State of New York
Office of the State Comptroller
Division of Management Audit and State Financial Services

DEPARTMENT OF HEALTH

MONITORING THE QUALITY OF MEDICAID MANAGED CARE

REPORT 96-S-70

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

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Dear Dr. DeBuono:

The following is our report on the Department of Health's practices for monitoring the quality of Medicaid Managed Care.

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
and State Financial Services

July 24, 1998

Executive Summary

Department Of Health
Monitoring The Quality Of Medicaid Managed Care

Scope of Audit

The Department of Health (Health) administers the Medicaid Managed Care program. Under this program, managed care organizations (MCOs) receive a monthly capitation payment for each enrolled Medicaid recipient. In return, the MCOs must ensure that each enrollee has a primary care provider (PCP), adequate access to a full continuum of quality health care, and 24-hour access to emergent and urgently needed services. Local social services districts (local districts) contract individually with MCOs to provide medical services to enrolled Medicaid recipients. Health reviews and approves all contracts and related modifications.

As of July 1, 1997, Health reported that about 661,000 Medicaid recipients were enrolled in MCOs throughout New York State. In July 1, 1997, Health received approval from the Federal government that will enable it to mandatorily enroll 2.3 million Medicaid recipients in managed care through six phases over a three year period. For calendar year 1996, Health reported that Medicaid paid more than $951 million for capitation premiums to MCOs for enrolled recipients; State government's share of this was $237.8 million.

Our audit addressed the following question relating to Health's monitoring of the quality of Medicaid Managed Care for the period January 1, 1996 through July 7, 1997:

- Has Health adequately monitored the quality of Medicaid Managed Care provided by the MCOs?

Audit Observations and Conclusions

Health does not have a formal statewide managed care surveillance plan to ensure Medicaid Managed Care is operating properly and meeting its goals. In the absence of such a plan, Health has made various efforts to monitor the quality of Medicaid Managed Care. However, we noted areas where Health's monitoring efforts need improvement. Making such improvements will be especially important as the State expands the Medicaid Managed Care program through mandatory enrollment in the coming years.

Health performs various types of surveillance activities to assess the quality of care provided by the MCOs. However, Health's surveillance activities were not comprehensive enough to examine MCO compliance.

Further, Health did not always prepare formal reports to summarize and document the surveillance work that was done. Without summary reports, Health is unable to appropriately plan for future surveillance and follow-up activities. (See pp. 5-10)

MCO enrollees may file complaints directly through Health on such matters as quality of medical care and operational issues, including waiting times and provider availability. We found that Health did not always resolve complaints in a timely manner, and was unable to effectively track complaint resolution. If complaints are not effectively resolved, enrollees may not be able to fully utilize managed care. (See pp. 10-14)

Health requires MCOs to submit annual performance measurement information to allow Health to assess MCOs' ability to meet statutory requirements for quality and delivery of services. Health contracted with a national organization that accredits and assesses quality in MCOs to audit the 1994 and 1995 information. Although Health generally provided adequate oversight during the validation audits, Health did not always ensure that pertinent issues directly affecting the results were considered by the contractor. We found that certain decisions related to audit methodology were sometimes determined solely by the contractor without Health's consideration, input or notification. This weakens assurance that the contractor performed in an appropriate manner and achieved the contract's objectives. (See pp. 19-27)

Health and the local districts are responsible for ensuring MCOs comply with the terms of their contracts. Health does not have an effective process in place to ensure all local districts are appropriately and uniformly performing monitoring activities, and as a result, there is no assurance that MCO contracts are being properly monitored. Health needs to establish a formal policy and supporting procedures to effectively coordinate local district monitoring activities. (See pp. 27-29)

The Americans with Disabilities Act of 1990 (ADA) prohibits public entities from discrimination on the basis of disability in all services, programs, and activities they provide. ADA provisions are also included in the 1996 Managed Care Omnibus Law and in the contract between local districts and MCOs. We determined, however, that Health was unable to appropriately assess if the ADA, State legislative and MCO contract provisions regarding discrimination against people with disabilities enrolled in Medicaid Managed Care are being met. Health needs to establish policies, procedures and measurements to define and examine compliance with ADA requirements among MCOs. (See pp. 33-40)

Comments of Health Officials

Department of Health officials generally agree with our recommendations.

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Major Contributors To This Report

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Comments of Department of Health Officials

Introduction

Background

The Department of Health (Health) administers New York's Medical Assistance Program (Medicaid), established under Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health's administration of Medicaid officially began in October 1996. However, Health had administered the Medicaid Managed Care Program prior to this period. Under Medicaid Managed Care, managed care organizations (MCOs) receive a monthly capitation payment for each enrolled recipient. In return, the MCOs must ensure that each enrollee has a primary care provider (PCP), adequate access to a full continuum of quality health care, and 24-hour access to emergent and urgently needed services.

Under the Statewide Managed Care Act of 1991, the Department of Social Services (Social Services)[1] designated each county responsible for developing its own Medicaid Managed Care program. The Medicaid Managed Care Act of 1996 extended the operation of these Medicaid Managed Care programs until June 30, 2000. In addition, the 1996 New York State Managed Care Omnibus Law added a series of consumer protections for managed care recipients.

Local social services districts (local districts) contract individually with MCOs to provide medical services to enrolled Medicaid recipients. Health reviews and approves all contracts and related modifications. Payment for Medicaid Managed Care, like other services covered under Medicaid, is funded by the Federal, State, and local governments (typically 50 percent, 25 percent, and 25 percent, respectively).

As of July 1997, the United States Department of Health and Human Services - Health Care Financing Administration (HCFA) approved two applications to obtain waiver approval that would release New York State from certain Federal requirements of the Social Security Act (Act). Waiver approval of Section 1915(b) of the Act allows 31 counties, including those within New York City, to mandatorily enroll Medicaid recipients who were in the former Aid to Families with Dependent

[1] On August 20, 1997, the Governor signed welfare reform legislation that abolished the Departmen Social Services and created a new agency in its place: The Department of Family Assistance. The Department of Family Assistance is composed of two independent agencies, the Office of Children and Family Services and the Office of Temporary and Disability Assistance.

Children program, which was renamed Temporary Assistance for Needy Families. Waiver approval of Section 1115 of the Act allows Health and the counties to establish a statewide mandatory Medicaid Managed Care program known as the Partnership Plan and continue to receive Federal reimbursement. Under this waiver, which includes people in the Home Relief (renamed Safety Net) and Supplemental Security Income programs, Health will mandatorily enroll 2.3 million Medicaid recipients in managed care through six phases over three years. Mandatory managed care programs have operated as demonstration projects in ten zip codes in southwest Brooklyn since October 1992 and in Westchester County since January 1996.

Voluntary managed care programs will continue to operate during the phase-in of mandatory managed care. The implementation of mandatory managed care in the initial 31 counties will not affect the continuation of voluntary programs in most of the remaining counties.

As of July 1, 1997, Health reported that about 661,000 Medicaid recipients were enrolled in MCOs throughout New York State. For calendar year 1996, Health reported that Medicaid paid more than $951 million for capitation premiums to MCOs for enrolled recipients; New York State government's share was $237.8 million.

Audit Scope, Objectives and Methodology

We audited Health's activities for monitoring the quality of Medicaid Managed Care, including available policies and procedures, for the period January 1, 1996 through July 7, 1997. The objectives of our performance audit were to assess the adequacy of Health's monitoring activities and compliance with practices that Health has established to evaluate the quality of Medicaid enrollees' care.

To accomplish our objectives, we interviewed officials from Health, Social Services, and HCFA, as well as consumer advocate group representatives. We visited the Albany, New York City, Rensselaer and Schenectady local districts and interviewed by telephone officials from the Erie, Greene, Monroe, Rockland and Westchester local districts. These local districts were selected to provide a range in both geographic location and size. We reviewed applicable Medicaid Managed Care policies, procedures, and records, as well as Federal and State laws and regulations. We relied on statistical consultants to assist us in determining the validity of certain methodologies used by Health to monitor managed care contracts.

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 that are included in our audit scope. Further, these standards require that we understand Health's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence 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 Officials to Audit

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

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

Surveillance and Monitoring

As the agency responsible for administering and overseeing the Medicaid Managed Care program, Health should have a formal statewide managed care surveillance plan. HCFA requires such a plan as part of its terms and conditions for approving the State's mandatory program. By following such a plan and maintaining formal documentation of the results, Health can have assurance that Medicaid Managed Care is in compliance with regulatory, statutory, and contractual requirements. In addition, these actions can ensure that Medicaid Managed Care is operating effectively and meeting its goals.

We found that Health does not have a formal statewide surveillance plan. In a memo dated September 27, 1996, Health officials outlined their process of developing and implementing such a plan, which is to consist of five major areas:

- compilation of a surveillance manual, reflecting current status of activities;
- refinement and field testing of revised annual surveillance policies, protocols, and tools;
- development of a managed care "data book" (compiled surveillance results);
- additional development of a focused surveillance plan; and
- development of a protocol delineating State and county surveillance responsibilities.

However, during our audit period, none of the five areas pertaining to the formal surveillance plan were complete. Health needs to work towards fully implementing a formal plan.

During our audit, Health conducted several ongoing surveillance and monitoring activities related to Medicaid Managed Care, even though it did not have a formal statewide surveillance plan implemented. These include MCO surveillance, complaint monitoring, and review of recipient materials, such as brochures. However, as detailed in our report, Health needs to make improvements in each of these areas.

In response to our draft report, Health officials acknowledged that some elements of the surveillance plan were not fully implemented, but disagreed with the statement that a surveillance plan was not in place at the time of our audit. However, as documented in our report, while Health conducted certain surveillance and monitoring activities during our

audit period, all activities were not contained and documented in a formal plan.

Surveillance

Health had procedures in place for some of its surveillance monitoring activities. For example, we noted Health had satisfactory procedures in place for its one time readiness reviews, which assess administrative readiness of MCOs prior to executing the managed care contract. During our audit period, Health conducted 44 readiness reviews. However, we noted that most of the procedures for recurring surveillance monitoring were not sufficiently comprehensive to include examining compliance with all appropriate regulatory, statutory, and contractual provisions. In addition, we found that Health performed a limited amount of focused surveillance, which allows Health to examine specific issues and operations. Further, Health did not always prepare formal reports to summarize and document completed work.

Annual Operational Survey

Health performs annual operational surveys to assess the general operations of MCOs, including MCO compliance with Title 10, Part 98 of New York Codes, Rules and Regulations. These regulations prescribe the overall organizational structure and operating guidelines that MCOs are required to follow. Health developed surveillance guidelines and corresponding survey tasks for use by its regional offices to ensure MCO compliance with these regulations. During our audit, Health conducted nine full annual operational surveys. However, our examination of the procedures used to conduct these surveys during our audit period showed the following:

- the procedures did not address several regulatory provisions;
- the procedures did not always incorporate sufficient steps to adequately assess certain regulatory provisions; and
- certain procedures were unrelated to assessing the regulatory provisions.

We provided Health with a detailed list of specific concerns related to these procedures. Health officials stated they believe the actual operational surveys do ensure all regulatory provisions are met, although the procedures themselves may not fully represent all the work that was performed. However, we believe that appropriately documented procedures are needed to ensure MCOs are in compliance with all regulatory provisions.

In response to our draft report, Health officials stated that missing procedures may have been addressed in the Department's review of pre-survey documentation submitted by MCOs. However, our review of this pre-survey document showed that it contains a list of required documentation, but no methods or procedures that can be used to evaluate this documentation for regulatory compliance.

We found that during our audit period the operational survey procedures did not include steps to examine MCO's compliance with several contract provisions. We also noted that the procedures had not been updated to encompass steps to assess compliance with statutory requirements that became effective on April 1, 1997. In addition, we found that even though Health required MCOs to comply with new statutory requirements providing new enrollees with managed care disclosure information, such as a description of the grievance procedures, Health did not provide MCOs sufficient time to do so. For example, Health did not inform MCOs of the actions they needed to take relating to disclosures until February 21, 1997, allowing MCOs only 38 days to comply. (Subsequent to our audit period, Health completed a newly drafted annual operational survey document that addresses the concerns we raised.)

In addition, the National Committee for Quality Assurance (NCQA) conducts examinations of MCOs to assess the quality of their operations. MCOs that meet NCQA's standards receive accreditations that demonstrate levels of compliance and imply a degree of confidence that consumers can place on the MCO. Health officials indicated to us that NCQA's accreditation review duplicates some of the same processes Health uses in its annual survey. For example, NCQA and Health both check to ensure that participating physicians are licensed. In a recent pilot project, Health advised its regional offices that they may use their own discretion to limit annual operational survey work for fully accredited MCOs. We noted that, during the pilot project, one regional office eliminated the entire operational survey for a fully accredited MCO. As a result, Medicaid specific processes, such as contract compliance, that are not included in NCQA's review were not assessed for this MCO. (Subsequent to our examination of this area, Health modified its procedures to specify that three components of the survey - credentialing, quality assurance and the medical record review - may be waived for fully accredited MCOs.)

Focused Surveillance

Focused surveillance allows Health to examine specific issues and operations within Medicaid Managed Care that aid in assessing the quality of care of the overall program. For example, by performing periodic

access and availability studies, a nationally recognized method of measuring quality of care, Health can assess how long enrollees have to wait to obtain appointments for medical care. This helps to ensure that the wait is within prescribed limits for different situations. These studies also can provide insight about the adequacy of the MCOs' provider networks. In addition, independent recipient satisfaction surveys allow Health to identify potential problematic issues experienced by enrollees, as well as providing useful information about how enrollees are using Medicaid Managed Care.

Health has not regularly performed access and availability studies (none since 1995) and recipient satisfaction surveys (none since 1993). During our audit period, Health conducted nine focused surveys covering a limited number of areas. Health contracted with Island Peer Review Organization to conduct a yearly statewide access and availability study that began in March 1997. Health has also developed a recipient satisfaction survey and has contracted with the Gallup organization to conduct this survey.

Health officials stated in response to our draft report that they performed 68 focused reviews, including 51 compliance reviews. However, our analysis of Health's records indicated that only 9 of the 17 focused surveys (excluding the compliance reviews performed in March 1997) were performed during our audit period. During our audit, Health officials indicated that focused reviews consist of specific narrowly scoped topics such as enrollment, complaints and access and availability. Therefore, we do not consider Health's examination of MCO's statutory compliance to meet Health's definition of a focused review.

