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

DEPARTMENT OF HEALTH

MONITORING MEDICAID MANAGED CARE CONTRACTS

REPORT 99-S-15

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. Novello:

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

This audit was performed 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. Major contributors to this report are listed in Appendix A.

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June 28, 2000

Executive Summary

Department of Health
Monitoring Medicaid Managed Care Contracts

Scope of Audit

The Department of Health (Department) is responsible for the overall operation of New York State's Medical Assistance Program (Medicaid). The Department administers the Medicaid Managed Care program, and the State's 58 social service districts (local districts), including New York City, are responsible for its implementation. Local districts enter into contracts with managed care organizations (MCOs) in their area and enroll eligible recipients in the MCOs. To help ensure MCOs provide quality care, the Department has designed model contracts which require the MCOs to submit a series of performance reports to the Department and local districts. The Department and local districts use these reports as one of several mechanisms to monitor MCOs' compliance with specific Medicaid Managed Care program requirements. The Department's goal is to enroll 2.25 million Medicaid recipients in MCOs by December 31, 2000. For the Federal fiscal year ended September 30, 1999, the Department reported paying MCOs nearly $1.1 billion in premiums for approximately 646,000 enrolled recipients.

Our audit addressed the following question about the Department's monitoring of Medicaid Managed Care programs for the period January 1, 1998 through August 31, 1999:

- Has the Department implemented appropriate policies and procedures to direct Department and local district monitoring of required MCO reports that provide information about the access, quality of care and financial issues at MCOs?

Audit Observations and Conclusions

MCOs are required to send many of the same performance reports to both the Department and the local districts, which use them for separate and specific oversight purposes. We found that, with the exception of three reports, the Department generally ensured it received required reports and carried out related monitoring activities. On the other hand, information we gathered from the 20 districts we surveyed and the six districts we visited, except for New York City district, confirmed that the local districts generally do not ensure that MCOs comply with reporting requirements. Our audit also found wide variations in MCO compliance levels and inconsistent documentation and follow up for the reports districts did receive. Improvements in these areas would help to ensure enrollees receive access to quality care at MCOs.

The Department uses the information in MCO reports to help provide comprehensive statewide oversight of MCOs in the Medicaid Managed Care program, including evaluating various financial and service issues.

We found the Department generally ensured MCOs submitted the required reports for 1998. However, we determined that the Department did not receive two reports (Appointment Availability Studies and 24-Hour Access Reviews) timely and/or in the proper format from over 50 percent of MCOs, and did not receive most of the Primary Care Provider Auto-Assignment reports due from MCOs contracting outside New York City. We believe this noncompliance occurred because the Department had not established a system to track and follow up on these reports. To help ensure enrollees have access to health care services and a choice of primary care providers, we recommend the Department track the submission of these reports and monitor the information they contain. (See pp. 8-12)

The local districts use the information in the MCO reports to evaluate managed care operations within their counties. We surveyed a judgmental sample of 20 local districts, including all 12 districts with mandatory Medicaid Managed Care programs (counties that enroll most eligible recipients in MCOs) and 8 districts with voluntary programs (counties that do not require recipients to enroll in MCOs) and visited 6 of these districts. Our survey information indicated that districts did not effectively monitor MCO reporting requirements during our audit period, and our on-site visits confirmed this noncompliance. At the 6 districts we visited, we found MCOs had submitted only 36 of the 63 reports they owed, collectively, to these districts. Although compliance levels were better in districts with mandatory programs than in those with voluntary programs, we found significant variations in compliance among districts. For example, the New York City district, which has a system to monitor and track MCO reports, achieved consistently high submission rates from its 20 MCOs in 1998. To help improve compliance at districts statewide, we recommend that the Department instruct districts to establish tracking systems similar to New York City's system. (See pp. 12-13)

We also found that, even when they do receive the required MCO reports, districts are inconsistent in performing and documenting their monitoring of contract compliance. We recommend the Department enhance current processes to help all districts improve their monitoring efforts. (See pp. 13-15)

Comments of Department Officials

In responding to our draft report, Department officials stated that during the audit period the Medicaid managed care program was in a developmental phase and that the information reported by managed care plans is one of the tools used by the Department to monitor the managed care program. While Department officials disagreed with certain aspects of the report, they agreed to implement several recommendations.

