

Executive Summary

Department Of Health and Department Of Social Services Controls Over Certain Medicaid Payments To Managed Care Providers

Scope of Audit

In managed care programs, the medical services needed by program participants are arranged for by a single service 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. State legislation in 1991 encouraged the development of managed care programs in New York's Medicaid program, which pays for medical services for needy people. During the two years ended December 31, 1995, New York's Medicaid program paid about $1.6 billion in fees to managed care providers. New York's Medicaid program is administered by the Department of Health (Health) and the Department of Social Services (Social Services). Officials intend to enroll about 2.8 million (87 percent) of New York's Medicaid recipients into managed care programs; as of December 31, 1996, the enrollment rate was about 20 percent.

Our audit addressed the following questions about Health's and Social Services' practices for paying certain kinds of Medicaid claims from managed care providers for the period January 1, 1990 through June 30, 1996:

- Are the practices adequate for paying claims relating to Medicaid recipients under the age of one?
- Are the practices adequate for paying claims relating to Medicaid recipients with other health insurance coverage?

Audit Observations and Conclusions

We identified Medicaid overpayments and duplicate health insurance coverage for Medicaid recipients in managed care programs. We also found that the circumstances surrounding some of the inappropriate claims need to be investigated to determine whether the claims were the result of error or fraud.

The monthly Medicaid fees paid to managed care providers vary for different types of Medicaid recipients, and are much higher for recipients under the age of one because of the costs associated with birth, particularly premature and low-weight births. Using computer-assisted audit techniques, we reviewed all the managed care claims relating to recipients under the age of one for the six years ended December 31, 1995. We found that many of these claims were overpaid because the recipient became one-year old during the period covered by the claim, but the automated claims processing system incorrectly calculated the payment at the rate authorized for recipients under the age of one. We determined that these overpayments totaled as much as $19.5 million.

After we informed Health officials of our findings, changes were initiated that should prevent such overpayments in the future. However, Health officials stated their belief that they cannot recover the $19.5 million of overpayments because of the contractual relationship between the managed care providers and the local social service districts, whereby the entire financial risk for providing recipients with medical services is transferred to the managed care provider in exchange for a prepaid capitation payment. We disagree with the position taken by Health officials. The overpayments resulted from a series of payment errors, attributable solely to the defective age calculation methodology in the Medicaid Management Information System a computerized payment system. Consequently, in our judgment, the entire $19.5 million can, and should, be recovered. (See pp. 5-7)

We also recommend that Social Services officials investigate certain inappropriate claims submitted by nine managed care providers. In some cases, providers submitted claims for infants who had yet to be born. In other cases, the provider changed the date of birth for infants to make the infants appear younger. As a result, these infants were considered less than one-year old by Medicaid for longer than one year, and the providers received the higher monthly payments for these infants for longer than one year. One of these infants was considered less than one-year old for 23 months, and the provider received the higher payments for the infant for all 23 months. (See p. 8)

Health and Social Services officials are attempting to increase the number of Medicaid recipients enrolled in managed care programs. However, we found that these enrollments may not be cost-effective when Medicaid recipients have other health insurance coverage. For example, when Medicaid recipients are also covered by Medicare, the coverage provided by Medicaid managed care providers (and the monthly fees paid to these providers) may duplicate the medical insurance coverage provided by Medicare. Moreover, in some instances the premiums for this duplicate Medicare coverage are paid by Medicaid. We also found that Medicaid managed care coverage is sometimes duplicated by private managed care coverage. In some instances, the simultaneous coverage is through the same provider, who is paid twice for serving the same patient.

We recommend that Health and Social Services take actions to prevent Medicaid payments for services that are duplicated by other health insurers. We also recommend that certain duplicate payments be recovered. (See pp. 9-12)

Comments of Officials

Department of Health and Social Services officials collectively agreed with eight of the report's nine recommendations. Health officials stated their belief that the audit process has been useful to the department as it develops the infrastructure needed to properly manage and oversee managed care as it becomes increasingly important in the Medicaid program. Health officials, while acknowledging errors in computer programming, disagree with our recommendation to recover the $19.5 million in overpayments to managed care providers.