To be effective, focused surveillance must examine processes, and based on risk, define indicators (or triggers) that can be used to determine if additional investigation or action is needed. Health performs focused surveillance of voluntary disenrollment from Medicaid Managed Care. Sudden increases in voluntary disenrollment can indicate MCO problems related to quality of care. However, we determined that Health's surveillance of this activity during our audit period entailed only summarizing MCO reported disenrollment information quarterly, and issuing semiannual and annual management reports. We also found that Health does not trend this information quarterly, and there are no triggers that could lead to additional investigation of problematic areas. For example, for the six month period ended June 30, 1996, one MCO reported nearly 60 percent (995) of its total voluntary disenrollments (1,685) were due to the enrollees' choosing a provider outside of the MCO's provider network. This could indicate that the MCO network may be insufficient. However, Health has not conducted any investigation into

this matter. (Subsequent to our examination of this area, Health drafted procedures to perform focused surveillance of disenrollment and other areas that would include the use of triggers that could lead to additional investigation.)

Reporting of Surveillance Activity

Health should ensure that surveillance activities are appropriately summarized and reported for the purposes of 1) assessing overall results of surveillance resources, 2) ensuring that the activities reached an appropriate conclusion and 3) aiding in future surveillance and follow-up.

We determined that Health does not always produce reports to summarize surveillance and monitoring activities. For example, when questioned in October 1996, Health officials were unable to produce reports summarizing the most current access and availability studies (August 1995) and follow-up of MCO corrective action. In May 1997, Health officials provided us with undated reports that documented the information we requested.

In addition, Health officials indicated that the regional offices each produced their own reports of surveillance activities that are forwarded to Health for review. However, when we asked to review the reports for the nine focused surveys, Health officials were unable to readily provide eight of these reports to us. Officials later indicated that some of these reports could not be located and had to be re-sent to Health by the regional offices. By failing to maintain summary reports, Health is unable to ensure that survey work was sufficiently performed and that activities reached an appropriate conclusion. In addition, without summary reports, Health is unable to appropriately plan for future surveillance and follow-up activities.

Recommendations

1. Formalize and implement a statewide Medicaid Managed Care surveillance plan.

   (In response to recommendation 1, Health officials stated that they have a comprehensive surveillance program plan in place to monitor all aspects of MCO performance. However, as documented in our report, we found that a formal surveillance plan was not in place during the period of time covered by our audit.)

2. Ensure that surveillance procedures include appropriate processes to ensure compliance with regulatory, statutory and contractual provisions.

3. Ensure that annual surveys of MCOs with NCQA accreditation include appropriate processes not covered by NCQA.

4. Ensure that focused surveillance includes processes that can be used to trigger additional investigation when needed.

5. Ensure surveillance and monitoring activities are appropriately summarized and reported.

Medicaid Managed Care Complaints

Historically, enrollees had the ability to try to resolve grievances or complaints relating to managed care directly through their MCO. The 1996 Managed Care Omnibus Law required MCOs to formalize their grievance procedures. For example, complaint investigations must be completed within specified time frames, depending on the nature of the complaint. However, under the 1996 law, no complaint should be unresolved after 45 days of receipt of all necessary information.

In addition to filing complaints through the MCOs, enrollees may also file complaints directly through Health. Health uses formal complaint resolution procedures that were revised in early 1997. These procedures address resolution of complaints relating to quality of medical care and operational issues, such as waiting times and provider availability. We found that Health did not always resolve complaints in a timely manner,

did not have a mechanism in place to ensure that appropriate action was taken and was unable to effectively track complaint resolution. If complaints are not timely and effectively resolved, there is an increased risk that enrollees may not be able to fully utilize managed care. In addition, we found that Health did not sufficiently analyze MCO complaint information.

Complaint Resolution

Complaints filed directly through Health can be made through either a dedicated toll-free telephone number or the mail. Complaints received directly by Health's main office are forwarded by the Complaint Unit to one of Health's regional offices for investigation and resolution. During our audit period, Health's procedures required that such forwarding be done within three business days of the complaint being filed. (In July 1997, subsequent to our audit period, Health revised its procedures to allow five business days to acknowledge receipt of complaints to the complainant and forward them to the regional office for investigation.) In addition, enrollees may file complaints directly with one of Health's regional offices or with the enrollee's local social services district. During our audit period, Health and its regional offices received 61 complaints relating to Medicaid Managed Care. While the volume of complaints filed during our audit period was low, Health anticipates an increase with the implementation of mandatory Medicaid Managed Care. Therefore, appropriate complaint resolution processes must be in place.

After examining Medicaid Managed Care complaint documentation, we determined that Health's complaint resolution process does not ensure timely and effective resolution. Regional offices took an average of 93 days to resolve a complaint. We noted that the New Rochelle office averaged 115 days to resolve complaints.

We determined that 33 of the 61 complaints filed had resolution times in excess of 70 days. Resolution times for these complaints were well above the 45 day standard required of MCOs, even after allowing time for the regional offices to receive all the necessary information. Further, 14 of these 33 complaints had resolution times of more than 140 days.

The following examples illustrate complaints that were not resolved in a timely manner:

- A complaint that alleged a hospital was influencing enrollees to switch PCPs took 238 days to complete.

- A complaint regarding appointment availability and medical care took 155 days to complete.

These problems occurred because Health's complaint procedures do not include guidelines that require resolution within certain time frames, as the law requires of the MCOs. We also noted that Health's untimely forwarding of complaints to regional offices may have contributed to the untimely resolution of some complaints. For example, one complaint received by the Complaint Unit in the main office took 69 days to be transmitted to the regional office for investigation.

In addition, our examination of Health's complaint documentation determined that the resolution process did not ensure that all complaint related issues were appropriately identified and resolved, as follows:

- Health did not timely resolve and take sufficient action relating to a serious complaint of an alleged MCO door-to-door marketing violation. Similar violations were responsible for suspending enrollment of New York City's Medicaid Managed Care program in 1995.

- Health did not take sufficient action regarding an alleged marketing violation lodged by a Spanish-speaking only enrollee. Although in this instance Health officials did contact the MCO, they relied on the MCO's assurance that appropriate marketing procedures were followed, without independently investigating such procedures. We believe that Health should have conducted an independent investigation of the MCO's marketing techniques.

These problems occurred because Health's complaint procedures do not include a mechanism that would ensure all complaint issues are appropriately addressed. Such a mechanism would provide for a quality review of complaint resolution files by Health.

Complaint Tracking System

Health's complaint procedures require Health and the regional offices to utilize a computerized tracking system to aid in monitoring the progress of complaint resolution. Our audit found, however, that Health was unable to monitor complaints effectively because its tracking system is outdated and complex. When complaints are filed and also during investigation, either Health or the regional office staff are required to enter related information on the tracking system. However, the regional offices frequently did not enter required complaint information on the tracking

system. In addition, Health was unable to access complaint information on this system until May 1997. As a result, Health was unable to ensure that the tracking system contained complete and accurate information on managed care complaints.

For our audit period, Health referred nine complaints to the regional offices for investigation. During this time, Health implemented a manual process to track complaints, since the Complaint Unit was unable to access complaint information on the tracking system. However, this process failed to ensure that Health and the regional offices had accurate and current complaint information. For example, we found that the manual records inaccurately identified three of these nine complaints as open. In addition, Health did not make any inquiries to the regional offices about the status of these complaints, despite the manual report indicating they were unresolved after 350 days. Two of the three complaints appeared serious in nature, relating to a denial of family planning services and to the quality of care given by an obstetrician during a birth. Without a sufficient system to track complaints, Health cannot ensure that complaints are investigated and resolved in an effective and timely manner.

We also noted that Health could not monitor complaint resolution at local districts because the tracking system was unavailable for local district use. As a result, Health could not provide us with such basic information as the number of complaints filed at local districts.

(Subsequent to our audit, Health modified the complaint tracking system to make it more effective. Our initial review of these modifications found that the updated tracking system would aid in meeting Health's needs. In addition, Health officials indicated that improvements would be made to allow access to local district complaint information. However, Health must ensure that when operational, the tracking system is appropriately utilized.)

Complaint Data Analysis

MCOs are required to submit Complaint/Grievance reports to Health quarterly, which document the MCOs' complaint activity for the quarter. Health compiles this information by MCO and then produces semiannual management reports. Our audit determined, however, that Health did not have a process to trigger a timely investigation into potential problematic areas based on analysis of complaint information. We noted the following:

- Health's semiannual complaint report for the period January 1 through June 30, 1996 identified that six MCOs with among the highest number of reported complaints for the period, also had the highest number of complaints for the previous period. However, Health did not take any additional action to investigate these MCOs to determine why they had such a high number of complaints, or if corrective action or sanctions may be warranted.

- Health's complaint report for the same period also identified the five issues that received the highest number of complaints. For this period, these five issues represented more than 90 percent of the total reported complaints. However, we noted that Health had no threshold in place that would trigger an investigation into these complaints or provide information as to what action should be taken. We noted that Health took only limited investigative action on one of these five issues, which represented less than 40 percent of the total reported complaints.

We also noted that Health had not implemented procedures to compile all Medicaid Managed Care complaint information, including complaints reported to MCOs and Health, as well as those complaints reported to the local districts. Without these procedures, Health cannot ensure that MCOs are operating and resolving complaints effectively, and that problematic trends regarding complaints are addressed on a timely basis.

(Subsequent to our audit period, Health drafted procedures to perform focused reviews of complaint issues to identify potential problem areas that may require immediate follow-up. These procedures incorporate the use of some triggers that would initiate investigation and also document certain investigative actions to take.)

Recommendations

6. Update the complaint procedure manual to reflect a mechanism to ensure effective complaint resolution and time frames.

7. Implement the modified complaint tracking system and ensure its appropriate use.

8. Implement focused complaint analysis procedures.

Monitoring Recipient Materials

New York Social Services Law provides that Health will supply materials to local districts to educate recipients on how managed care works. The prepared materials should be reasonably understandable and have appropriate form with regard to culture and language, to assist recipients in making an informed choice regarding managed care and PCPs. During our audit, however, we found instances where Health provided informational materials and forms for recipient use that were misleading or incomplete.

Managed Care Brochure

In September 1996, Health developed a brochure titled "Now You Can Choose a Health Plan - Information About Medicaid Managed Care." This brochure, printed in 14 languages for statewide distribution, uses a question and answer format designed to supply recipients with basic information about services available under managed care and how it works. Our examination of the brochure identified a conflicting statement that "all" managed care plans will offer family planning services. Such a statement implies that complete family planning services will be provided by all MCOs.

Title 18, Part 505 of New York Codes, Rules and Regulations defines family planning services as the offering, arranging, and furnishing of those health services that enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. During our audit, however, we noted one MCO that does not provide many family planning and reproductive services and has opted to have reimbursement for these services excluded from its capitated rate.

Medicaid recipients, whether enrolled in managed care or receiving their health care from fee-for-service Medicaid providers, are guaranteed the right to access family planning and reproductive services (free access policy) through any Medicaid provider without obtaining a referral (approval) from their PCP. It is important that recipients reviewing even basic managed care materials be alerted that enrolling into an MCO will not automatically allow the recipient to access all family planning and reproductive services through the MCO as implied in this brochure.

We also found that the brochure, which detailed general services available under managed care, could be improved to offer similar details as to services available under the free access policy for family planning and reproductive services. These issues raise concerns that recipients are not being properly educated in various aspects of Medicaid Managed Care before enrollment. Further, enrollees requiring free access services who are unaware such services are not provided by their MCO, may find

themselves without the benefit of medical advice, support, or referral from their MCO.

(In February 1997, Health directed MCOs to provide appropriate notification to all enrollees of reproductive age of their right to access the full range of family planning and reproductive health services. Such information must also be noted in member handbooks provided by the individual MCOs. During our audit, Health officials indicated that they would amend wording on future brochures.)

Enrollment Attestation Form

New York Social Services Law requires that in locations where managed care enrollment is still voluntary, Medicaid recipients must sign an attestation form that certain required information was provided to them prior to joining an MCO. For example, recipients must be informed that managed care is a voluntary program and that they have a choice of MCOs. In response to the Medicaid Managed Care Act of 1996, Health developed a member enrollment attestation form in November 1996. Counties and MCOs should use the form as a guideline when enrolling Medicaid recipients into voluntary managed care. We determined that the form, which requires both recipient and witness signatures, although in compliance with the wording of the law, can be improved in two areas:

- In the "confirmation" section of the form, recipients are attesting that they have been told about all options available under the managed care program. However, the form does not list these options. For example, using this form, the local district would not know and cannot be sure that the recipient was informed of their option to use the MCO's grievance process to correct a problem. Without such a list of appropriately worded options on the attestation form, the recipient cannot be sure that all options were discussed during enrollment.

- In the "understanding" section of the form, recipients are acknowledging that they understand they have a choice of PCPs and that all their primary health care will be provided or approved by their PCP. This provision includes no reference to the free access policy for family planning and reproductive services. Such a provision can help recipients avoid confusion about how they can access such services under managed care.

We noted that the New York City Human Resources Administration (HRA) uses an attestation form that is more comprehensive. If used

correctly and in conjunction with a face-to-face interview with HRA staff, HRA's form provides increased assurance that important information regarding Medicaid Managed Care was discussed with the recipient by the MCO's marketing representative.

Recommendations

9. Amend the wording on future brochures to provide additional information related to family planning and reproductive services offered by MCOs.

10. Amend the enrollment attestation guideline form to provide necessary information, allowing recipients to appropriately confirm their enrollment encounter.

Contract Issues

Contract Monitoring of Performance Measure Validation

Health requires MCOs to submit annual performance measurement information to allow Health to assess MCOs' ability to meet statutory requirements for quality and delivery of services, continuity of care and accessibility. This information, which is collected for both the non-Medicaid (commercial) and Medicaid populations, must be accumulated in accordance with Health's Quality Assurance Reporting Requirements (QARR).

