H. CARL MCCALL
STATE COMPTROLLER

A.E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 23, 1998

Barbara A. DeBuono, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 98-F-1

Dear Dr. DeBuono:

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, we have reviewed the actions taken by the Department of Health (Health) as of January 26, 1998, to implement the recommendations contained in our prior audit report 95-S-135. The report, issued February 6, 1997, reviewed the management controls established by Health and the Department of Social Services (Social Services) over Medicaid managed care rate setting and claims processing.

Background

New York State's Medicaid program, which provides medical assistance to needy people, is administered by Health. The Medicaid Management Information System (MMIS) is a computerized payment and reporting system, which processes and pays claims for services to Medicaid recipients. MMIS pays providers' claims using the fee-for-service or the capitation method. Under fee-for-service, MMIS pays a claim for every Medicaid-eligible service delivered; under capitation, MMIS pays a managed care provider a monthly premium based on a negotiated payment rate, regardless of the number of services provided. Health is responsible for setting managed care payment rates. Health's policy establishes the managed care payment limit at 95 percent of the approximate fee-for-service cost for similar recipients. The State's 58 local social services districts (districts) are responsible for enrolling recipients in managed care plans. As of December 31, 1997, nearly 637,000 (about 23 percent) of the State's 2.77 million Medicaid recipients were enrolled in managed care plans.

During our prior audit period, Social Services administered New York's Medicaid program, and used MMIS to process Medicaid claims and make payments to health care providers for services rendered to recipients. After October 1, 1996, Health was responsible for administering Medicaid and MMIS.

Summary Conclusion

In our prior audit, we found that Health had not established adequate controls over the managed care rate setting process to ensure rates are economical, set according to uniform procedures, and established in a timely manner. Further, we found that Health needed to activate certain MMIS edits to ensure the accuracy of managed care claims.

In addition to the items discussed in report 95-S-135, we provided Health officials with a letter relating to matters of lesser significance, in which we recommended that Health take further steps to improve controls over the payment of Medicaid claims from managed care providers.

In our follow-up review, we found that Health officials have made significant progress in implementing eight of our ten prior audit recommendations. They have also implemented all of the recommendations included in the letter on matters of lesser significance.

Summary of Status of Prior Audit Recommendations

Of the ten recommendations in our prior report, Health officials have fully implemented six recommendations, have partially implemented two recommendations, and have not implemented two recommendations.

Follow-up Observations

Recommendation 1

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

a) developing a managed care rate setting procedures manual to guide staff and to help ensure that all rates are consistently developed;

b) ensuring that all managed care rates, especially transition rates, are documented and approved;

c) establishing a monitoring process to ensure that managed care rates are properly recorded on MMIS for use in paying providers' claims; and

d) formalizing rate setting documentation requirements (including requirements for evidence of supervisory review, management approval of unique situations and the progress of the rate negotiation process).

Status - Fully Implemented

Agency Action - Health's Rate Setting Unit (Unit) has developed a rate setting procedures manual which includes the steps to follow in developing managed care rates consistently. Rate setting documentation requirements are formalized in this procedures manual. The Unit has also established logs to track rates through their development, including obtaining Division of the Budget approval for the rates and transmitting them to MMIS. The provider rates are listed in these logs.

Recommendation 2

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

Recommendation 3

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

Status - Fully Implemented

Agency Action - The Unit has established deadlines for managed care providers to accept or reject negotiated rates when rates are established through a competitive bidding process. Providers are warned they will not be able to participate in Medicaid managed care if they do not respond by the deadline dates. The Unit sends reminder letters to providers when deadlines are approaching and the providers have not yet responded. The Unit also established due dates for providers to submit applications for capacity rate adjustments and to submit documentation for a Physician Incentive Plan.

The current rate setting methodology has been set by legislation through March 31, 1999. There will be a second rate adjustment, also required by legislation, that is to be completed by December 31, 1998. Providers will not have to submit rate proposals in either case. The Unit intends to establish new procedures to ensure timely submission and review of rate proposals, for rate periods after April 1, 1999. Health officials stated these new procedures will include the possibility of penalties if providers do not meet submission deadlines.

Recommendation 4

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

Status - Fully Implemented

Agency Action - Health officials investigated the feasibility of having the fiscal agent develop new MMIS programs to accomplish this consolidation. The officials decided this was not feasible because much of the processing Health does could not be duplicated on the fiscal agent's computer system. They stated they will continue to explore whether other annual file revisions could be made to assist the managed care rate setting process.