Contents

Introduction

Background

The New York State Department of Social Services (Social Services) administers the State's Medical Assistance Plan (Medicaid), which was established under Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Social Services uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and make payments to health care providers for services rendered to recipients.[1]

Two different methods are used to pay the providers: fees for services or capitation premiums. Under the fee-for-service method, providers are paid every time a recipient receives a Medicaid-eligible service. Under the capitation method, which is used by managed care providers, providers are paid monthly fees based on the number and types of Medicaid recipients enrolled in their managed care programs, regardless of the number and types of services provided to the recipients each month. In exchange for this monthly fee, the managed care providers are responsible for providing various medical services to the recipients when the services are needed. State legislation was passed in 1991 encouraging the development of managed care programs in New York's Medicaid program. Because managed care providers are paid capitation premiums rather than separate fees for each individual service, it is hoped that they can reduce the costliness of the Medicaid program.

The Department of Health (Health) is responsible for setting the monthly capitation premiums, which are also called managed care rates. Social Services coordinates the activities of the State's 58 local social services districts (local districts). These activities include determining an individual's Medicaid eligibility, contracting with managed care providers and enrolling the individual into a managed care plan. For the two years ended December 31, 1995, a total of about $1.6 billion in capitation premiums was paid to managed care providers.

Medicare is a Federal health insurance program primarily for people who are age 65 or older. Medicare provides two basic forms of health care coverage: Medicare hospital insurance (Part A) and Medicare supplemental medical insurance (Part B). Part A pays for inpatient hospital services, post hospital care in skilled nursing facilities and home health programs. Part B covers ancillary services such as physician care and laboratory, X-ray and outpatient

[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 was responsible for administering Medicaid and MMIS.

services. Part B requires the recipient to pay a monthly premium, which during 1995 was about $46. When a Medicaid recipient is covered by Medicare, Medicare pays a substantial portion of the recipient's medical costs. Therefore, to decrease Medicaid costs, local districts pay the monthly Part B premiums of Medicaid recipients who are eligible for Medicare.

Medicare is funded 100 percent by the Federal government, while New York's Medicaid program is typically funded 50 percent by the Federal government, 25 percent by the State and 25 percent by local governments. In addition, some Medicaid recipients have private insurance coverage from commercial insurance carriers. Such commercial carriers also offer managed care insurance. In the Medicaid program, commercial insurance carriers as well as Medicare are referred to as third-party insurance payers. The Social Security Act requires medical service providers to submit a claim for payment to all third-party insurance carriers, including Medicare, before the provider can bill Medicaid.

Audit Scope, Objectives and Methodology

We audited Health's and Social Services' policies and procedures for paying certain kinds of Medicaid claims from managed care providers during the period January 1, 1990 through June 30, 1996. The objectives of our performance audit were to assess the adequacy of the policies and procedures for claims relating to Medicaid recipients who were either under the age of one or who were covered by third-party health insurers.

To accomplish our audit objectives, we interviewed officials from Health and Social Services, reviewed relevant records at Health and Social Services, and reviewed applicable Medicaid payment policies and procedures. We also developed computer programs to extract, analyze and evaluate (1) all the managed care claims paid for the two years ended December 31, 1995 and (2) the managed care claims paid at the rate authorized for patients 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 Health and Social Services that are included in our audit scope. Further, these standards require that we understand Health's and Social Services' 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 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.

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 and the Commissioner of the Department of Social Services 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.

Payments for Recipients Under the Age of One

Managed care providers are paid at a higher monthly rate for Medicaid recipients who are under the age of one. We examined the payments made to managed care providers for such recipients and identified as much as $19.5 million in overpayments. While Health officials have corrected the internal control weakness that permitted the overpayments, they need to initiate action to recover all of the overpayments. In addition, some of the inappropriate billings submitted for recipients under the age of one may represent an abuse of Medicaid procedures.