MCOs directly report QARR data to Health. To ensure public accountability of MCOs and their operations, Health analyzes and publicly reports annual QARR data in a comparative manner. Health recognized the importance of the public relying on accurate information, and as a result, initiated a process to validate QARR information that is submitted by MCOs to ensure its reliability. This process uses medical record reviews to validate different performance measures from year-to-year. For example, one performance measure identifies the number of women enrolled in an MCO (meeting certain criteria) who received a mammography screening for that year versus the number that should have been screened.

Health contracted with a national organization that accredits and assesses quality in MCOs to validate 1994 and 1995 QARR information through an audit. Health's contract objectives were to develop a cost effective means to evaluate the validity of QARR data, with appropriate revisions to validate future data. The objective of the validation audit was to detect over-reporting of performance measures by identifying instances where MCO medical records could not provide sufficient evidence of the reported services for specific performance measures.

Selection of measures to be audited was based on a vulnerability assessment score that rated the risk associated with processes used by the MCO to report QARR measures. The contractor was to select measures that met a high assessment score. The contractor was also responsible to decide the appropriate number and combination (commercial versus Medicaid) of performance measures to audit. The contractor provided draft and final audit reports to both Health and individual MCOs. The reports that went to the MCOs also included a detailed computation of grades associated with the overall quality of the MCO's records.

Reporting QARR data can affect the public's view of an MCO's operations, competition among individual MCOs, and MCO participation in the Medicaid Managed Care program. For example, people would be more likely to want to become members of MCOs whose QARR ratings imply that high quality services are provided. Appropriate monitoring by Health of the QARR validation audit process is necessary to ensure that the audit is performed accurately and fairly represents the reported results of all MCOs. The contractor's validation audit and Health's monitoring efforts should also ensure appropriate consideration of issues that can directly affect audit results.

We noted that Health generally provided adequate oversight during the validation audit. For example, Health officials advised the contractor to consider the 1994 QARR audit results when developing the 1995 audit methodology. In addition, Health maintained frequent telephone contact with the contractor to discuss validation audit issues. Our audit determined, however, that Health's monitoring of the validation audit did not always ensure that pertinent issues directly affecting the results were considered. We found that certain decisions related to audit methodology were sometimes determined solely by the contractor without Health's consideration, input or notification. This weakens assurance that the contractor performed in an appropriate manner and achieved the contract's objectives.

In response to our draft report, Health officials stated that allowing the contractor to make decisions in its area of expertise did not weaken the achievement of contract objectives. However, during our audit, we noted and documented several instances where Health was unaware of certain methodologies performed by the contractor. We believe that this lack of oversight weakened assurance that the contractor performed in an appropriate manner and achieved the contract's objectives, as demonstrated below.

Allocation of Audit Resources

The 1994 and 1995 QARR contain nearly three times as many Medicaid performance measures as commercial performance measures. We noted that, each year Medicaid measures are subjected to more frequent changes than commercial measures. For example, the 1995 QARR added four new Medicaid measures (well care visit for age 1, ages 4-6, and ages 12-21, and glyco-hemoglobin) and dropped three Medicaid measures (blood pressure, vision screening and hearing screening) that had been included in the 1994 QARR. During this period, the commercial measures remained unchanged.

We found that despite there being a significantly higher number of Medicaid than commercial measures, the QARR validation audit consistently covered a higher proportion of commercial measures for both 1994 and 1995. Our analysis determined that the audit effort expended was 42 percent and 31 percent greater for commercial measures than Medicaid measures for 1994 and 1995, respectively.

In response to our draft report, Health officials indicated that we are inaccurate in stating that the QARR validation audit consistently covered a higher proportion of commercial measures for 1994 and 1995. However, as noted above, our audit verified that there was indeed a higher proportion of commercial measures audited.

Health officials indicated that the difference in the number of measures (i.e., the higher number of Medicaid measures versus commercial measure) should not be a factor for validation selection. Health officials maintain that the selection methodology used by the contractor associated certain Medicaid measures with less risk, resulting in a decreased likelihood of such measures being over-reported. However, we believe that by not considering this difference, several MCO's Medicaid measures identified by the contractor with moderate amounts of risk may remain unaudited for prolonged periods. This would reduce assurance that Medicaid QARR data is valid. In contrast, an increase in the audited Medicaid measures may provide Health additional assurance as to the accuracy of QARR data associated with medical services for Medicaid Managed Care, for which the State paid $237.8 million in 1996.

In response to our draft report, Health officials disagreed with our statements regarding the consideration of Medicaid measures with moderate amounts of risk. Health officials stated that measures were selected for audit based on the combination of the following three criteria:

- the MCO's previous audit failure of the measure;
- the methodology used to collect the data for the measure; and
- whether the measure had been over-reported in the past.

However, our audit found that the contractor did not always use the selection criteria detailed above. We also noted that, despite there being a higher number of measures for Medicaid than for commercial MCOs, the audit selection methodology provided no consideration of this factor. In addition, there was no consideration of risk for measures that had not been audited in the past. Health officials indicated that there were no decisions made or discussed with the contractor to show how audit

resources would be divided between Medicaid and commercial measures. Health officials further stated that the audit imbalance will decrease as time goes on.

Adjustments for Risk

An audit vulnerability assessment or selection methodology typically assigns a score corresponding to risks associated with certain operations. Higher scores are equated with increased risks. For the QARR validation audits, the selection methodology should include analysis to determine the minimum number of measures to audit that will appropriately identify occurrences of over-reporting. In addition, such analysis should adjust for historical results and changes in both risk and the number of MCOs audited from year-to-year. We found that the contractor did not perform sufficient analysis to incorporate these attributes in the 1994 and 1995 QARR validation audits.

a. Minimum Number of Measures to Audit. Establishing a minimum number of measures to audit directly influences audit results. For example, our statistical consultant advised us that there is a significant increase in the likelihood that an MCO will fail the validation audit when the number of measures audited decreases from three to two. When too few measures are audited, the result may not appropriately reflect the MCO's operations and could inappropriately indicate audit failure.

We found that the methodology the contractor used to select the number of measures audited for each MCO for 1994 and 1995 was based on budget constraints. This methodology did not ensure that an appropriate minimum number of measures were audited. Although an additional four MCOs were audited in 1995 - from 37 to 41 - the total number of records contracted for review remained the same. Overall, fewer measures were audited for 1995, resulting in fewer measures audited for some MCOs. For example, in the 1994 audit, 3 of 37 MCOs had 2 measures audited, while in the 1995 audit, 12 of 41 MCOs had 2 measures audited. Six of these 12 MCOs failed the validation audit because 1 of the 2 audited measures failed. In these instances, although the MCOs may continue to operate, the public may have an incorrect perception that the MCOs are not appropriately providing health care services.

In response to our draft report, Health officials indicated that we have misstated the criteria for audit measure selection by stating that it was based on budget constraints. We do not agree. The contractor informed us that budget constraints drove the number of measures selected for audit. Budget constraints were also a factor in the 1995 validation audit

because, while there were more MCOs in 1995 than in 1994, there were fewer measures selected per MCO.

Health officials also stated that preliminary audit results indicated that six MCOs failed the audit because one of the two audit measures failed. We do not agree that these failures were identified through preliminary audit results. Documentation we obtained during our audit identifying the six MCOs that failed shows that the audit was completed and the results submitted to Health and the MCOs on March 12, 1997. Health later commissioned the contractor to audit an additional measure for each of the six MCOs.

This situation occurred because Health did not require that the contractor evaluate and set an appropriate minimum number of measures to audit. Further, Health officials were unaware that the contractor would base validation audits on only two measures for 1995. As a result, Health entered negotiations with the contractor to audit an additional measure for 6 of the 12 MCOs that originally had 2 measures audited and had failed the validation audit. Auditing an additional measure would provide assurance that the MCOs should, in fact, have failed. Health officials indicated that the time spent auditing additional measures after the 1995 QARR draft report was issued would not delay issuance of the final report. However, as a result, the State had to pay an additional $20,000 for this work.

b. **Adjustments Based on Historical Results.** Annual audits should include appropriate adjustments to audit methodology to aid in determining what tests should be performed based on historical results from previous audits. Spending additional audit resources on previously failed measures provides an effective way to determine whether MCOs have taken corrective action and also shows MCOs the emphasis Health places on accurate QARR reporting. In addition, to foster efficient use of resources, fewer tests should be considered for operations that had successful results.

We found that although the contractor's validation audit methodology did include 1994 measure failure as a factor in selecting the measures to audit for 1995 QARR, there was insufficient consideration of historical QARR results. For example, in the 1994 audit, of the 19 MCOs that were audited for cervical cancer screening, 17 passed the audit for that measure. During the 1995 audit, the contractor again reviewed the same measure for 11 of the 17 MCOs that passed the 1994 audit. In contrast, the contractor did not audit this measure for the two MCOs that originally failed cervical cancer screening validation for 1994. Re-auditing for the

MCOs that failed this measure would have helped to ascertain if those MCOs took corrective action.

In response to our draft report, Health officials stated their belief that previous failure of a measure should not mandate "re-measurement" in the following year. We agree that there should be no mandate to re-measure all previously failed measures. However, we believe that in selecting measures to audit, appropriate analysis should be performed to provide individual consideration of a measure's historical audit results in determining the need for re-measurement. This validation audit did not use such a methodology.

We also determined that only 4 of the 11 (36 percent) MCOs that failed the 1994 audit had more measures audited in 1995. In comparison, we found that 8 of the 26 (31 percent) MCOs that passed the 1994 audit had the same number or more measures audited in 1995. This occurred because the contractor's selection methodology did not include analysis to appropriately account for the risk of previously failed measures. Health officials indicated that there may have been insufficient time to incorporate such analysis, due to the short time frame between the 1994 and 1995 QARR validations. As a result, the 1995 audit did not appropriately consider the efficient allocation of resources based on historical results.

Compliance with Methodology

a. Vulnerability Assessment. The vulnerability assessment is used to identify and select MCO measures at risk of being over-reported using a scoring system where higher scores are equated with increased risks. The contractor's methodology required that the highest scoring MCO measures be selected for audit. Our audit found, however, the contractor did not always follow its methodology in selecting the measures to audit. We noted a total of six instances for the 1994 and 1995 audits (two and four instances, respectively) where the contractor audited the MCO's lower scoring measures instead of the highest scoring measures. When questioned, the contractor was unable to provide any explanation or documentation regarding this deviation from required methodology in four of the instances noted.

Health officials were unaware of these departures from stated methodology and expressed concern over the lack of the contractor's documentation to support such actions. However, Health officials stated their belief that there was no purposeful manipulation by the contractor during the validation audits. In addition, Health officials stated that despite the deviation from prescribed selection methodology, the MCOs' overall audit

results (pass or fail) were not affected. In the absence of documentation supporting the contractor's actions, we believe there is no assurance that these four measures were selected objectively.

b. Availability of Information. Ten percent of an MCO's grade was associated with overall data quality related to their ability to provide the contractor with correct information. The contractor assigned three possible values (0, 0.5 and 1.0) for the "Availability of Information Score." However, we found that the contractor used vague and subjective criteria to assign the value of this score. For example, the contractor's criteria assigned a score of 0.5 when the MCO "supplied information with difficulty or that later had to be corrected." Such vague criteria preclude assurance that the contractor consistently applied the scoring for this component. This occurred because neither Health nor the contractor formalized specific criteria, such as the number of records needing correction, that would have facilitated evaluation of this component.

We further noted that in the 1994 validation audit, the contractor erroneously assigned an undefined score of 0.6 to four MCOs for this component. The contractor did not provide documentation to support use of this score. Although the four errors had no material effect regarding an MCO passing or failing, such inconsistencies in the performance of an audit weaken assurance that audit results are reliable.

Review of Reports

General business practice dictates that reports should be free of errors. In November 1996, the contractor issued a final report for the 1994 QARR audit, after providing Health an initial draft report on the validation results. As part of our audit, we reviewed this final report and found 61 errors among four of five tables included in the report. Most errors - in the form of 52 blank entries - occurred in one table that was incomplete in reporting the actual measures audited and the results for each MCO. Most of the remaining errors occurred due to mistakes in the compilation of audit measure results.

In response to our draft report, Health officials stated their belief that the number of errors in the report is overstated, because 52 of the 61 errors were blank entries. However, our analysis of this report determined that in each of the 52 blank entries, a number should have appeared where we found a blank. We considered each instance to be an error. These numbers were important in this final report, because they identified the audit results for individual measures examined for each MCO.

The contractor also provided each of the 37 audited MCOs their individual audit report showing measure-specific results used to compute their overall record quality score (grade). We reviewed this documentation and found that seven of the 37 MCO reports (19 percent) contained errors. Most of the errors occurred because the contractor changed its methodology to compute the MCO grades. For example, after the audit was completed, the contractor and Health decided to exclude one measure from the grade computation for all 37 MCOs. However, the contractor failed to completely revise all the MCO reports to reflect this change. Other errors appeared to be caused by incorrect number rounding and typographical errors.

The contractor indicated that most of its work is performed manually. We determined that the contractor did not have appropriate compensating controls in place to ensure that its manual processes produced accurate and reliable data. We also found that Health does not have a process in place to ensure the accuracy of contract deliverables and therefore did not review the reports for accuracy.

We notified Health of our findings and, as a result, the contractor reissued the final report to Health. In our review of the reissued report, we found one computational error. The contractor considers the errors we identified to be insignificant because their correction did not materially alter the outcome of the report. However, we disagree that these errors are insignificant. The number of errors identified and the lack of controls in place to verify the contractor's work raises questions as to the quality of the contractor's work.

Recommendations

11. Document and monitor the minimum audit requirements and the expectations for future QARR validation audits.

12. Enhance future validation selection methodology to include appropriate analysis based on audit risks associated with historical results.

    (In response to recommendation 12, Health officials stated that they will continue to select QARR measures to be audited based on three criteria: previous failure of the measure; whether the data is collected through an administrative record review versus a medical record review versus a hybrid review; and, whether measures have been previously over-reported. In our judgment, the first of Health's three criteria for audit selection - evaluation of previously failed measures - does not sufficiently consider historical results. Appropriate analysis of each MCO's previous results viewed individually and in total should also be considered within this criteria, as well as analysis of the allocation of audit resources based on historical results.)

13. Establish a policy and supporting procedures to ensure review of all contract deliverables for accuracy and completeness.