Recommendation 5

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

Status - Partially Implemented

Agency Action - Health officials stated they investigated the error, and found it was not in the regression analysis but in the data entry to a spreadsheet used to compute the Home Relief trend factor. They stated the resulting overstatement of the Home Relief trend factor was immaterial (.002 percent per month). The officials disagree with recovering any overpayments as a result of the error. They stated the managed care rates are set by negotiated contracts with providers and that considering any type of retroactive adjustment to contracted payments is inappropriate.

Auditors' Response - We disagree with Health's position concerning its inability to recover such overpayments. We believe the State has the right to recover funds paid in error to managed care providers.

Recommendation 6

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

Status - Fully Implemented

Agency Action - Health officials met with staff in Health's Office of Quality Assurance and Audit (QA&A) to consider the feasibility of implementing this recommendation. The officials

decided it would not be feasible because QA&A's audit recoveries are not service category-specific or time-specific. They stated there is no way to determine what time period an audit recovery applies to and which costs should be included or excluded in calculating the upper payment limits of managed care rates.

Recommendation 7

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

Status - Fully Implemented

Agency Action - Health's Bureau of Managed Care Financing staff meet with fiscal agent staff regularly to review the status of MMIS managed care edits that may be problematic. The four managed care edits for New York City recipients have been activated.

Recommendation 8

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

Status - Partially Implemented

Agency Action - Bureau of Managed Care Financing and Office of Quality Assurance and Audit (QA&A) staffs have discussed what defines whether a managed care provider was "at risk" to provide services, because it would be inappropriate to recover payments from a provider who was at risk. Bureau officials stated they and QA&A reached agreement on the meaning of "at risk," and that QA&A audits to recover overpayments should begin in the near future.

Auditors' Comments - We are pleased Health officials have taken action to begin recovery of overpayments. We encourage Health officials to start recovering overpayments through the audit process as soon as possible.

Recommendation 9

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

Status - Not Implemented

Agency Action - Health did not take action to modify MMIS. Instead, Health officials are attempting to get managed care providers and local social services districts (districts) to improve their efforts to provide information essential to processing managed care claims properly. Health added provisions to provider contracts and to district policies and procedure manuals that emphasize the providers are responsible for notifying the districts of recipient pregnancies and births and the districts are responsible for updating the Welfare Management System (WMS) after getting such notification from providers. (MMIS uses WMS to update MMIS' reference files used in processing claims.) Health is providing training to the districts to emphasize their responsibilities.

Auditors' Comments - Health's actions address a need to improve information gathering and reporting at the provider and district levels. While accurate information input is essential, it does not address the need to modify MMIS to select only the appropriate managed care payment rate in all instances. Payment of managed care claims with inappropriate rate codes continues to be a problem. MMIS must be able to identify and reject managed care claims with the wrong rate code as long as providers and districts continue to provide erroneous information or do not provide all the information needed to properly process claims.

Recommendation 10

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

a) verifying the accuracy of the recipient's date of birth through computer matching with Health's vital statistics file; and

b) developing controls to ensure that a recipient's date of birth cannot remain "unknown" on MMIS reference files for longer than six months.

Status - Not Implemented

Agency Action - Health officials agreed they should establish procedures to obtain missing date of birth information on MMIS, but they stated their belief that computer matching to Health's vital statistics file does not provide adequate results. Health officials stated that what they are doing for Recommendation 9 will also apply to Recommendation 10.

Auditors' Comments - Health's actions address a need to improve information gathering and reporting at the provider and district levels, but do not address the need to develop

procedures to identify Medicaid recipients who lack date of birth information and record this information on MMIS. Health's vital statistics file should be accurate and up-to-date for determining recipient birth dates. Matching with this file should be done as long as managed care plans and/or districts are providing inaccurate information or are not providing any birth date information needed to properly process claims. Health's actions also do not ensure that "unknown" birth dates do not remain on MMIS reference files for more than six months. MMIS should be able to reject provider claims when the recipient's birth date is still unknown after six months. There is no incentive for managed care plans and/or districts to obtain and provide missing birth date information if MMIS will continue to process and pay claims without this information.

Major contributors to this report were William Clynes, Paul Alois and Lawrence Julien.

We would appreciate receiving your response to this report within 30 days, indicating any actions planned or taken to address the unresolved matters discussed in this report. We wish to thank your staff for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Robert L. King