Overpayments

Health develops different capitation premiums for each managed care provider. These premiums vary based on the characteristics of the recipients that can be enrolled with managed care providers. Health has developed various actuarial groups based on recipient characteristics. One actuarial group is made up of recipients under the age of one. Because recipients in this actuarial group are treated for premature, low birth weight and also incur the costs associated with normal deliveries, the rate for this actuarial group is much higher than the rates for other actuarial groups. For example, for one provider, the rate for recipients under the age of one (male or female) was $574 per month, while the rate for female recipients age 1 through 14 was $66 per month, a difference of $508 per month.

Social Services has developed controls within the MMIS to help ensure that managed care providers are paid on the basis of the correct actuarial groupings. To determine whether these controls are effective for recipients under the age of one, we reviewed all managed care claims relating to such recipients for the six years ended December 31, 1995. We found that many of these claims were overpaid because the MMIS incorrectly used the rate authorized for recipients under the age of one to pay for services for recipients who were over age one during the period covered by the claim. Unless the recipient was born on the first day of a month, the recipient was not considered to be one-year old by the MMIS until the month after the recipient's first birthday. For example, the MMIS would not consider a recipient born on March 12, 1993 to be one-year old until April 1, 1994. We identified more than 51,000 claims in which the MMIS considered recipients aged one or older to be under the age of one and therefore incorrectly used the higher actuarial rate to pay the managed care providers. We recalculated these claims using the proper actuarial rate and found that the managed care providers had been overpaid as much as $19.5 million.

After we informed Health officials of our observations, changes were made in the method used by the MMIS to calculate a recipient's age and, as of

December 29, 1995, the higher actuarial rate was no longer paid for recipients who were at least one-year old. Health officials also made other changes in the rates paid to managed care providers for recipients under one year of age. Beginning in January 1996, the actuarial group of infants with the highest payment rate was changed from recipients under the age of one to recipients under the age of six months. Beginning in October 1996, delivery and post natal costs were no longer considered in the capitation rate calculation but were paid on a separate one-time premium, or "kick" payment basis instead. As a result of these changes, Health officials expect the monthly capitation rate for infants under the age of six months to be about $140.

However, Health officials stated their belief that they do not have the ability to recover prior payments made to managed care providers in accordance with existing policies, regardless of whether the policies were flawed or subsequently revised. The officials expressed concern that we approached the audit as if the managed care providers are "cost-based" providers whose payment rates are calculated and paid based on detailed rules and regulations resulting in rates unilaterally imposed upon providers through explicit legislation. Health officials also told us that their legal counsel has advised them that they cannot recover the $19.5 million in identified payments because the contracts between the managed care providers and local social services districts support the State's intent to transfer the entire financial risk for providing recipients with an unlimited amount of comprehensive medical services to the managed care provider in exchange for a prepaid capitation payment. In addition, the policies and regulations governing Medicaid payments to managed care providers do not explicitly state that, for the purpose of determining actuarial groups, a year may not exceed 365 days.

We disagree with Health officials. We fully understand the difference involved in setting rates for managed care and "cost-based" providers. In a related audit report (95-S-135), we audited Health's managed care provider rate setting practices. The issue at hand regarding the $19.5 million overpayment to managed care providers is a computer error and not a rate setting or risk assumption issue. We must also note that the monthly capitation premiums set by Health were actuarially based on the costs incurred during the first 12 months of an infant's life, not the costs incurred in the first 13 months of life. We therefore believe that the $19.5 million in overpayments can be recovered without regulations specifying the length of a year. Moreover, our legal counsel reviewed this issue and the corresponding contractual arrangements and expressed the opinion that the $19.5 million was paid in error and that there appears to be no legal reason why Health could not attempt to recover the entire amount.