Coordination of Local District Monitoring Activities

Medicaid Managed Care contracts identify Health and the local districts as the parties responsible for contract monitoring and evaluation. The contracts require MCOs to submit several reports to local districts on a periodic basis. These reports should aid the local districts and Health in assessing the integrity of the MCO's operation and ensuring appropriate quality of care is provided. The reports also provide some assurance that the MCO is in compliance with the contract. For example, semiannually, each MCO is required to provide the results of its medical appointment availability studies. The managed care contract requires that these studies test for difficulty in obtaining initial prenatal visits, baseline physicals, as well as routine, specialty and urgent care appointments. In addition, local districts are responsible for monitoring other quality of care issues for Medicaid Managed Care such as complaint resolution. With Medicaid Managed Care programs operating in most counties, each with varying numbers of recipients enrolled and local district resources available, Health

should have an effective process in place to ensure all local districts are appropriately and uniformly performing monitoring activities.

Our audit found that local districts are individually interpreting their role regarding monitoring quality of care for Medicaid Managed Care, including contract monitoring relating to the submission of reports. We interviewed local district officials from Albany, Rensselaer, and Schenectady counties and New York City about their managed care monitoring processes for ensuring MCO submission of reports relating to quality of care and contract compliance. We found that while the three upstate counties employed some type of monitoring, the processes were frequently informal and each county placed emphasis on different aspects of managed care operations. New York City officials were in the process of formalizing their monitoring procedures.

While officials from each of the three upstate counties stated that Health had helped them in the contract approval process, they indicated to us that they received little guidance from Health on contract monitoring. Even though New York City officials indicated a closer working relationship with Health, the resulting contract monitoring efforts were not complete and were not coordinated with Health.

We interviewed nine staff members of Health's unit responsible for local district coordination of Medicaid Managed Care. These staff members all stated that Health had not provided them with specific guidelines, instructions or forms to use in monitoring local districts. Health officials indicated that the Social Services Policy and Procedure Manual (93 ADM-1) is currently in use and addresses the role of the State in coordinating managed care contracts. We noted, however, that staff members indicated the procedure manual was outdated and under revision during our audit. Further, we noted that in their *Final Federal Monitoring Report of the New York State Medicaid Program*, dated April 10, 1996, HCFA found that 93 ADM-1 "does not reflect current policy or practice." As a result of this lack of coordination, Health cannot determine the extent that local districts are appropriately monitoring Medicaid Managed Care contracts. Such information is needed to ensure that MCOs across the State are providing the services specified and meeting the reporting requirements in the contracts for which Health and the local districts are paying them.

Health officials indicated that they are currently working on a memorandum of understanding with New York City to establish a policy and supporting procedures in anticipation of mandatory program implementation. In addition, Health plans to work with other local districts to achieve the same goal. Health should, however, recognize that coordina-

tion of monitoring efforts among local districts is also needed while the managed care program is operating voluntarily.

We also found that quality of care monitoring efforts for the two mandatory managed care demonstration projects that exist in Westchester County and within certain zip codes in Brooklyn, are not coordinated between Health and the local districts. For example, Health did not monitor Westchester county's auto-assignment rates during the county's 1996 implementation of mandatory Medicaid Managed Care. Auto-assignment is a process through which the Medicaid agency selects an MCO for recipients who have failed to choose one for themselves within a specified period.

The rate of auto-assignment can aid in measuring the effectiveness of a mandatory program's outreach and education related to enrollment. The optimal time to examine auto-assignment rates is when Medicaid Managed Care programs are transitioning from voluntary to mandatory, often resulting in a high enrollment volume within a specified period. In a 1993 report (GAO/HRD-93-46), the General Accounting Office (GAO) found that low auto-assignment rates are one indicator of successful programs. The GAO stated, "experience has shown that beneficiaries who make their own selections are generally more satisfied with their care and are more responsive." In fact, HCFA has made monitoring of auto-assignment rates a requirement in the terms and conditions of the waiver approvals permitting the State to operate mandatory Medicaid Managed Care. However, as noted above, during our audit Health failed to independently monitor the auto-assignment rates or coordinate such monitoring with Westchester county.

Monitoring of Medicaid Managed Care can be different in each county. Without a formal coordination policy for these activities, Health has no assurance that local districts are performing appropriate monitoring. Such monitoring would assist in ensuring the Medicaid Managed Care program has a high level of quality.

Recommendation

14. Establish a formal policy and supporting procedures to effectively coordinate appropriate and uniform local district contract and quality of care monitoring activities.

Monitoring of Medicaid Managed Care Contract Approval Process

To prepare for the statewide mandatory Medicaid Managed Care program, Health solicited proposals in November 1995 from MCOs interested in providing managed care services. Once the proposal evaluations were complete, local districts decided the number of contracts to be awarded based on the adequacy, location and enrollment capacity of the qualifying MCOs' provider networks.

Both Health and HCFA approve all contracts and related amendments for Medicaid Managed Care. HCFA officials indicated to us that they require Health to submit contracts to them for approval 60 to 90 days prior to the effective date of the new or renewed contract. (We noted that HCFA correspondence to State Medicaid directors dated April 27, 1995 requests final contract submittal at least 30 days prior to the proposed effective date.) Contracts submitted after a HCFA-prescribed deadline risk the loss of Federal financial participation for the previous calendar quarter.

We found that Health did not ensure local districts submitted contract renewals for approval in time to prevent expiration of existing contracts and within prescribed time frames for final approval by HCFA. As a result, we found that of 64 contracts with expiration dates of January 1, 1997, 37 expired before their renewals were submitted to or approved by Health. However, all medical services continued to be provided during the period of expiration and all contracts were submitted for HCFA approval in time to ensure Federal financial participation.

Although Health had a documented process in place to monitor contract approvals, we found this process was ineffective and could not appropriately identify the current status of all outstanding contracts. Further, this process did not ensure that contracts were submitted timely for approval. For example, Health monitored the contract approval process using three separate worksheets. We found that each worksheet contained fragmented, inconsistent and outdated information. Worksheets failed to identify the contracts set to expire. As a result, Health was unable to readily provide us with accurate information identifying both the total number of managed care contracts and the number of contracts that had expired.

Section 110 of the State Finance Law provides that the head of a department, or the party they authorize, is responsible for approving accounts and vouchers. Payments should not be approved without a valid contract in place. We noted, however, that Health approved nearly $760,000 in payments to two MCOs for three contracts that had expired. (We requested Health to withhold these payments. The payments were held and later released once the MCOs' contracts were approved by Health.)

Recommendations

15. Modify procedures to effectively monitor the contractual process for Medicaid Managed Care and ensure timely contract submission to HCFA.

16. Develop a mechanism to ensure valid contracts are in place before payment approval.

Laws and Regulations

Monitoring ADA Compliance

Subtitle A of Title II of the Americans with Disabilities Act of 1990 (ADA) prohibits public entities from discrimination on the basis of disability in all services, programs, and activities they provide. The ADA specifically states the following:

- People with disabilities cannot be denied the benefits or services, programs or activities of the public entity directly or through contractual, licensing or other arrangement.

- Benefits, aids or services must be equal to and as effective in providing the opportunity to obtain the same result, to gain the same benefit or to reach the same level of achievement as that provided to others.

- A program, when viewed in its entirety, should be readily accessible to and usable by individuals with disabilities (program accessibility).

- Communications with applicants, participants, and members of the public with disabilities should be as effective as communications with others.

In addition to the provisions in the ADA, New York State has attempted to strengthen requirements aimed at preventing discrimination against people with disabilities enrolled in Medicaid Managed Care through the 1996 Managed Care Omnibus Law, as well as through contract requirements between local districts and MCOs. The 1996 legislation formalized Health and MCO requirements for services provided to people with disabilities, as follows:

- New York Public Health Law provides that to assure the enrolled population's access to health care, the Health Commissioner must consider the availability of appropriate and timely care provided in compliance with the ADA. This assessment must be done when an MCO is initially licensed and at least every three years thereafter.

- New York Social Services Law requires that managed care providers and special needs MCOs comply with applicable State

and Federal law provisions prohibiting discrimination on the basis of disability.

Health's model contract for fully capitated managed care providers, dated May 1996, requires MCOs to implement the following:

- Satisfactory methods for ensuring participating providers are in compliance with the ADA.

- Satisfactory methods for identifying persons at risk of having chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc.

- Satisfactory case management systems to ensure all required services are furnished on a timely basis.

- Satisfactory systems for coordinating service delivery with out-of-network providers, including behavioral health providers for all members.

- Policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when it is considered in the best medical interest of the member.

We determined, however, that during our audit period, Health was unable to appropriately assess if the ADA, State legislative and MCO contract provisions regarding discrimination against people with disabilities enrolled in Medicaid Managed Care were being met. This occurred because Health has not established sufficient policies, procedures and measurements to define compliance criteria and then examine the operations of MCOs to evaluate such compliance. As a result, Health was unable to determine if appropriate and timely Medicaid Managed Care was provided in compliance with ADA requirements during our audit period.

Interpretation of ADA issues is complex, and misinformation regarding ADA compliance has circulated among both consumers and providers of medical care. Our research disclosed that the ADA regulations, related national studies, and GAO reports concerning people with disabilities and chronic illnesses in Medicaid Managed Care all demonstrate and recommend that adequate planning and consensus-building by states, with MCOs, consumers (people with disabilities and chronic illnesses), and their advocates provide the best assurance for compliance with ADA. During our audit period, we determined that Health officials met with

consumers and their advocates as stakeholders in developing the ADA compliance guidelines for Medicaid Managed Care. We support Health's actions. However, we believe that in conjunction with the recommendations cited above, Health should expand these consensus-building techniques, possibly by forming an ongoing ADA committee. Input from such a committee would help to establish guidelines, criteria and performance measurements that would appropriately assess ADA compliance for the Medicaid Managed Care program.

Since there was no State oversight of ADA compliance under Medicaid fee-for-service, Health conducted substantial ADA research and analysis to develop compliance guidelines for Medicaid Managed Care. In March 1997, Health and the New York City Office of Medicaid Managed Care (OMMC) drafted ADA Compliance Guidelines to provide standards for review of MCO compliance plans and ensure that MCOs act to assess and assure program accessibility for persons with disabilities and chronic illnesses. We noted, however, that while the guidelines addressed the contract requirements noted above, they provide only for MCOs' individual interpretation of what is considered satisfactory. We believe that interpretation of these issues will vary widely among the numerous MCOs. Lack of criteria by Health allows MCOs to develop their own, possibly vague, biased, or incomplete assessment of provider compliance. For example, when MCOs submitted proposals in November 1995 to participate in mandatory Medicaid Managed Care, OMMC required them to submit ADA compliance plans. During our review, we noted considerable variations in both form and content among the MCOs' compliance plans.

Establishing detailed criteria and definitions in the guidelines to standardize interpretation and uniform reporting by MCOs of the issues surrounding ADA compliance would facilitate Health's ADA compliance monitoring. In addition, such detailed guidelines would improve comparability of ADA compliance among MCOs and provide assurance of the Medicaid Managed Care program's accessibility to people with disabilities or chronic illnesses.

We noted the following, which serve to illustrate some of our concerns regarding ADA compliance of the State's Medicaid Managed Care programs.

Readily Accessible

Health must assess the Medicaid Managed Care program's ADA compliance to be "readily accessible to and usable by individuals with disabilities." According to the ADA, accessibility encompasses not only access for persons with mobility impairment, but also access for persons with sensory and cognitive impairments as well. However, we found that Health's review of ADA compliance over access issues merely consisted of asking MCOs to describe services and screening processes available to ensure that they conform with the ADA. Health did not verify that these services and screening processes were actually available and utilized.

Health made the ADA physical accessibility checklist available to MCOs. However, Health did not require MCOs to hold their provider networks accountable to comply with this checklist. For example, MCOs provided Health with limited information showing if their networks were wheelchair accessible. In this instance, MCOs provided no documentation of the existence of wheelchair accessibility, and Health could not determine if MCOs meet the needs of those using wheelchairs.

Health officials responded to our draft report by indicating that Health and MCOs have no authority to enforce ADA Title III requirements on public accommodations. We agree and our report does not refer to Title III issues. We also agree with Health that MCOs are responsible for ensuring that their programs and services are accessible to Medicaid enrollees; for identifying services that are not accessible and making reasonable accommodation; and, as contractors providing a government service, for providing information to government agencies regarding the overall accessibility of their networks. However, Health does need MCO information regarding Title II compliance. As a result, MCOs, in gathering this information for Title II compliance, would likely perform similar steps that would pertain to Title III issues.

We noted that Health's interpretation of "access" during our audit period also overlooked other methods of requiring MCOs to hold their providers accountable for satisfying ADA compliance such as:

- making accommodations for home or alternate site visits,
- supplying adaptive equipment and aids (such as adjustable height examination tables for wheelchair users), or
- supplying auxiliary aids and marketing materials in alternative formats to people with communication-related disabilities (such as making large type print materials or sign language interpreters available for people with vision or hearing limitations).

Operational Issues

ADA compliance ensures that services are equal to, and provide as effective an opportunity for people with disabilities as those given to others. For example, Health's model managed care contract requires that MCOs have "satisfactory case management to ensure all required services are furnished on a timely basis." However, Health has not defined standards of satisfactory case management, and the draft guidelines developed during our audit period simply require MCOs to develop their own case management protocols. Without minimum standards of case management for people with disabilities or chronic illnesses, fragmentation and disruption of treatment plans could occur. Also, without standards, it will be difficult to determine if required services are furnished on a timely basis.

In response to our draft report, Health officials stated that case management literature is clear that the term "case management" means identification, assessment, service linkage, service provision and monitoring. Health officials further stated that each individual MCO's case management program will be assessed during operational surveys to evaluate the program's effectiveness in addressing the enrolled population. We reiterate that, during our audit, Health had no standards to define what "satisfactory" case management is. In our judgment, such standards are needed to effectively evaluate MCO case management activities as required by the managed care contract.

