H. CARL MCCALL
STATE COMPTROLLER

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

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

July 28, 1999

Antonia C. Novello, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 99-F-2

Dear Dr. Novello:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have reviewed the actions taken by officials of the Department of Health (Health) as of July 6, 1999, to implement the recommendations contained in our audit report, *Controls Over Certain Medicaid Payments to Managed Care Providers (Report 96-S-67)*. Our report, which was issued on April 4, 1997, reviewed the Department of Health's and the Department of Social Services' practices for paying certain kinds of Medicaid claims submitted by managed care providers for the period January 1, 1990 through June 30, 1996.

Background

Medicaid is a Federally aided, State-operated and administered program that provides medical benefits for certain low-income persons in need of health and medical care. The program is authorized by Title XIX of the Social Security Act. Subject to broad Federal guidelines, each state determines how the Medicaid program in that state will be administered, including the benefits covered, the rules for eligibility, and the rates of payment to providers. Prior to October 1, 1996, Medicaid was administered by the Department of Social Services. After that time the Department of Health began administering the Medicaid program in New York State. Health contracts with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and make payments to providers. The fiscal agent processes claims and pays providers for services rendered to eligible Medicaid recipients through the Medicaid Management Information System (MMIS), a computerized payment and information reporting system.

Medicaid uses two different methods to pay medical service providers: fees for services or capitation premiums. Under the fee-for-service method, providers are paid every time a recipient receives a Medicaid-eligible service. Under the capitation method, providers are paid monthly fees based on the number and types of Medicaid recipients enrolled. In managed care programs, the medical services needed by program participants are arranged for by a single service provider. Because managed care providers are paid capitation premiums rather than separate fees for each individual service, it is hoped that they can reduce the costliness of the Medicaid program.

Furthermore, when a Medicaid recipient is also covered by Medicare, Medicare can pay a substantial portion of the recipient's medical costs. Medicare is a Federal health insurance program primarily for people who are age 65 or older. Medicare provides two basic forms of health care coverage: Medicare hospital insurance (Part A) and Medicare supplemental medical insurance (Part B). Unlike Part A, Part B requires the recipient to pay a monthly premium, which during 1995 was about $46. In order to decrease Medicaid costs, local districts pay the monthly Part B premiums of Medicaid recipients who are eligible for Medicare. In addition, some Medicaid recipients have private insurance coverage from commercial insurance carriers. Such commercial carriers also offer managed care insurance. In the Medicaid program, commercial insurance carriers as well as Medicare are referred to as third-party insurance payers. The Social Security Act requires medical service providers to submit a claim for payment to all third-party insurance carriers, including Medicare, before the provider can bill Medicaid.

Our audit focused on Health's and Social Services' policies and procedures for paying certain kinds of claims relating to Medicaid recipients who were either under the age of one or who were covered by third-party health insurers during the period January 1, 1990 through June 30, 1996.

Summary Conclusions

In our prior audit, we found that Medicaid overpaid managed care providers by as much as $19.5 million for the six year period ended December 31, 1995. We also found that the circumstances surrounding some of the inappropriate claims needed to be investigated to determine whether the claims were the result of error or fraud. In addition, we determined that Medicaid managed care coverage is sometimes duplicated by private managed care coverage. In some instances, the simultaneous coverage is through the same provider, who is paid twice for serving the same patient.

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

recipients under the age of one. We determined that these overpayments totaled as much as $19.5 million.

In our follow-up review, we found that Health officials have made progress in implementing the recommendations contained in our prior audit report. Health has established policies and corrected programming logic, which should prevent some of the potential overpayments from occurring in the future. However, Health officials disagreed with our recommendation to recover the $19.5 million in overpayments we identified by our audit and did not take any steps to recover the overpayments.

Summary of Status of Prior Audit Recommendations

Of our nine prior audit recommendations, Department of Health officials have implemented two recommendations, have partially implemented five recommendations and have not implemented two recommendations.

Follow-up Observations

Recommendation 1

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

Status - Not Implemented

Agency Action - Health has taken no action to recover the potential overpayments. Health officials acknowledge that an error in programming may have occurred, resulting in managed care providers receiving $19.5 million in excess Medicaid payments. However, Health officials stated their belief that the managed care providers assumed risk for the cost of care for the recipients, in accordance with a contractual agreement, and are therefore entitled to retain these payments.

Recommendation 2

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

Status - Partially Implemented

Agency Action - Health has modified its actuarial classification to include a group covering recipients under the age of six months. Health instructed the MMIS fiscal agent to correct the programming logic to assure that a managed care provider receives no more than six payments under this actuarial class.

Auditors' Comment - While Health officials have corrected the programming logic, they have not made any explict changes to the regulations. Without explicit language in regulations, Health's ability to recover Medicaid overpayments may be impaired.

Recommendation 3

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

Status - Implemented

Agency Action - The cases have been forwarded to the Attorney General's office for investigation.

Recommendation 4

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

Status - Partially Implemented

Agency Action - Health's current policy does not allow enrollment into the Medicaid managed care program if a recipient is covered by Medicare. If such a recipient becomes enrolled in the Medicaid managed care program, the recipient should be immediately disenrolled from the program. Once Health officials allow these dual-eligible recipients to enroll, they will develop capitated rates.

Recommendation 5

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

Status - Partially Implemented

Agency Action - Health officials have established policies addressing this recommendation, but have not made any regulatory changes to help assure recovery of Medicaid overpayments.

Recommendation 6

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

Status - Implemented

Agency Action - Health's current policy does not allow enrollment into the Medicaid managed care program if a recipient is covered by Medicare. If such a recipient becomes enrolled in the program, the recipient should immediately be disenrolled from the program. Health has established procedures to support this policy. For example, Health provides manage care providers and local districts with access to a computerized file of recipients who simultaneously are enrolled in both Medicare and Medicaid.

Recommendation 7

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

Status - Not Implemented

Agency Action - Health officials have performed a preliminary analysis of the identified overpayments, but have not taken action to recover any of these overpayments.

Recommendation 8

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

Status - Partially Implemented

Agency Action - Health officials have given instructions to the local districts on the importance of evaluating the cost-effectiveness of enrolling recipients into the managed care program. However, they are not assuring that all local districts comply with these instructions. Health monitors the ten largest local districts, to evaluate recipients without third party insurance. In the event this analysis identifies third party insurance coverage for a recipient enrolled in the managed care program, Health officials stated that they will evaluate the cost-effectiveness of continuing enrollment in the managed care program.

Recommendation 9

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

Status - Partially Implemented

Agency Action - Health has established procedures to support its policy of not allowing enrollment into the Medicaid managed care program if a recipient is covered by Medicare. However, Health has not developed an automated process to prevent the purchase of Part B Medicare premiums for recipients enrolled in managed care programs.

Major contributors to this report were Lee Eggleston, Bill Clynes, Paul Alois and Lisa Rooney.

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

Very truly yours,

Kevin M. McClune
Audit Director

cc: Charles Conaway