We also note that the managed care providers who did not enroll infants at birth were paid at a rate that took into account the high cost of birth (both normal and premature). We determined that about two-thirds of the infants

enrolled in the 25 largest managed care programs during the six years ended December 31, 1995 were enrolled in these programs after they were four months old. These providers were therefore reimbursed for costs they did not incur. While the rate change made by Health officials will prevent such inefficiencies in the future (delivery and post natal costs are no longer considered in the monthly rate calculation), in light of the past inefficiencies, we believe it especially inappropriate for managed care providers to retain the $19.5 million in overpayments for infants whose age was incorrectly calculated by the MMIS.

Recommendations

To Health and Social Services:

1. Recover the $19.5 million in potential overpayments identified by our audit.

2. Ensure that the Medicaid regulations governing payments to managed care providers for recipients under the age of six months explicitly prohibit payments at the higher rate for recipients who are six months or older.

(Health officials have already implemented computer programming and premium group changes to correct this payment problem in the future. However, while acknowledging errors in computer programming, officials disagree with our recommendation to recover the $19.5 million because they believe that New York State cannot retroactively change its definition of a premium group. They also cited the contractual relationship between managed care providers and local social services districts, whereby managed care providers accept full financial risk for providing an unlimited amount of services in exchange for a negotiated prepaid monthly premium. We disagree with Health's position. The $19.5 million overpayment is a computer error; it is not a rate setting or risk assumption issue. Moreover, OSC legal counsel reviewed this issue and the corresponding contractual arrangements. According to OSC counsel, there is no legal reason why Health officials could not recover the $19.5 million. Notwithstanding our disagreement on this issue, we are pleased that Health officials have corrected the system problems and have followed our recommendations to prevent such overpayments in the future.)

Inappropriate Billings

Generally, before paying a managed care claim, the MMIS refers to information about each recipient, such as the recipient's age, sex and other characteristics, to determine the recipient's actuarial grouping. The recipient information is contained in MMIS reference files. The reference files generate monthly rosters for each managed care provider. Managed care providers review the roster and add or delete recipients as necessary. When a local district becomes aware that a Medicaid recipient is pregnant, the local district will establish Medicaid eligibility for the unborn child on MMIS reference files. This is done to expedite the eligibility process after the child's birth. However, monthly capitation premiums should not be paid for such children until after they are born.

We identified nine managed care providers who received monthly capitation premiums for recipients before the recipients were born. To receive such payments, the providers had to submit claims and specifically indicate a date of birth and a sex for the unborn children. We also determined that, on at least one occasion, seven of these nine providers changed the date of birth for an infant to make the infant younger. As a result of these changes, the infants were considered less than one-year old by the MMIS for longer than one year, and the providers received the higher monthly payments for the infants for more than 14 months. One of these infants was considered less than one-year old for 23 months, and the provider received the higher payments for the infant for all 23 months.

One of the nine providers submitted these inappropriate billings repeatedly, and in at least one instance even changed the sex of the infant; the other eight providers submitted the inappropriate billings less frequently. We provided Health and Social Services officials with the names of the nine providers. In its own audit of these providers, Social Services identified overpayments of about $385,000 relating to infants who had yet to be born. However, Social Services has not investigated the claims of the providers to determine whether the inappropriate billings were the result of error or fraud. We believe the circumstances of the billings warrant such investigation.

Recommendation

To Social Services:

3. Determine whether fraudulent billings were submitted by the nine providers identified by our audit and make any appropriate referrals to the New York State Attorney General's Office.

(Social Services officials are reviewing the billings to determine if such billings should be referred to the Attorney General's Office.)

Payments for Recipients With Third-Party Insurance Coverage

As of December 31, 1996, there were about 650,000 Mediciad recipients enrolled in managed care programs, or about 20 percent of all Medicaid recipients. Health and Social Services are attempting to increase the number of Medicaid recipients enrolled in managed care programs. Through a proposed Federal demonstration project called the Partnership Plan (which had not been approved at the time of our audit), Health and Social Services intend to enroll about 87 percent (roughly 2.8 million) of all Medicaid recipients in New York State into managed care plans, by two years after implementation of the Partnership Plan. However, we found that these enrollments may not be cost-effective when Medicaid recipients are also covered by certain third-party health insurers. We further found that managed care providers may receive duplicate payments for Medicaid recipients with certain third-party health insurance coverage.