Measures of Care

The GAO has previously reported that states cannot rely solely on patterns of disenrollments or complaints to detect systematic deficiencies in Medicaid Managed Care for enrollees with disabilities. Instead, the GAO recommended states collect comprehensive and consistent data to measure this care. As noted above, the model managed care contract lists specific MCO requirements in addressing people with chronic illnesses and physical or developmental disabilities. We found, however, that Health has not established performance measures to report specifically on care for enrollees with disabilities.

Health monitors quality of care indicators such as complaints and disenrollments, as well as numerous performance measures for the QARR, in the overall MCO enrolled population. Health officials have stated that concerns related to quality of care for people with disabilities or chronic illnesses could be identified through their general analysis of these

indicators and measures. However, such general analysis excludes measurement of the quality of care surrounding medical conditions and the provision of services that are unique to people who are chronically ill and people with disabilities.

An effective starting point for Health in the analysis of quality of care for people with disabilities may be access-specific questions in the required annual recipient satisfaction survey. Such questions could determine if the enrollee required special accommodations in order to access services and if the accommodations were satisfactory.

Other states have recognized the need to specifically monitor managed care for people with disabilities and chronic illnesses. For example, Oregon and Arizona both collect information on specific medical services (encounter data) provided to enrollees with disabilities. The GAO identified several uses of such encounter data to:

- track patterns of services by MCO or member category;
- track movements of high-cost patients; and
- analyze patterns of service to reveal access problems.

While Health collects encounter data for Medicaid Managed Care, during our audit, there was no specific analysis relating to care for people with disabilities or chronic illnesses. As a result, Health cannot adequately assess the level of care given or determine whether care is in compliance with the ADA. Monitoring enrollees with disabilities and chronic illnesses would also enable Health to use the results to apply incentives and sanctions to positively influence MCO operations.

Legislative Interpretation

New York Public Health Law §4403(6)(c) requires that MCOs establish procedures allowing enrollees with a life-threatening or a degenerative and disabling condition that requires specialized medical care over a prolonged period to select a specialist to serve as their PCP. This would allow the enrollees to seek specialized care directly and bypass the referral process. However, this and other provisions in §4403 do not provide definitions regarding the medical conditions that should be included that would ensure that MCOs uniformly interpret such requirements.

There are people with disabilities or who are chronically ill who, while not in a life-threatening or degenerative state, require specialized medical care over a prolonged period. Not receiving this specialized care in a timely manner can cause adverse health outcomes. For example, people

with spinal cord injuries are more susceptible to urinary tract infections (UTIs). Typically, UTIs are treatable by PCPs. However, such infections are serious for people with spinal cord injuries and require timely treatment by a specialist to secure a positive outcome.

Without definitions regarding the medical conditions that should be included, such enrollees may not consistently be allowed to have a specialist as their PCP, since they often achieve a maintainable health status that may not be life-threatening or degenerative. In these instances, having to visit a general practitioner PCP to obtain a referral to see a specialist could adversely impact the enrollee's health and outcome. As a result, some enrollees with disabilities or who are chronically ill may be inappropriately excluded from receiving the same benefit or services as others.

In response to our draft report, Health officials stated that a list of conditions and definitions would be restrictive in nature, would not take special circumstances into consideration and may exclude some conditions that a provider may consider as "disabling". We agree that, depending on its use, a list could exclude certain conditions and definitions. However, we believe that a mechanism should be in place to show conditions and definitions, and provide the capability to be amended as needed. This would ensure consistent opportunity for treatment among MCOs. Such a mechanism would also allow Health to monitor MCOs and ensure that people with disabilities having chronic illnesses receive appropriate referrals for specialist care.

Recommendations

17. Establish comprehensive guidelines to measure and implement procedures to appropriately assess MCO compliance with the ADA. Consider defining accessibility in a broader context.

18. Establish monitoring guidelines and quality of care measurements specifically for disabled treatment outcomes and results. Consider analyzing enrollees with disabilities or who are chronically ill as a separate category in monitoring complaints, disenrollments, grievances, utilization review decision appeals, or enrollee satisfaction surveys.

    (Subsequent to our audit period, Health officials revised the format of their draft ADA compliance guidelines to incorporate many of the issues we raised. In addition, access-specific questions covering physical and communication access, as well as questions regarding disabilities and chronic conditions were added to Health's statewide recipient satisfaction survey conducted in September 1997.)

Notice of Fair Hearing Rights

A fair hearing is a formal procedure provided by the Medicaid agency based on a request by an applicant or recipient to determine whether an action taken or failure to act by a social services agency was correct. Title 42 of the Code of Federal Regulations for Public Health provides that state Medicaid agencies provide recipients with written notice of their opportunity for a fair hearing. This should occur when the agency takes any action to suspend, terminate, or reduce services. New York Social Services Law §364-j(9) provides that an MCO or local districts, as appropriate, will provide enrollees notice of their respective rights to a fair hearing and continuing aid (known as "aid continuing"), according to applicable State and Federal laws. Aid continuing gives recipients the right to have medical assistance continued unchanged, until the fair hearing decision is issued. In addition, Title 18, Chapter II, Part 358 of New York Codes, Rules and Regulations, which details procedures related to fair hearings, requires that recipients receive timely notice of fair hearing rights. Medicaid Managed Care enrollees are afforded fair hearing rights in addition to their rights under the formal managed care grievance process. During our audit, Social Services administered fair hearings for Medicaid issues.

In August 1996, Health officials documented in its Complaints Procedure Manual, four types of instances relating to managed care enrollment eligibility that they consider eligible for a fair hearing. For example, one such instance would occur when recipients who enrolled in managed care under one medical or public assistance aid category, are later disenrolled because their aid category changed to one for which Health has not yet set appropriate managed care rates. (Subsequent to our audit period, Health agreed with HCFA regarding other additional Medicaid Managed Care situations that would also be considered eligible for a fair hearing and is working to distribute information on the complete policy to local districts. Health officials met with the local district officials of the counties that were scheduled to be implemented first into mandatory managed care.)

During our audit, we determined that local districts and MCOs are not consistently notifying recipients of their right to a fair hearing and aid continuing for issues relating to their enrollment in Medicaid Managed Care. This occurred because Health failed to provide local districts with its updated policy on this matter, or any other information to supplant the outdated 93 ADM-1 manual. Such communication would have helped to ensure consistent notification of fair hearing rights.

We interviewed local district officials from seven counties and determined that none had received Health's policy on fair hearing issues under Medicaid Managed Care. All the officials we interviewed expressed confusion over this issue. If the policy had been provided to the local districts, at a minimum enrollees with eligibility concerns over Medicaid Managed Care would have been able to be notified about their fair hearing rights.

Only one county whose officials we interviewed had a procedure in place requiring MCOs to send fair hearing notices to recipients. However, even this county's procedure did not include the provision of notices for all four situations covered by Health's policy. As a result, recipients are unaware of their recourse to request a fair hearing and continue their enrollment while Social Services determines if an action relating to such enrollment was correct.

Social Services officials reported that in 1996, there were only 39 requests for managed care related fair hearings. In contrast, Social Services officials stated they receive approximately 20,000 such requests per year for fair hearings by recipients in fee-for-service Medicaid. As of July 1, 1997, there were 661,000 Medicaid Managed Care enrollees compared to nearly 2.3 million fee-for-service Medicaid recipients. While Health and

Social Services officials expect less fair hearing requests under managed care, due to both the lower population and the formal MCO managed care grievance process in place, we believe the small number of hearings requested confirms that recipients do not understand their fair hearing rights because they are not receiving appropriate notification.

Recommendations

19. Meet with officials from all counties operating Medicaid Managed Care programs and review Health's policy regarding managed care fair hearing issues.

20. Ensure that local districts or MCOs appropriately issue fair hearing notices that alert recipients to their right to aid continuing.

Consistency of Managed Care Laws

In 1996, the State Legislature approved and the Governor signed into law amendments to New York Social Services Law §364-j. The amendments formalized the development of marketing and enrollment guidelines. These guidelines include the prohibition of certain MCO marketing practices such as door-to-door solicitation at recipients' homes. As stated above, the amended law also requires completion of enrollment attestation forms and audits of these forms. Such audits can result in suspended enrollment or MCO sanctions for failure to notify recipients appropriately about managed care.

During our audit, we examined the amended law and determined that certain provisions were inconsistent. The required guidelines, marketing prohibitions, and sanctions were specified only for counties operating voluntary Medicaid Managed Care programs. Section 364-j(4)(e)(i) of the law relates to counties that have not implemented mandatory managed care and includes the provisions cited in the previous paragraph. We noted, however, that §364-j(4)(e)(ii) of the law, relating to those counties having mandatory managed care provided no corresponding requirements.

While Health has developed marketing and enrollment guidelines which MCOs in all counties operating managed care are required to follow, there was no law to support Health's efforts for counties operating mandatory programs. Recipients enrolled in managed care in Westchester county and portions of southwest Brooklyn, where mandatory programs are operating,

were not guaranteed the same consumer protections afforded under State law as other counties. In addition, as more recipients are moved from voluntary to mandatory managed care, the consumer protections gained through the amendment of this law will be lost. During the course of our audit, we brought this matter to the attention of Health officials. In July 1997, the Legislature approved technical amendments to New York Social Services Law §364-j that provide consistent consumer protections as recommended.

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May 13, 1998

Kevin M. McClune
Audit Director
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Alfred E. Smith State Office Building
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Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report (96-S-70) entitled, "Monitoring Quality of Medicaid Managed Care".

Thank you for the opportunity to comment.

Very truly yours,

Barbara DeBuono

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

Appendix B

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 96-S-70 Entitled "Monitoring the Quality of Medicaid Managed Care"

The following are the Department of Health's (DOH) comments in response to the above cited Office of State Comptroller (OSC) Draft Audit Report entitled "Monitoring Quality of Medicaid Managed Care" (96-S-70).

I. GENERAL COMMENT

Thank you for the opportunity to respond to the Office of the State Comptroller (OSC) draft audit report entitled "Monitoring the Quality of Medicaid Managed Care" which covered the period January 1, 1996 through July 7, 1997. As the draft audit report indicates, the State Department of Health's administration of the Medicaid program, including Medicaid managed care, began in October 1996, during the first quarter of the audit period. New York State's 1915 (b) waiver, authorizing mandatory enrollment of the Aid for Dependent Children (AFDC) population in 31 counties, was approved by the federal Health Care Financing Administration (HCFA) on March 17, 1997; and the State's 1115 Waiver, authorizing mandatory enrollment statewide, was approved on July 15, 1997. Both of these approvals occurred during the last quarter of the audit period and have had profound effects on the operation of New York State's Medicaid Managed Care Program.

An important goal of the DOH and of both waiver demonstration projects is to improve access to comprehensive, quality care for the Medicaid population. Monitoring the quality of Medicaid managed care is critical to achieving this goal, and an important function of the DOH. It has always been the intention of the DOH to continuously improve, enhance and monitor the quality of Medicaid managed care through the implementation of both waiver programs.

The OSC audit occurred concurrently with the DOH's efforts to identify, design, and implement activities to change and improve many elements of the Medicaid Managed Care Program, consistent with the enactment of the 1996 Amendments to the Statewide Managed Care Act, the 1996 Managed Care Omnibus Act, and the two demonstration project waivers approved by HCFA. In fact, a number of the audit findings and recommendations represent opportunities for improvement, which had been already identified by the DOH and which were being addressed by the DOH during the period of the audit. As a result, the department is able to report significant concurrence and compliance with a number of the OSC audit recommendations at this time.

II. DOH COMMENTS ON AUDIT FINDINGS

The DOH has provided extensive comments and supporting documentation to OSC in response to preliminary findings of this audit and is pleased that a number of these clarifications have been incorporated in the draft audit report. Outstanding concerns with OSC's presentation of findings are presented as follows.

Executive Summary

(Page 1, Audit Observations and Conclusions, Paragraph 1)

The report indicates that "...Health does not have a formal statewide managed care surveillance plan to ensure Medicaid managed care is operating properly and meeting its goals."

The DOH disagrees with this subjective statement of conclusion as a surveillance plan was in place at the time of the audit. Admittedly some elements of the plan were not fully implemented, due to the ongoing evolution of the Medicaid managed care program. The surveillance plan and activities at the time included the following components:

(1) comprehensive readiness reviews of plans prior to their entering into contracts with counties for participation in the Medicaid waiver program;

(2) annual operational surveys of all participating plans to ensure ongoing compliance with all appropriate statutory, regulatory and contractual requirements;

(3) focused surveys of all plans to investigate issues of statewide significance and focused surveys targeted to specific plans, issues or problems identified through complaints, repeat patterns of non-compliance with regulatory provisions, or reports indicating problems with respect to plan marketing, claims payments, access and availability, financial data, quarterly encounter data, and quality assurance reporting requirements, etc.; and

(4) complaint tracking and monitoring.

Surveillance and Monitoring

(Page 5, Annual Operational Survey, Paragraph 1.)

The report indicates that procedures used to conduct annual operational surveys during the period of the audit "...did not address several regulatory provisions."

The DOH maintains that the annual operational surveys did address all appropriate statutory, regulatory and contractual requirements for plans even though citations for each regulatory provision did not appear in the on-site survey tool. Annual operational surveys consist of two components: (1) the pre-survey collection and review of documentation submitted by plans; and (2) the on-site survey. A number of regulatory requirements are addressed through the review of materials plans are required to submit to the DOH as part of the pre-survey component of the annual operational survey. The concern raised by OSC that the survey did not address all regulatory provisions may be due to the fact that the on-site survey document did not address all regulatory provisions since a number of the regulatory provisions were addressed in the review of pre-survey documentation submitted by plans.

(Page 6, Focused Surveillance, Paragraph 2.)

The report indicates that "...Health conducted nine focused surveys covering a limited number of areas."

As indicated in a previous response to OSC, the DOH conducted 68 focused surveys during the audit period, including 51 statutory compliance reviews.

(Page 6, Focused Surveillance, Paragraph 2.)

The report indicates that subsequent to their examination of this area, "...Health contracted with the Island Peer Review Organization to conduct a yearly statewide access and availability study that began in March 1997."

The DOH would like to note that this contract was initiated during the audit period and represents the <u>first time nationally</u> that any state has conducted an access and availability study of this scope.

(Page 7, Reporting of Surveillance Data, Paragraph 2.)

The report indicates that "...Health officials were unable to produce reports summarizing the most current access and availability studies (August 1995) and follow-up of MCO corrective action."