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Introduction

Background

The Department of Health (Department) administers New York State's Medical Assistance Program (Medicaid), which was established under Title XIX of the Federal Social Security Act (Act) to provide medical assistance to needy people. The Department assumed responsibility for Medicaid in October 1996. As of July 1997, the Federal Health Care Financing Administration (HCFA) approved a waiver that released New York State from certain requirements of the Act and allowed the Department and participating counties to establish a statewide mandatory Medicaid Managed Care program. The objective of the Medicaid Managed Care program is to provide recipients with quality health care services and a "medical home" in a local managed care organization (MCO).

The Department, through its Office of Managed Care, is responsible for the overall operation of the Medicaid Managed Care program, and the State's 58 social service districts (local districts), including New York City, are responsible for its implementation. Individuals apply for medical assistance at local district offices. The local districts, which enter into contracts with MCOs in their area, enroll eligible recipients in the MCOs. For each enrolled recipient, MCOs receive a monthly "capitation" payment, a monthly payment determined by the number and type of recipients enrolled in the MCO. In return, the MCOs must ensure that each enrollee has a primary care provider, adequate access to a full continuum of quality health care and 24-Hour access to urgently-needed services. The Department's responsibilities include designing model MCO contracts. The model contracts state the minimum requirements MCOs must meet to participate in the Medicaid Managed Care program, including the requirement to report information to the Department and local districts. The Department also sets capitation rates and establishes policies and procedures for ensuring that MCOs comply with contract requirements and deliver quality health care services to enrolled recipients.

The Department designs, and HCFA approves, model MCO contracts for two kinds of Medicaid Managed Care programs currently in operation in local districts throughout the State: mandatory programs and voluntary programs. Local districts with mandatory programs are those counties that have been approved by HCFA to require most of their non-elderly and non-institutionalized recipients to enroll in MCOs. During our audit period, 12 local districts had mandatory programs. Local districts with voluntary programs are those which allow their recipients the choice of enrolling in MCOs or continuing to receive health care services from providers on a fee-for-service basis. Some of these districts (13 at the time of our audit) are scheduled to move from a voluntary participation status to a mandatory status by December 2000, upon HCFA approval. The remaining 33 local districts

with voluntary programs are exempt from being moved to a mandatory enrollment status (at least until March 2001) for a variety of reasons, including a shortage of physicians in the area or the existence of only one MCO in the counties. (In responding to our draft report, Department officials stated that since our report was written, one county requested that its exemption be rescinded. Therefore, 32 local districts are exempt from participation in the State's mandatory Medicaid Managed Care program.)

The model contracts for the mandatory and the voluntary programs, as designed, state slightly different reporting requirements for MCOs. The Department amended contracts for certain voluntary programs in December 1997 to make the reporting requirements comparable to those for mandatory programs by January 1998. However, some counties' contracts were not amended until October 1998. Even before the amendment, however, both types of contracts required many of the same kinds of reports from MCOs. For example, both types of contracts require MCOs to submit their semi-annual financial statements. Both contracts also require MCOs to report "No-Contact Data" to local districts every month. These statistics represent the number of new members the MCOs were unable to contact within 90 days of enrollment, as required by the contract. The Department and local districts can review such performance data to determine whether MCOs are achieving targeted goals and to follow up on problem areas or complaints. The frequency of report submission is detailed in the model contract and varies depending on the report.

MCOs are often required to send the same reports to both the Department and the local districts. However, the Department and local districts use the information in the reports for separate and specific oversight purposes. The reviews performed by the Department focus on broad-based, statewide issues, while the local districts' monitoring focuses on county-specific operations. Thus, both the Department and local districts monitor MCOs' compliance with the reporting requirement, but from different perspectives. The Department shares contract monitoring responsibilities for the New York City district with the New York City Department of Health (NYCDOH). A formal memorandum of understanding between the Department and NYCDOH gives NYCDOH responsibility for 8 of the 13 types of reports the district's MCOs are required to submit.