When a Medicaid recipient is covered by Medicare, a substantial portion of the recipient's medical costs should be paid by Medicare. According to MMIS records, during the two years ended December 31, 1995**,** about 600,000 Medicaid recipients were covered by Medicare (such recipients are called dual-eligible recipients). Like Medicaid providers, Medicare providers may be paid on a fee-for-service basis or through monthly capitated premiums in Medicare managed care programs. According to the Federal Health Care Finance Administration, in January 1995, a total of about 100,000 of New York's Medicare recipients were enrolled in Medicare managed care programs. Neither Health officials nor Social Services officials know how many dual-eligible recipients are enrolled in Medicare managed care programs.

Health's policy is not to enroll dual-eligible recipients into Medicaid managed care programs. However, according to MMIS records, about 7,700 dual-eligible recipients are enrolled in such programs. Health does not set capitation rates for such recipients. Instead, the managed care providers for these recipients are paid on the basis of "transition rates" that are set by Social Services. Unlike the capitation rates set by Health, the transition rates are not based on actuarial calculations, and therefore may not accurately reflect the costs that would reasonably be incurred by the providers in treating the recipients covered by the rates. In fact, the amounts paid using these rates may exceed the amounts that would have been paid on a fee-for-service basis, and therefore may fail to realize one of the expected benefits (cost containment) of enrolling Medicaid recipients in managed care programs.

We believe Medicaid's costs are more likely to be reduced if capitated rates were used for dual-eligible recipients enrolled in Medicaid managed care programs. However, these capitated rates should account only for the deductibles and services (called "wraparound services") not covered by Medicare, and therefore be lower than the normal capitated rates.

We also question whether dual-eligible recipients already enrolled in Medicare managed care programs should also be enrolled in Medicaid managed care programs. In such cases, the monthly payments made by Medicaid may duplicate the monthly payments made by Medicare. The Health Care Finance Administration maintains data identifying the individuals enrolled in Medicare managed care programs. If Social Services had access to this data, it could compare these individuals to the individuals enrolled in Medicaid managed care programs to identify duplicate coverage. Social Services requested access to the data in April 1995; however, as of August 1996, Social Services had not obtained such access.

We note that Social Services has developed a standard model contract, which is used by the local districts as the basis for their contracts with managed care providers. According to the model contract, if a Medicaid recipient is already enrolled in a non-Medicaid managed care program, the recipient should not be enrolled in a Medicaid managed care program. While this guideline is included in the standard contract, no such provision is included in the regulations of Health and Social Services. As a result, the guideline is less likely to be followed.

We reviewed the MMIS reference files for 1994 and 1995 and found that the guideline often was not followed. In total, we identified about 5,700 recipients who, for part of the period, were simultaneously enrolled in a commercial managed care program and a Medicaid managed care program. Moreover, about 2,650 of these recipients had the same provider for both programs. During these two years, we estimate that Medicaid paid about $2 million in monthly capitation premiums for the 5,700 recipients. About $1 million of these premiums was paid for the 2,650 recipients who had the same provider for both programs. Since it is likely that many of the services covered by the Medicaid premiums were also covered by the commercial managed care programs, the premiums may have duplicated coverage provided elsewhere. We believe any duplicate premiums should be recovered from the insurers who provided both commercial and Medicaid coverage to the same recipients.

In March 1994, the local districts were instructed by Social Services to analyze the cost-effectiveness of enrolling recipients with private insurance into Medicaid managed care programs and select the less costly alternative for the recipients. We conclude that these instructions have not been effective. When we contacted the officials at one local district where recipients with

commercial managed care coverage had been enrolled in Medicaid managed care programs, the officials agreed that the recipients should not have been enrolled in the Medicaid programs. We note that neither Health nor Social Services monitors the local districts to ensure that the cost-effectiveness of the enrollments is analyzed.