A report entitled "Follow-Up Activity Report for Access Study, August 1995" was provided to OSC by the DOH in response to a preliminary audit report, along with a summary of the

results of the access and availability study. These documents described the results of the survey and actions taken by the DOH to ensure Managed Care Organizations (MCO) implementation of approved plans of correction.

(P. 9, Complaint Resolution, Paragraphs 2 and 3.)

The report states that "...After examining Medicaid Managed Care complaint documentation, we determined that Health's complaint resolution process does not ensure timely and effective resolution. Regional offices took an average of 93 days to resolve a complaint."

The DOH Office of Managed Care's complaint policies and procedures were first drafted in August 1995 with revisions in August 1996 and in July 1997. The most current revisions have brought the procedures into full compliance with the provisions of the Managed Care Bill of Rights and the HCFA 1115 waiver requirements.

Historically, time frames for complaint resolution were not incorporated in the policies and procedures used by the DOH except for complaints deemed to be urgent. This enabled the DOH to address the most serious complaints first, and to prioritize the follow-up of other complaints based on the nature and severity of the complaint. Complaint investigations are often resource-intensive and can involve interviewing several complainants, plan employees, on-site investigations, and medical record reviews.

In July 1997, time frames were established for DOH resolution of all complaints, consistent with the Managed Care Bill of Rights and HCFA waiver requirements. Specific time frames were also established for managed care plans to advise the DOH's regional offices of the status of their efforts to investigate complaints. DOH staff are now required to make their determinations of complaints within 45 business days after receipt of all necessary information for all complaints except in the following circumstances: complaints regarding referrals or disputes involving enrollee contract benefits must be resolved within 30 business days after receipt of all necessary information; and complaints determined to involve an immediate risk to a complainant's health must be resolved within 2 business days after receipt of all necessary information.

The DOH maintains that the examples of untimely complaint resolution cited by the OSC in the draft report are overstated. In a review of the 24 complaints initiated during the audit period which appeared to be open for more than 45 days, the DOH found that complaints were acknowledged within an average of 4 days and that investigations were initiated by regional office staff within an average of 18 days. Many of these complaints may, in actuality, have been resolved prior to all appropriate information being entered into the complaint tracking system used at the time, since a complaint was not closed out in the

tracking system until all outstanding correspondence and reports were filed, even if other appropriate actions satisfying the complaint had been taken.

Contract Issues

(P. 16 and 17, Background)

As the OSC draft audit report indicates, the DOH initiated a contract with the National Commission for Quality Assurance (NCQA) to develop a cost effective means to evaluate the validity of Quality Assurance Reporting Requirements (QARR) reported by MCOs for 1994 and 1995. This was among the first audits of its kind nationally. NCQA's "limited" experience was the most extensive experience around at the time. The DOH believes that OSC's audit findings on the performance measure validation audit should be interpreted in this light.

(P. 17, Background, Paragraph 2.)

The report states that "...certain decisions related to audit methodology were sometimes determined without Health's consideration, input or notification. This weakens assurance that the contractor performed in an appropriate manner and achieved the contract's objectives."

The DOH conducted weekly conference calls with NCQA to monitor the contract and to provide insight and input on each step of the validation process. While some decisions were made by NCQA, the DOH maintains that allowing this contractor to make decisions in its area of expertise did not weaken the achievement of contract objectives as suggested by OSC.

(P. 17, Allocation of Audit Resources, Paragraph 2.)

The report states that "...despite there being a significantly higher number of Medicaid than commercial measures, the QARR validation audit consistently covered a higher proportion of commercial measures for both 1994 and 1995."

The DOH maintains that this statement is not accurate or particularly meaningful. Since an audit of this nature is designed to assess a health plan's reporting capacity and since the information systems and personnel used to generate QARR are the same regardless of payor type, the DOH believes that a plan's reporting capacity can be assessed regardless of the proportion of Medicaid or commercial QARR measures audited. However, for the record, the DOH audited 76 commercial measures and 83 Medicaid measures, and 59 commercial measures and 89 Medicaid measures in 1994 and 1995,

respectively. Also of importance is the fact explained to OSC auditors previously, that measures were selected to be audited based on their potential to be over-reported by plans. Measures which can be validated by medical chart reviews are less likely to be over-reported and therefore were weighted less than those measures which would have to be initially assessed by plans, and later audited by NCQA, using administrative measures. Most Medicaid measures can be collected through chart reviews.

(P.17, Allocation of Resources, Paragraph 1.)

The report states that "...Health officials maintain that the selection methodology used by the contractor associated certain Medicaid measures with less risk , resulting in a decreased likelihood of such measures being over-reported. By not considering this difference, several Medicaid measures identified by the contractor with moderate amounts of risk may remain unaudited for prolonged periods."

The DOH disagrees with this logic because measures are selected for audit based on the combination of three criteria: the plan's previous failure of the measure; whether the measure is collected through an administrative review versus a medical record review versus some kind of a hybrid review; and whether the measure has been over-reported in the past. These three criteria constitute the majority of risk in performance measurement and do not reduce assurance that Medicaid QARR data with moderate amounts of risk may remain unaudited.

(P. 18. Allocation of Audit Resources, Paragraph 1.)

The report indicates that " ...an increase in the audited Medicaid measures may provide Health additional assurance to the accuracy of QARR data associated with medical services for Medicaid Managed Care, for which the State paid $237.8 million in 1996."

The DOH wishes to clarify that this initiative of performance measurement of managed care plans is not specifically targeted solely to the Medicaid program. The Office of Managed Care has oversight responsibility for the quality of care for the commercially insured population as well. There are ten times as many commercial enrollees as Medicaid enrollees in managed care plans in New York State at this time. The DOH does not believe that designing an audit strategy which would have audited ten times as many commercial measures as Medicaid measures would be rational or prudent, although this would be an extension of the "parity" argument raised by OSC with respect to the type of measures audited, by payor. In summary, the DOH does not believe that the cost of auditing additional Medicaid measures would be worth the marginal gain, if any, likely to be achieved from such an effort.

(P18, Adjustments for Risk, Paragraph 3.)

The report states that "...the methodology the contractor used to select the number of measures audited for each MCO for 1994 and 1995 was based on budget constraints."

The DOH maintains that this statement is not accurate. The criteria used in developing the strategy for this validation audit have already been enumerated in this document.

(P. 18, Adjustments for Risk, Paragraph 3.)

The report states that "...six of 12 MCOs failed the validation audit because 1 of the 2 audited measures failed. In these instances, although the MCOs may continue to operate, the public may have an incorrect perception that the MCOs are not appropriately providing health care services."

When preliminary audit results indicated that six plans failed the audit because one of the two audit measures failed, the DOH commissioned NCQA to audit an additional measure for each of the six plans. The publicly-released audit results reflected the inclusion of the additional measure.

(P. 19, Adjustments for Risk, Paragraph 3.)

The report states that there were "...insufficient consideration of historical QARR results."

Historic results are only one of the three criteria used to select a measure to be audited. Data from 1994 through 1996 show that previously failed measures pass at a high rate upon pre-audit. For this reason, the DOH does not believe that previous failure of a measure should mandate re-measurement.

(P. 21, Review of Reports, Paragraph 1.)

The report states "As part of our audit, we reviewed this final report and found 61 errors among four of the five tables included in the report."

While the DOH is also concerned with computational errors in the reports from NQCA, the DOH believes that the number of errors in the report is over stated. The "errors" were blank entries for 52 of 61 so-called errors identified. None of the nine remaining computational errors resulted in a change of a plan's pass/fail status. The DOH has since developed processes to safeguard against computational errors in contract deliverables in the future.

Laws And Regulations

(P 29, Readily Accessible, Paragraphs 1 & 2.)

The report indicates that MCOs should be required to "...hold their providers accountable for satisfying ADA compliance..."

OSC has an inaccurate understanding of the scope of Titles II and III of the Americans with Disabilities Act (ADA). MCO responsibilities for compliance with the ADA are imposed under Title II when, as a contractor in a Medicaid program, a plan is providing a government service. The goals of compliance with ADA Title II requirements are to offer a level of services that allow people with disabilities access to the program in its entirety, and the ability to achieve the same health care results as any program participant. If an individual provider under contract with the MCO is not accessible, it is the responsibility of the MCO to make arrangements to assure that alternative services are provided. The MCO may determine it is expedient to make arrangements with other providers, or to describe reasonable alternative means and methods to make these services accessible through existing contractors.

MCO responsibilities for compliance with the ADA are also imposed under Title III when the MCO functions as a public accommodation providing services to individuals (e.g. when plans offer services such as marketing, education, member services, orientation, complaints and appeals). The goals of compliance with ADA Title III requirements are to offer a level of services that allows people with disabilities full and equal enjoyment of the goods, services, facilities or accommodations that the entity provides for its customers or clients. New and renovated areas and facilities must be as accessible as possible to persons with disabilities. Whenever MCOs engage in new construction or renovation, compliance is required with accessible design and construction standards promulgated pursuant to the ADA as well as with State and local laws. Title III also requires that public accommodations undertake "readily achievable barrier removal" in existing facilities where architectural and communications barriers can be removed easily and without much difficulty or expense.

MCOs are not required to "hold their provider networks accountable" for ADA compliance. DOH has no authority to enforce Title III requirements on public accommodations, and neither do MCOs. The DOH has no authority, for example, to enforce Title III requirements on commercial providers. MCOs are, however, responsible for: ensuring that their programs and services are accessible to Medicaid enrollees; identifying services that are not accessible and making reasonable accommodation; and, as contractors providing a government service, for providing information to government agencies regarding the overall accessibility of their networks. For services directly provided by the MCO., (e.g. member services and orientation), the MCO has Title III responsibility as a public accommodation

as well as Title II responsibility for total program accessibility.

(Page 29, Operational Issues, Paragraph 1.)

The report states, "...Health has not defined standards of satisfactory case management, and the draft guidelines developed during our audit period simply require MCOs to develop their own case management protocols."

Under the request for proposals for plans to participate in the 1115 waiver program, a primary care provider is responsible for delivering medically necessary primary care services; making referrals for specialty care and other medically necessary services; coordinating each patient's overall course of care with out-of-network providers to the extent possible; and maintaining current medical records for each patient. These activities are case management functions, and they are required for **every** enrollee, including enrollees with disabilities. All participating MCOs must have in place adequate case management systems to identify the service needs of all chronically ill and disabled members and ensure that medically necessary covered benefits are delivered in a timely way. Case management literature is clear that the term "case management" means identification, assessment, service linkage, service provision, reassessment and monitoring. Each individual MCO's case management program will be assessed during annual operational surveys to assess the program's effectiveness in addressing the enrolled population. MCOs are expected to provide the most appropriate level of care and coordination for **every** enrollee, regardless of diagnosis. The intent of the ADA legislation is to prevent discrimination on the basis of disability, and to increase access to services for people with disabilities, without further stigmatizing or segregating them. Effective case management recognizes differences in needs and preferences, and inserts coordination and assistance where necessary and desirable. MCOs need to have flexibility in establishing case management systems tailored to the needs of actual enrollees.

(Page 30, Measures of Care, Paragraphs 1 & 2.)

The report states, "...Health has not established performance measures to report specifically on care for enrollees with disabilities." OSC also states, "For example, the rate of enrolled women wheelchair users who have had mammography screening would be useful since most mammography equipment is inaccessible to these women."

SSI recipients account for the largest percentage of people with disabilities receiving Medicaid benefits. Medicaid managed care enrollment of SSI recipients has been very low since currently, the SSI population is not a mandatory category, but a voluntary one. As the Medicaid managed care program evolves and the rate of SSI enrollees increases, the need for monitoring of services for this population will be even greater. Analysis of QARR

and encounter data is being tailored to capture measurement of services utilized by populations with disabilities.

The DOH recently completed a study of chronically ill populations to assess mental health and substance abuse treatment. The data from this study will assist the DOH in the development of performance measures for these populations.

The DOH questions the OSC's statement that most mammography equipment is inaccessible to women using wheelchairs.

The federal Mammography Quality Standards Act of 1994 established stringent requirements regarding mammography equipment, which required many, if not most, radiology departments offering mammography to replace old, obsolete equipment with new equipment. Many of these newer models are adaptable for people with disabilities. Additionally, many wheelchairs have retractable arms, making them adaptable to positioning for mammography. Also, many wheelchair users can be moved to a regular chair for the period of time it takes to complete the mammography. These facts lead us to question the issue raised by OSC. In the event that none of these options are viable, it would be the responsibility of the MCO to make reasonable accommodations that would allow persons using wheelchairs to have the necessary screening performed. If most mammography equipment is truly inaccessible to persons in wheelchairs, the issue is pervasive and needs to be addressed for commercially enrolled populations and fee-for-service populations as well as for populations served by Medicaid managed care.

(Page 31, Legislative Interpretation, Paragraph 1.)

The report states, "Without definitions regarding the medical conditions that should be included, such enrollees may not consistently be allowed to have a specialist as their PCP, since they often achieve a maintainable health status that may not be life-threatening or degenerative." OSC also states, "Typically, UTIs are treatable by PCPs. However, such infections are serious for people with spinal cord injuries and require timely treatment by a specialist to secure a positive outcome."

The DOH agrees with OSC that Section 4403 does not provide definitions of the medical conditions that are covered in this section; however, we see this as a positive aspect of the legislation. A "list" of conditions and definitions would be restrictive in nature, would not take special circumstances into consideration, and might exclude some conditions that a PCP would consider to be "disabling".

The current managed care contract requires MCOs to provide the following:

1. Satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc.

2. Policies and procedures to allow for standing referrals to specialist physicians for enrollees who have ongoing needs for care from such specialists;

3. Policies and procedures to allow enrollees with a life-threatening or degenerative and disabling disease or condition, which requires prolonged specialized medical care, to receive a referral to a specialist, who will then function as both the primary care and specialty care provider for that enrollee;

4. Policies and procedures to allow enrollees with a life-threatening or a degenerative and disabling condition or disease, which requires prolonged specialized medical care, to receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition.