In October 1999, the Department updated its Operational Protocol that HCFA requires for mandatory Medicaid Managed Care programs. The Operational Protocol, which HCFA has approved, describes operational policies and procedures of mandatory programs. It also identifies the service, reporting and/or monitoring responsibilities for the MCOs, local districts and the Department. The Department has also established overall policies for monitoring MCOs, and began using a Local District Managed Care Program

Review (Review) process in January 1999. The Review process is used as a tool to assess mandatory districts' monitoring effectiveness, in addition to several other managed care operations performed at the local districts. However, these additional processes were not included within the Medicaid Managed Care contract reporting requirements. During the Review process, the Department measures the district's performance against a checklist of some of the reports the district should receive and the practices it should follow to ensure MCOs' compliance with contract provisions, such as conducting surveys of new enrollees. In addition, the Department performs its own comprehensive annual operational surveys and other on-site reviews of MCOs to identify noncompliance, to monitor areas of particular concern (such as provider availability) and to analyze member satisfaction. The Department also conducts targeted studies in response to specific problems, such as determining the reasons for sudden increases in the number of complaints.

As of September 1999, more than 646,000 Medicaid recipients were enrolled in MCOs in New York State; the Department's stated goal is to enroll 2.25 million of the State's Medicaid recipients in MCOs by December 31, 2000. For the Federal fiscal year ended September 30, 1999, the Department reported paying MCOs nearly $1.1 billion in capitation premiums for enrolled recipients. 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). New York State's share of monies paid to MCOs for the above Federal fiscal year totaled almost $353 million.

Audit Scope, Objective and Methodology

We audited the Department's policies and procedures for monitoring MCOs' compliance with requirements of Medicaid Managed Care contracts for the period of January 1, 1998 through August 31, 1999. The objective of our performance audit was to determine if the Department has implemented appropriate policies and procedures to direct Department and local district monitoring of required MCO reports that provide information about the access, quality of care and financial issues at Medicaid Managed Care program providers.

This audit is the third in a series of audits of the Department's management of the State's efforts to transition the majority of its Medicaid population from a traditional fee-for-service health care services model to a managed care services model. The first two reports (Report 96-S-70, issued July 24, 1998 and Report 97-S-59, issued June 3, 1999) addressed, respectively, the Department's monitoring of quality of care issues at MCOs, and its assessment of the managed care network's capacity to handle the influx of new members and provide them with adequate accessability to health care services.

To accomplish our audit objective, we interviewed Department officials about their roles in monitoring the contract reporting requirements. We evaluated the Medicaid Managed Care program model contracts for the voluntary and mandatory programs, the Operational Protocol, Department documentation of contract monitoring efforts and the actual reports submitted by MCOs.

We also surveyed a judgmental sample of 20 local districts to develop summary information about the reports districts receive from MCOs, what districts do with the reported information and how the Department and local districts follow up on reported information. The 20 local districts we selected were as follows: all 12 local districts that operated mandatory Medicaid Managed Care programs in 1998 (Albany, Broome, Columbia, Erie, Greene, Monroe, Niagara, Ontario, Onondaga, Rensselaer, Saratoga and Westchester); 4 local districts that had voluntary contracts during our audit period which they plan to convert to mandatory programs (Cortland, New York City, Schenectady and Suffolk); and 4 local districts operating voluntary programs that were exempt from mandatory participation (Cattaraugus, Chemung, Sullivan and Warren). We selected the eight local districts with voluntary programs on the basis of the percentage of their respective Medicaid populations enrolled in managed care and the number of MCOs under contract in the districts. We then selected six of the 20 local districts to visit so we could review MCO reports and district monitoring processes in detail. We selected districts to visit (Albany, Columbia, Onondaga, New York City, Suffolk and Sullivan) based on their survey responses and their descriptions of their monitoring processes. Further, we selected New York City based on the large size of its Medicaid Managed Care program and its stated objective of converting to a mandatory program as soon as possible.

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 the Department that are included in our audit scope. Further, these standards require that we understand the Department'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 generally prepared on an "exception basis." However, while this report does highlight those areas needing improvement, in conformance with exception-based reporting, it also recognizes certain effective monitoring practices in place at one local district.

Response of Department of Health Officials to Audit

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

In responding to the draft report, Department officials stated that the Medicaid Managed Care program continued its developmental phase during the period of the audit and that program requirements were being refined to be more efficient and effective. The officials noted that a new model contract became effective October 1, 1999 which modified many of the reporting requirements subject to audit. They also stated that self-reported information by managed care plans is just one tool the Department and local districts use to evaluate the effectiveness of the Medicaid Managed Care program. For example, the Department uses an external contractor to conduct independent access and availability studies.