Social Services has encouraged the local districts to pay the Medicare Part B insurance premiums for eligible Medicaid recipients. This procedure is cost-effective for Medicaid recipients who are not enrolled in a managed care program, because the providers for such recipients are paid on a fee-for-service basis. Therefore, even though Medicaid pays the monthly Part B premium, since most of the fee for each service is paid by Medicare, total Medicaid payments are reduced. However, this procedure is not cost-effective for Medicaid recipients who are enrolled in managed care programs, because the monthly capitated premiums generally duplicate the Medicare coverage.

To determine whether the local districts pay Medicare Part B insurance premiums for Medicaid recipients who are enrolled in managed care programs, we reviewed MMIS records for 1994 and 1995. We determined that Medicaid had paid a total of $3.6 million in Medicare Part B premiums for more than 5,200 recipients enrolled in Medicaid managed care programs. (About 70 percent of these payments were made on behalf of recipients who were enrolled with one New York City provider.) Since the capitation premiums paid to these managed care providers duplicated the Medicare coverage, any Medicare payments received by the providers under the duplicate coverage represented duplicate payments.

We determined that Part B premiums were paid for recipients in managed care programs because of procedural weaknesses. To help the local districts, Social Services developed a computerized process to identify Medicaid recipients who are eligible for, but lacked Medicare Part B insurance. However, this process does not identify whether any of these recipients are enrolled in managed care programs. No other controls have been developed by either Health or Social Services to prevent the purchase of Part B premiums for such recipients. Such controls would save the Medicaid program about $1.8 million annually.

Recommendations

To Health and Social Services:

4. Develop capitated rates for dual-eligible recipients enrolled in Medicaid managed care programs. Ensure that these rates account only for the deductibles and services not covered by Medicare.

5. Develop policies and regulations requiring that recipients who are enrolled in either Medicare managed care programs or commercial managed care programs not simultaneously be enrolled in Medicaid managed care programs.

6. Develop procedures for identifying recipients who are simultaneously enrolled in Medicaid and Medicare managed care programs.

7. Recover duplicate capitation payments from insurers who provided commercial and Medicaid managed care coverage to the same recipients.

8. Ensure that the local districts evaluate the cost-effectiveness of enrolling recipients in managed care programs.

9. Develop procedures for preventing the purchase of Part B Medicare premiums for recipients enrolled in managed care programs.

(Health officials agreed with recommendations four through nine and will provide guidance and monitoring to local districts to ensure that enrollment into managed care is cost-effective. Health officials agreed that recipients should not be enrolled in both Medicaid managed care plans and Medicare or commercial managed care plans. They will prevent the purchase of Medicare Part B insurance for Medicaid managed care recipients and recover duplicate capitation payments from insurers who simultaneously provide commercial and Medicaid managed care coverage to the same recipient. Health officials will set future capitation premiums for dual eligible recipients, which reflect only services not covered by Medicare.)

Major Contributors to This Report

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November 8, 1996

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RE: OSC Draft Audit 96-S-67 Controls Over Certain Medicaid Payments To Managed Care Providers

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit 96-S-67 entitled, "Controls Over Certain Medicaid Payments To Managed Care Providers".

Thank you for the opportunity to provide comments.

Sincerely,

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

enclosure

Department of Health Response to the Office of the State Comptroller's Draft Audit Reports, 96-S-67, entitled "Controls Over Certain Medicaid Payments to Managed Care Providers"

The Department of Health has reviewed the Comptroller's audit on "Controls Over Certain Medicaid Payments to Managed Care Providers" and believes that the audit process has been useful to the department as it develops the infrastructure needed to properly manage and oversee the managed care mechanism as it becomes increasingly important in the provision of medical care services in the Medicaid program. While the department agrees with nearly all of the Comptroller's recommendations reflected in the audit, it must disagree with the one recommendation dealing with the retroactive financial recoupment. The crux of the issue involves a fundamental precept in the mutual exchange of considerations and risks which is inherent in the managed care financing structure. This fundamental difference between the traditional, historic cost-based reimbursement methodology used extensively by New York State in the past for both inpatient and outpatient services and the contractual capitated model used in managed care's comprehensive reimbursement methodologies is highlighted in the department's disagreement with the Comptroller's auditors regarding the State's ability/inability to recover funds from managed care plans. Recognition of this inability reinforces the need for appropriate internal controls in establishing and implementing the managed care payment structure. The Department is committed to maintaining strong internal controls in this process and the Comptroller's audit is an important element in reinforcing this need as the managed care program matures.