It is clear that the **needs** of the individual are key in these requirements. In reference to the OSC example of spinal cord injury and UTI, the DOH would agree that a spinal cord injury would qualify as both disabling and degenerative, even if the condition can be temporarily stabilized. The DOH would also agree with OSC that UTIs are serious infections for people with spinal cord injuries, and that they require timely treatment. However, the DOH would disagree that this treatment requires a specialist to secure a positive outcome. Competent PCPs know how to treat UTIs in people with complex, high-risk conditions. As the law states, if the PCP or MCO in consultation with a medical director of the organization and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the enrollee would be referred to such a specialist.

III. DOH RESPONSE TO RECOMMENDATIONS IN OSC DRAFT AUDIT

The following comments represent DOH's responses to each of the recommendations contained in the draft audit report.

Recommendation #1: Formalize and implement a statewide Medicaid Managed Care surveillance plan.

Response #1: The DOH has a comprehensive surveillance program plan in place to monitor all aspects of MCO performance. To participate in Medicaid managed care, managed care organizations (MCOs) must be certified and participate in the DOH's qualification process. MCOs are required to submit proposals which provide detailed information on their general technical capabilities, their network composition, and their current financial status and capitation rate proposal. Local social services districts (LDSS) participate with the DOH as co-reviewers in the plan qualification process. A LDSS makes a selection from the qualified plans of those with which it intends to contract. Before a LDSS executes a contract with a qualified plan, the DOH must verify the readiness of MCOs to enroll and serve Medicaid beneficiaries under the waiver program. Using a formal readiness review tool and trained staff from the central and regional offices, the DOH conducts the reviews, analyzes the results, requests and receives corrective action plans from MCOs as necessary, and monitors compliance with these corrective action plans. Readiness reviews serve to assure that MCOs are able to operationalize all 1115 waiver and contract requirements. Once plans are participating in the Medicaid managed care program, they are monitored by the DOH's other surveillance activities which include the following components: 1) routine analysis and monitoring of performance data submitted by MCOs; 2) comprehensive annual operational surveys; 3) other focused reviews or surveys designed to monitor areas of statewide concern; and 4) special targeted studies implemented as needed in response to problems or issues identified through routine monitoring efforts or complaints. These activities and the respective roles of the DOH, LDSSs and MCOs are enumerated in the Office of Managed Care's 1115 Waiver Operational Protocol and the Policies and Procedures Manual. Both of these documents have undergone several revisions based on input from HFCA and affected parties and are expected to be finalized in the near future.

Examples of data MCOs are required to routinely report to the DOH include: encounter data, third party health insurance information, quality assurance reporting requirements, complaint reports, provider network reports, results of appointment availability and 24-hour access studies, and results of member satisfaction surveys. These data are compiled by DOH and used to monitor trends, evaluate performance, and target problem areas for follow-up either through operational surveys or focused studies or reviews. Much of this data is reported back to MCOs and LDSSs to assist them in promoting self-improvement. Other data will be made available to consumers to assist them in selecting plans to meet their needs.

The DOH conducts operational surveys of all MCOs on an annual basis to ensure compliance with all appropriate statutory, regulatory and contractual requirements for plans participating in the Medicaid managed care program. A new survey tool and protocol (interpretive guidelines) for conducting operational surveys was finalized and staff were trained in the use of these tools in October 1997. The operational survey includes a pre-survey review of reported data and other documentation that plans must submit prior to the on-site review by DOH survey teams. The on-site review is used to validate reports and data previously submitted by the MCO and to conduct more in-depth reviews of areas that have been identified as potentially problematic. An important component of the operational survey is an in-depth review of each MCO's internal quality assurance activities. The on-site component of the operational survey generally takes 2-3 days and concludes with an exit interview during which DOH staff inform plans of the positive findings, concerns and deficiencies identified by the review. If deficiencies are identified, the State must issue a written statement of deficiency which cites the specific area(s) of non-compliance within 20 business days of the on-site survey. Plans are required to submit plans of correction within 20 business days of their receipt of the deficiency statements. DOH staff conduct follow-up visits as necessary to assess an MCO's progress in implementing the plans of correction.

Focused studies or reviews include statewide or plan-specific reviews targeted to issues or suspected deficiencies that may be identified through complaints, repeated patterns of non-compliance, or routine monitoring of reported data. Focused studies may also be required to monitor compliance with new program requirements. Examples of such studies include a survey to determine plan compliance with the Managed Care Omnibus Act, appointment availability studies, marketing and enrollment studies, and claims payment studies. As with the annual operational reviews, the DOH will issue statements of deficiency to MCOs found to be out of compliance with statutory, regulatory or contractual requirements as a result of a targeted study and will require the MCO to submit a plan of correction.

Ongoing statewide focused studies include a statewide access and availability study which began in March 1997, a statewide survey of patient's experience of care which began in September 1997, and a statewide survey of MCO compliance with disclosure requirements which began in January 1998.

Recommendation #2: Ensure that surveillance procedures include appropriate processes to ensure compliance with regulatory, statutory and contractual provisions.

Response #2: The DOH agrees that surveillance procedures should include appropriate processes to ensure compliance with regulatory, statutory and contractual provisions applicable to MCOs. The DOH Article 44 Operational Survey HMO/PHSP Review Tool and accompanying Protocol for Operational Surveys finalized in October, 1997, explicitly directs

the survey process and includes citations of all statutory, regulatory and contractual requirements applicable to MCOs. The pre-survey documentation required to be submitted by plans prior to the on-site review is now clearly itemized as part of the protocol. This should serve to address many of the concerns OSC auditors expressed relative to the completion of surveillance elements.

Recommendation #3: Ensure that annual surveys of MCOs with NCQA accreditation include appropriate processes not covered by NCQA.

Response #3: The DOH agrees that annual surveys of MCOs with NCQA accreditation should include appropriate processes not covered by NCQA. The department's guidelines for Article 44 Operational Surveys, revised in 1997, permits the DOH to waive certain components of the annual operational review---those dealing with credentialing/recredentialling, quality assurance/improvement or medical records review---if the MCO has full NCQA accreditation. The decision to waive these components is made by the regional office based on a plan's overall compliance history, its level of Medicaid enrollment, and proximity in time of the NCQA accreditation review. The guidelines state that PHSPs and MCOs serving the Medicaid population must always undergo a medical records review since PHSPs do not traditionally obtain NCQA accreditation, and since NCQA does not review the medical records of Medicaid enrollees in MCOs.

Recommendation #4: Ensure that focused surveillance includes processes that can be used to trigger additional investigation when needed.

Response #4: The DOH agrees with the recommendation that the findings of focused surveillance should be used to examine specific issues and operations that can aid in assessing the quality of Medicaid managed care. The findings from such surveys and studies, from the annual operational surveys, and from data routinely reported by plans should be used by the DOH to forecast problems, and to trigger interventions or other activities by the DOH, by LDSSs and by MCOs to improve the quality of care offered by the Medicaid managed care program. To further address this issue, the Office of Managed Care will develop a process to review all available data sources and recommend algorithms that might be routinely applied to such data sources to serve as a management tool for initiating future activities or interventions by the Office of Managed Care to improve the quality of Medicaid managed care.

Recommendation #5: Ensure surveillance and monitoring activities are appropriately summarized and reported.

Response #5: The DOH agrees that surveillance and monitoring activities should be appropriately summarized and reported. Currently citations are given to plans to the form of a statement of deficiency (SOD) when problems are detected during the surveillance

process. An MCO is expected to respond in writing with a plan of correction (POC). The POC is reviewed and approved by regional office staff who are also responsible for ensuring that compliance is achieved. Regional staff communicate with central office staff and provide paper copies of appropriate documents for central office files. The DOH intends to improve this process by establishing an electronic data base that can be used to track SODs and compliance with POCs on a real time basis. Such a data base would enhance the ability of the DOH to generate and use routine summary reports on surveillance and monitoring activities a in timely manner.

Recommendation #6: Update the complaint procedure manual to reflect a mechanism to ensure effective complaint resolution and time frames.

Response #6: The DOH revised its complaint resolution procedures in July 1997 to include time frames and procedures for complaint resolution in compliance with the Managed Care Bill of Rights and all 1115 Waiver requirements. These procedures can be found in both in the most current revisions of the 1115 Waiver Operational Protocol and the Policies and Procedures Manual of the Office of Managed Care. These improved procedures include requirements for DOH resolution of complaints, including specific time frames for MCOs to advise the regional offices of the status of an MCO's complaint investigation. DOH staff must respond to all complaints and appeals filed within 45 business days after receipt of all necessary information except in the following circumstances: complaints regarding referrals or disputes involving enrollee contracts benefits must be resolved within 30 business days after receipt of all necessary information; and complaints determined to involve an immediate risk to a complainant's health must be resolved within 2 business days after receipt of all necessary information.

Recommendation #7: Implement the modified complaint tracking system and ensure its appropriate use.

Response #7: A modified complaint tracking system has been developed and implemented by the DOH. The revised Uniform Complaint Tracking system was field tested in August 1997 and subsequently phased in on a region by region basis. Currently in use statewide, this system facilitates timely data entry and the generation of management reports such as total complaints by MCO, total complaints by category, resolution time frames, etc. This information can be produced by region and statewide. In addition, the central office will have the capacity to link into regional office databases which will facilitate the exchange of complaint information.

On a quarterly basis, MCOs in counties implementing the 1115 waiver must now submit information on the number of complaints and appeals received in defined categories. Complaints that have not been resolved within a 45-day time frame must be reported separately. A summary of these individual complaints and actions taken by the MCO must

be made available as needed. The DOH and local social service districts use the same format to capture complaints received directly by them. The use of standardized formats allows for a more comprehensive review of complaint activity and the timely identification of and response to potential problems or issues.

In general, LDSSs review complaints relating to eligibility, enrollment and disenrollement issues, while the DOH is responsible for reviewing complaints dealing with medical/clinical issues, dissatisfaction with quality of care, difficulty in obtaining referrals to specialists, appointment availability, dissatisfaction with ancillary services and special care services, billing/reimbursement and marketing issues. The review of marketing complaints is coordinated between LDSS and DOH.

Recommendation #8: Implement focused complaint analysis procedures.

Response #8: The semi-annual and annual complaint report was redesigned to enable the DOH to target plans and/or issues resulting from the implementation of the Medicaid managed care program. The information is self-reported by the plans and is integrated with complaints received by the state to assist to in obtaining a complete profile of complaints generated by Medicaid managed care enrollees. The review and analysis of this information will be used to identify the need for focused surveys. Complaint data are also reviewed by survey staff prior to conducting on-site surveys so that potential problem areas may be flagged. As described above, information is routinely monitored and used to trigger additional activities to improve the quality of Medicaid managed care.

Recommendation #9: Amend the wording on future brochures to provide additional information related to family planning and reproductive services offered by MCOs.

Response #9: The DOH is currently reviewing all brochures to ensure their accuracy and consistency with state law and HCFA requirements for the 1115 waiver. Revised materials will be produced by June 30, 1998 which will clarify the free access policy for all managed care enrollees.

In the interim, a new brochure was developed for use in 1115 waiver counties that makes it clear that managed care enrollees may go to any health care provider participating in the Medicaid program for family planning services without a referral from their primary care doctor, or use their MCO for these services if their MCO offers them. This information has been available as a two-sided black and white printed fact sheet, but has recently been produced in a colored brochure format.

Additionally, to assist in promoting this message, the DOH has contracted with the New York City Planned Parenthood and three upstate Planned Parenthoods to develop educational materials related to the Medicaid managed care free access to family planning

and reproductive health services policy.

Recommendation #10: Amend the enrollment attestation guideline form to provide necessary information, allowing recipients to appropriately confirm their enrollment encounter.

Response #10: By June 30, 1998, the DOH will review both voluntary and mandatory attestation forms to ensure consistency with state statute and HCFA 1115 waiver requirements. Consideration will be given to amending the attestation forms to broaden the list of client rights and responsibilities under the managed care program to provide greater assurance that important information about the Medicaid managed care program is addressed with the recipient during the enrollment process.

Recommendation #11: Document and monitor the minimum audit requirements and the expectations for future QARR validation audits.

Response #11: For the QARR 1996 audit completed in January 1998, a minimum of three measures were established for commercial plans; five measures for Medicaid-only plans; and seven measures for plans that serve both populations. The 1996 QARR audit and future audits will only report a pass/fail grade for plans with at least three measures audited. So if a plan is audited on less than three measures (due to the small size of the plan or because the plan was new), the results would not be assessed as pass/fail.

Recommendation #12: Enhance future validation selection methodology to include appropriate analysis based on audit risks associated with historical results.

Response #12: The DOH will continue to select QARR measures to be audited based on the combination of three criteria: previous failure of the measure, whether the data is collected through an administrative record review versus a medical record review versus a hybrid review, and whether measures have been previously over-reported. For QARR 1996 and future validations of QARR, the combination of these three criteria will define risk in performance measurement.

Recommendation #13: Establish a policy and supporting procedures to ensure review of all contract deliverables for accuracy and completeness.

Response #13: Policies have been established to review and examine all contract deliverables for accuracy and completeness. Staff have been assigned to review the 1996 QARR audit for errors and consistency of results. Future QARR validation studies will adhere to these policies. Draft reports are commented on, and reviewed for errors in computation and in presentation.

Recommendation #14: Establish a formal policy and supporting procedures to effectively coordinate appropriate and uniform local district contract and quality of care monitoring activities.

Response #14: All LDSS's implementing the 1115 waiver as approved by HCFA have begun expanded monitoring activities as required by the Special Terms and Conditions. The DOH will be reviewing their progress through a new process of annual LDSS surveillance visits, which will begin in the summer of 1998. A protocol to guide the DOH annual local district managed care program review has been developed and field-tested by staff and will be finalized in the near future.

The most recent revisions of the DOH Office of Managed Care's Policy and Procedures Manual and the 1115 Waiver Operational Protocol address uniform procedures for local district monitoring of contracts. These procedures clearly delineate the local district's role in monitoring contracts, as well as the DOH's role, and will result in more standardized monitoring activities statewide. For the record, it must be noted that local LDSSs have varying levels of staff resources available for Medicaid managed care-related activities. This may influence the ability of districts to carry out the required contract monitoring activities. In districts unable to play an active role in monitoring, the State will assume a more active role. In general, the LDSS is responsible for review and approval of MCO marketing materials (unless delegated to DOH); routine on-site monitoring of the MCO marketing and enrollment assistance activities; monitoring of MCO enrollments against projections to ensure MCOs do not exceed capacity; investigation and resolution of enrollment and marketing-related complaints and grievances; and referring other complaints to the DOH.