The department's detailed comments on the specific issues raised by the audit are addressed in the following pages and organized by each section of the audit.

Response to Draft Audit Report

Payments for Recipients Under the Age of One

Clarification

The audit report, on page 5, paragraph one, states that beginning October 1996, delivery and postnatal costs were not paid as capitation, but on a fee-for-service basis. In fact, delivery and postnatal costs remain capitated; the costs of the newborn's hospital stay are paid as a separate one time premium, or "kick" payment, not through a fee-for-service mechanism.

Recommendation #1: Recover the $19.5 million in potential overpayments identified by our audit.

Response: The report concludes that MMIS incorrectly paid the premium for the under age one enrollees in cases where the enrollee turned one after the date the premium was paid, but prior to the end of the month. On the basis of this, the audit report recommends recovery of $19.5 million in premiums paid to plans based on this incorrect definition. The audit also erroneously states that the department's position is based solely on the fact that the policies governing actuarial groups do not explicitly state that a year may not exceed 365 days rather than addressing the underlying rationale of the department.

The department believes that managed care providers, having contractually accepted risk for the cost of care for these recipients, for a capitated amount, cannot be advised that New York State retroactively decided to change its definition. This was a premium group definition that was uniformly applied to all plans using a New York State developed systems program which assigned Medicaid recipients to premium groups for payment. While acknowledging that errors appear to have occurred in programming, the department cannot agree to recovery of $19.5 million on this issue; the recommendation is contrary to the theory upon which managed care is designed and, as discussed below, recoupment is without a legal basis. (Fortunately, as the audit acknowledges, the underlying problems were previously identified by the department and corrected.)

The department has explained to the auditors that there is an important distinction

between an audit of customary fee-for-service rates and an audit of managed care premiums. The auditors have approached this audit as if the managed care providers are "cost-based" providers whose payment rates are calculated and paid based on explicit, detailed rules and regulations, with rates unilaterally imposed upon the providers through explicit legislation. In contrast to cost-based providers (providers whose rates are set based on their historical costs of providing the same service for a specific encounter), managed care providers agree via contract with each local social services district to accept the full financial risk, to an unlimited amount of services for a comprehensive package of medical care, in exchange for a negotiated prepaid monthly premium.

New York State cannot retrospectively determine that, because a particular policy or procedure may not have worked as expected, the managed care plans suddenly owe a portion of previously paid premiums back to New York State. The contract supports the intent of New York State to transfer the entire financial risk for services to the managed care provider in exchange for a prepaid capitation.

In summary, the department's position is that there were not actual "overpayments," nor is there an ability to recover prior payments made to managed care providers in accordance with the existing policies, regardless of whether the policies were flawed or subsequently revised. This position is supported by the department's legal counsel. Although discussed with audit staff on numerous occasions, the audit report does not reference or describe the department's position.

In addition, the department, while agreeing that the under one year premium was calculated based on a 12 month payment, also stated that there is no contractual basis for recovery even for the $1 million cited by the audit as being related to the 13th monthly payment. The auditors claim to be "puzzled" by the distinction the department is making between the $18.5 million and the $1 million; the department is not making a distinction since it believes there is no basis to recover either amount.

The department's legal analysis explaining the statutory, regulatory and contractual basis of the department's position is being forwarded under separate cover.

Recommendation #2: Ensure that the Medicaid regulations governing payments to managed care providers for recipients under the age of six months explicitly prohibit payments at the higher rate for recipients who are six months or older.

Response: The department developed new premium groups almost a year ago, based upon recommendations of its consulting actuary. The age span for the new premium group relates to the first 6 months of life (i.e., month of birth plus 5 additional monthly payments). Therefore, the recommendation has already been reflected in rate policy and has been implemented.

Inappropriate Billings

Recommendation to Social Services

Recommendation #3: Determine whether fraudulent billings were submitted by the nine providers identified by our audit and make any appropriate referrals to the New York State Attorney General's Office.

Since this recommendation is directed to the Department of Social Services, the department has no comment.

Payments for Recipients With Third Party Insurance Coverage

Recommendations to Health and Social Services

Recommendation #4: Develop capitated rates for dual-eligible recipients enrolled in Medicaid managed care programs. Ensure that these rates account only for the deductibles and services not covered by Medicare.

Response: The audit report says "We found that Health does not set capitation rates for such recipients," and then recommends that such rates be developed. A statement that current policy precludes enrollment of dually eligible recipients into managed care -- which is why there are no specific capitation rates established -- should be reflected in the audit. The department does not intend to allow enrollment of dually eligible recipients once appropriate policies regarding conduct of Medicaid and Medicare benefits have been developed and adopted. Premiums developed in the future will reflect only services covered by Medicaid, as recommended by the audit.

Recommendation #5: Develop policies and regulations requiring that recipients who are enrolled in either Medicare managed care programs or commercial managed care programs not simultaneously be enrolled in Medicaid managed care programs.

Response: The department agrees that recipients enrolled in Medicare or commercial managed care programs should not be simultaneously enrolled in Medicaid managed care plans. The recommendation should acknowledge that this is the department's current policy and it is reflected in the current managed care contract.

Recommendation #6: Develop procedures for identifying recipients who are simultaneously enrolled in Medicaid and Medicare managed care programs.

Response: The department agrees that more guidance should be provided to local districts on the issue and that local district activities must be monitored to ensure that such recipients are properly identified and excluded from enrollment.

Recommendation #7: Recover duplicate capitation payments from insurers who provided commercial and Medicaid managed care coverage to the same recipients.

Response: The department agrees that recovery should be made from a managed care plan for the time periods that Medicaid capitation payments were made to the plan for recipients simultaneously enrolled in the same plan for commercial coverage, as long as the commercial coverage was substantially the same as the Medicaid coverage.

Recommendation #8: Ensure that the local districts evaluate the cost-effectiveness of enrolling recipients in managed care programs.

Response: The department agrees that guidance should be provided and local district activities should be monitored to ensure the cost-effectiveness of enrolling Medicaid recipients in managed care plans.

Recommendation #9: Develop procedures for preventing the purchase of Part B Medicare premiums for recipients enrolled in managed care programs.

Response: The department agrees that purchase of Part B Medicare premiums for recipients enrolled in managed care programs should be prevented.

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

BRIAN J. WING
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Deputy Commissioner
Management Support and
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November 21, 1996

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: DOH/DSS Controls Over Certain Medicaid Payments to Managed Care Providers 96-S-67 (96-025)

Dear Mr. McClune:

The following represents our response to the referenced report's recommendations that impact this Department.

Recommendation: Recover the $19.5 million in potential overpayments identified by this audit.

Response: The Department's collection actions are dependent upon the Department of Health's legal position on the appropriateness of the payments.

Recommendation: Determine whether fraudulent billings were submitted by the nine providers identified by this audit and make any appropriate referrals to the New York State Attorney General's Office.

Response: The Department is reviewing the billings submitted by the providers and will make a determination whether it is necessary to refer any of the providers to the Attorney General's Office for further action.

Recommendation: Recover duplicate capitation payments from insurers who provided commercial and Medicaid managed care coverage to the same recipients.

Response: The Department of Health must determine whether any of the identified payments were duplicative. Once a decision is made, this Department can then make the recoveries.

Thank you for sharing the report with us and we trust our comments will be considered in preparation of the final report.

Sincerely,

David P. Avenius
Deputy Commissioner
Management Support and
Quality Improvement