In February, 1998, the DOH and the New York City Office of Managed Care executed a Memorandum of Understanding and a Side Letter of Agreement to effectuate a collaborative process between the two entities in the administration of the Medicaid managed care program in New York City and to clarify the roles and responsibilities of each entity.

The level of auto-assignments have been monitored by the DOH and the LDSS since February 1998 which was the first month that auto-assignment occurred. If, at any time, the auto-assignment rate rises above 40% but remains below 50%, the DOH will investigate the potential reasons for this level of auto-assignment. If the rate rises above 50%, the DOH will develop a corrective action plan for the district which includes targeted initiatives for lowering the auto-assign rate by increasing the level of self-selection. The DOH will consult with the Enrollment and Benefits Counselor in NYC or the local district on any specific efforts and initiatives to be undertaken to reduce the auto-assignment rate and to minimize the number of persons so assigned to a plan. So far, the auto assignment rate in Phase I Counties has remained below 25%.

The DOH will also monitor the level of MCO change requests received from auto-assigned persons within the first 60 calendar days of their enrollment in an MCO. The DOH will analyze the rate of MCO change requests on an inter-district comparative basis and evaluate the rate in terms of the experience of other states with mandatory managed care programs. In districts where the rate of change appears high, the DOH will work with the LDSS to improve its outreach and educational efforts.

Recommendation #15: Modify procedures to effectively monitor the contractual process for Medicaid Managed Care and ensure timely contract submission to HCFA.

Recommendation #16: Develop a mechanism to ensure valid contracts are in place before payment approval.

Responses #15 and #16: The Office of Managed Care, as a direct result of an OSC preliminary audit recommendation, has consolidated the tracking of Medicaid managed care contracts into one computerized database. This database, which utilizes Approach software, includes important information on each contract such as the contract term, date of submission, status of review , date of submission to, and approval by HCFA, etc. The tracking system can also generate management reports that identify contracts which will expire within a targeted time frame. This will enable the DOH to ensure that steps are taken to renew contracts prior to their expiration, to monitor the status of contract modifications, and to ensure that contracts are in place prior to payment approval.

Recommendation #17: Establish comprehensive guidelines to measure and implement procedures to appropriately assess MCO compliance with the ADA. Consider defining accessibility in a broader context.

Response #17: The DOH has developed final guidelines for compliance with Americans with Disabilities Act (ADA). The methodology used by the DOH to develop ADA guidelines included: analysis of the ADA; analysis of current programmatic and contract requirements related to ADA compliance and service provision to individuals with chronic illnesses and conditions; analysis of State managed care laws and regulations; consultation with the New York State Office of the Advocate for People with Disabilities; dialogue with advocates for people who are disabled or chronically ill; and review of nationally recognized studies. Unfortunately, as there was formerly no state oversight of ADA compliance in the fee-for-service Medicaid program, there was no guidance for the DOH to use in the development of compliance guidelines.

In the fall of 1996, the Office of Managed Care began working with the New York City's Office of Medicaid Managed Care (OMMC) on the development of guidelines for ADA compliance by MCOs. A workgroup was established that included representatives from: NYC OMMC, DOH, health plans, advocacy groups, and the NYC Office for People with

Disabilities. Advocacy groups included representatives from the New York City Task Force on Medicaid Managed Care, the Eastern Paralyzed Veterans Association, the NY Society for the Deaf, and the Gay Men's Health Crisis. Representatives with expertise in specific disabilities (e.g. mobility, hearing, vision) from the advocate community addressed the workgroup to voice specific concerns. Plan representatives and advocates openly discussed potential issues surrounding compliance and potential methods of achieving and measuring compliance.

Subsequently, from March to August, 1997, draft guidelines were developed by the DOH and OMMC, with review and advisement from the NYS Office of Advocate for Persons with Disabilities and the NYC Office for People with Disabilities. During this time, the New York City Task Force on Medicaid Managed Care responded with a thirty page letter addressing issues raised during the workgroup meetings. Most of the recommendations contained in this letter were incorporated into the guideline document. On 9/25/97, the draft guideline document was widely distributed for comment to approximately 20 affected/interested groups:

On October 31, 1997, final guidelines were distributed to MCOs currently serving Medicaid recipients. These MCOs were required to submit, by January 2, 1998, an ADA compliance plan, which lists its program site(s) and describes in detail how it intends to make its services, programs and activities readily accessible to and usable by individuals with disabilities, including but not limited to people with visual, auditory, or mobility disabilities, at such site(s). In the event the program site is not readily accessible to and usable by people with disabilities, the health plan will include in its compliance plan a description of reasonable alternative means and methods that result in making the services, programs and activities accessible. The MCO must abide by the compliance plan and implement any action detailed in the compliance plan to make the services, programs and activities accessible to and usable by individuals with disabilities. An ADA compliance summary, which lists the number or percentage of compliant providers, by county, in each MCO's network was due on 2/15/98.

On November 17, 1997 Cycle II Plan Qualification Guidelines were released to all MCOs and interested parties. Included in the requirements for an MCO to be qualified to participate in the Medicaid managed care program were requirements for the submission of the same ADA compliance plan (due on 1/9/98), and ADA compliance summary (due on 2/5/98). All MCOs have submitted both compliance plans and compliance summaries.

On December 3, 1997, OMC hosted a technical assistance conference for MCOs regarding ADA compliance. A similar conference was held in NYC by OMMC. These conferences gave MCOs an overview of ADA requirements under both Title II and Title III, suggestions for methods of achieving compliance, definitions of ADA-specific terms, and clarification and comparison of ADA responsibilities for the State, the MCO and individual providers.

Currently, OMC is working with Cornell University's School of Industrial Relations, to develop an evaluation tool for review of the compliance plans. The tool developed through Cornell will be utilized by OMC and DOH to evaluate the MCO compliance plans submitted, and to work with MCOs toward assuring access to services for persons with disabilities. Additionally, in response to requests by MCOs, DOH is scheduling 10 MCO's for ADA awareness/sensitivity training.

MCOs will be expected to demonstrate appropriate methods for communication with members with visual and hearing disabilities and language barriers. MCOs will also be expected to demonstrate protocols for case management and treatment of the following conditions/patient types: asthma; substance abusing pregnant women; diabetes; physical disabilities; and chronic mental health needs. These requirements will be reviewed as part of the plan qualification process.

In the guidelines, the meaning of accessibility is addressed in the following terms:

> Public programs and services, when viewed in their entirety, must be readily accessible to and useable by individuals with disabilities. This standard includes physical access, non-discrimination in policies and procedures and communication. Communications with individuals with disabilities are required to be as effective as communications with others. The MCO Compliance plan must include a detailed description of how MCO services, programs and activities are readily accessible and usable by individuals with disabilities. In the event that full physical accessibility is not readily available for people with disabilities, the MCO Compliance plan will describe the steps or actions the MCO will take to assure accessibility to services equivalent to those offered at the inaccessible facilities.

This is a very broad definition of accessibility.

Recommendation 17 implies that OMC has no guidelines to measure nor implementation procedures to assess MCO compliance with ADA. This is not the case. The audit occurred during the early developmental stages of the guidelines; however OMC staff met several times with OSC staff, and shared both draft material and clear concepts of how the process was envisioned, along with anticipated milestones for implementation. The OMC has developed a flexible approach that is consistent with ADA statutory and regulatory language, tailoring New York's program to meet the expressed needs of disabled consumers, their advocates, and providers.

Recommendation #18: Establish monitoring guidelines and quality of care measurements specifically for disabled treatment outcomes and results. Consider analyzing enrollees with disabilities or who are chronically ill as a separate category in monitoring complaints, dissenrollments, grievances, utilization review decision appeals, or enrollee satisfaction surveys.

Response #18: Monitoring guidelines and quality of care measurements are an evolving area of ADA for DOH. Again, the ground-breaking nature of this process dictates that DOH assess the levels and methods of compliance that currently exist in MCOs and their networks. Planned future actions include analysis of MCO compliance plan submissions. Utilizing demonstrated methods of compliance already in operation in MCO and provider sites, the DOH plans to develop a compendium of "best practices," and move forward with an evaluation of the adequacy and effectiveness of those practices. Selected methods will then be incorporated into ongoing surveillance activities, with specific methods being incorporated into formal measurement guidelines and implementation procedures.

Currently, DOH collects and analyzes encounter data from MCOs; identifies many disabled enrollees from SSI eligibility codes; conducts statewide enrollee satisfaction surveys; plans to conduct focused surveys of disabled populations; requires plans to conduct enrollee satisfaction surveys; and uses a revised, HCFA-approved complaint and appeals process with expedited processes for clinical care concerns. Analysis of data from these divergent sources will enable the DOH to monitor quality of care for disabled persons as a subset of all Medicaid enrolled recipients.

The current ADA compliance guidelines define the compliance criteria, discuss specific considerations, and give examples of activities which would exemplify compliance. One of the objectives of the guidelines is to increase MCO and provider awareness of ADA issues and requirements, so that deficiencies in compliance may be identified and reasonable accommodations made to increase program access. A logical next step for DOH is to use the ADA compliance guidelines in monitoring. Indeed, interpretation by MCOs may vary slightly, but those variations will become evident when the MCO compliance plans are reviewed by DOH staff, during readiness and annual operational reviews of MCOs, and during the investigation of complaints from enrollees. Flexible approaches to compliance are consistent with ADA statutory and regulatory language, and are more effective than approaches which attempt to anticipate and categorize every possible scenario. DOH staff have been in continuous contact with the Office of the Advocate for People with Disabilities regarding guidelines for ADA compliance. Feedback from that office regarding the draft guidelines includes support for the approach requesting MCOs to "explain how" specific compliance criteria will be met, as opposed to using a strict checklist approach. The intent of the ADA legislation is to prevent discrimination on the basis of disability, and to increase access to services for people with disabilities, without further stigmatizing or segregating them. The use in the ADA statute of terms like "reasonable accommodation" and "undue hardship" allows for variation from MCO to MCO in how compliance is achieved.

In the fall of 1996, the DOH began to develop a methodology and tool for a statewide consumer satisfaction survey of managed care enrollees, with a parallel survey of similar MA recipients in fee-for-service. The DOH plans to follow-up the statewide general survey

with a focused survey of individuals with disabilities and chronic conditions. The contract for the survey process was awarded to the Gallup Corporation in March, 1997. Due, in large part, to revisions of the survey instrument, modifications to Gallup's phone system, and the nature of the population being surveyed (unreliable name, address, phone number data, etc.), the statewide survey has taken longer than originally expected. The data gathering phase is currently nearing completion. Over 5,000 phone surveys, and approximately 850 fee-for-service surveys have been completed as of 3/18/98. Many of the questions asked in the current survey will enable DOH to identify the existence of disabilities in the sample population, perceptions of problems in obtaining access, and satisfaction levels among enrollees and fee-for-service recipients.

Since the survey is confidential and not anonymous, DOH should be able to cross reference Medicaid utilization data with the survey responses. This is a significant initial step in an effort to analyze enrollees with disabilities or who are chronically ill in terms of their perception of access, utilization and satisfaction.

Additionally, funding has been sought for a project to improve accessibility to health care services for the disabled. The goal of the project is to improve the overall accessibility of health care services to the disabled by studying barriers and providing funds to make recommended improvements. Funds would be used to employ a consultant with experience in ADA issues as they relate to managed care to conduct a study of current barriers within MCO provider sites and to make recommendations for improvement. Funds would also be made available to providers for a limited number of improvements that would significantly increase access. Funds would also be used to conduct a study to compare fee-for-service and managed care service accessibility for the disabled.

Recommendation 18 implies that the DOH has no criteria in place to identify persons with disabilities and measure/monitor quality of care. DOH collects and analyzes encounter data from MCOs. This data is specific to utilization, and includes all enrollees, including those with disabilities. DOH identifies many disabled enrollees from SSI eligibility codes, and exempts these persons from mandatory participation. DOH is conducting a statewide enrollee satisfaction survey and if funds become available, plans to conduct a focused survey of disabled populations and provider access. DOH requires MCOs to conduct enrollee satisfaction surveys. DOH has a revised and HCFA-approved complaint and appeals process with expedited processes for clinical care concerns. This process provides retrospective monitoring of access and care issues, as does analysis of dissenrollment. Analysis of data from these divergent sources enables DOH to monitor quality of care for disabled persons as a subset of all Medicaid enrolled recipients.

Recommendation #19: Meet with officials from all counties operating Medicaid Managed Care programs and review Health's policy regarding managed care fair hearing issues.

Response #19: The DOH recently held regional training sessions to discuss many aspects of the program with all LDSS managed care staff. Included in this training was a session which outlined the DOH's fair hearing policy, and local district procedures for implementation. In addition, notices for the mandatory program counties are being printed that include the appropriate fair hearing language, adjusted for readability. Notices for the voluntary counties will be developed within the next quarter and will also be printed for LDSS use.

Recommendation #20: Ensure that local districts or MCOs appropriately issue fair hearing notices that alert recipients to their right to aid continuing.

Response #20: The DOH continues to negotiate details with the HCFA for the Medicaid managed care fair hearing and aid continuing policy. All local districts and MCOs have been given fair hearing language that will be used to inform enrollees of their right to obtain a fair hearing for specific situations and disputes. This information will be included in member handbooks as they are reprinted. It should be noted that specific fair hearing notices will only be issued by the DOH and LDSS. MCOs will not issue four hearing notices to enrollees. The OMC continues to work on the development of a statewide policy relating to aid continuing. The proposed policy has been discussed with the HCFA, the Office of Administrative Hearings and NYC (HRA and OMMC); and has been submitted to the DOH Division of Legal Affairs for review and approval prior to being finalized. All MCOs, LDSSs, and consumers will be informed of this policy when finalized.

Additional training will be conducted to promote clarity and understanding of the fair hearing and aid continuing policy. MCOs operating in 1115 districts have included a handbook insert which outlines mandatory managed care policies and the fair hearing policy in a readable format.