Department officials disagreed with certain aspects of the report. In response to our statements that the Department did not monitor Access Reviews and that districts did not adequately monitor MCO contract compliance, Department officials stated their belief that other mechanisms are in place to ensure that it and the local districts can monitor the managed care program. Department officials also stated that the report was misleading or incorrect in certain other respects. Further, Department officials disagreed with our recommendation to improve the process to track missing and incorrect Appointment Availability/24-Hour Access Studies, stating that the October 1, 1999 model contract no longer requires MCOs to submit these documents to the Department and local districts. Department officials agreed with the other four recommendations, while stating that they were not required to implement three of them.

As a result of our review of the Department's response, we made various revisions to the final report. For example, we modified our comments on pages 9 and 10 of the report to clarify that, when contractually required reports are not submitted, the Department and districts could not obtain assurance from the reporting process about recipient access to health care services and other important aspects of MCO operations. Given the changes in reporting requirements reflected in the October 1, 1999 model contract, we deleted our recommendation that the Department improve the process to track Appointment Availability/24-Hour Access Studies. We also made other technical modifications to the report.

Notwithstanding the changes we made in consideration of the Department's response to the draft report, it is important to note that the focus of our audit was on the Department's and districts' monitoring of MCO's compliance with the reporting requirements of Medicaid Managed Care contracts for the period January 1, 1998 through August 31, 1999. We acknowledged in our draft report that the Department and local districts use the contractually required reports as one of several mechanisms to monitor MCO's compliance with specific Medicaid Managed Care program requirements. However, our audit identified non-compliance with the reporting requirements, especially at the district level, which could impair the Department's and districts' ability to monitor MCO operations. In general, Department officials agreed to implement our recommendations.

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.

Monitoring Medicaid Managed Care Contracts

Since the mandatory and voluntary contracts require MCOs to regularly report indicators that show whether they are achieving program goals related to both the quality of care and the accessibility of services, this audit examined whether the Department and local districts have processes in place to ensure they receive and monitor the reports required by the contracts.

As stated previously, MCOs are required to send many of the same reports to both the Department and the local districts, which use them for separate and specific oversight purposes. We found that, with the exception of three reports, the Department generally ensured it received the required reports and carried out related monitoring activities. On the other hand, information from the 20 districts we surveyed indicated, and our on-site visits to 6 districts confirmed, that local districts generally do not ensure MCOs submit required reports. The 6 counties we visited had received only 36 of the total 63 reports required. There were also significant reporting variances among districts and among MCOs within districts. Districts with mandatory programs generally had better rates of compliance than those with voluntary programs. Unless they receive the reports, districts cannot ensure MCOs are providing adequate services to recipients, track MCO performance or follow up on problems. We believe many local districts have difficulties enforcing contract compliance because they lack a formal system for tracking MCO reporting.

Most eligible recipients statewide will eventually be served through the Medicaid Managed Care program. The Department's goal is to ensure adequate access to quality health care for all these recipients. To help meet this responsibility, the Department gives districts training and technical assistance related to Medicaid Managed Care. By enhancing this guidance, we believe the Department can help improve the effectiveness and consistency of local district monitoring. We encourage the Department to instruct districts to develop formal guidelines to track and follow up on MCO reports. These guidelines could include some of the aspects of New York City's compliance tracking system, which we found to be effective. We believe the Department can further improve districts' monitoring of MCOs by reviewing contract compliance issues at voluntary as well as mandatory districts.

Department Monitoring Efforts

The Medicaid Managed Care program model contracts require MCOs to submit numerous reports to the Department. Department officials indicated that they use these reports, along with other Department and local district monitoring efforts, to help provide comprehensive oversight of MCOs in the Medicaid program. For example, the Department uses reported information to determine whether participating MCOs are financially sound and to identify the types of health care services used. During our audit period, we found the Department generally ensured MCOs submitted the required reports, with three exceptions. We found the Department did not ensure MCOs timely or properly submitted Appointment Availability Studies, 24-Hour Access Reviews or Primary Care Provider Auto-Assignment reports, as explained below.

Appointment Availability Studies

The Medicaid Managed Care model contracts require that MCOs send the results of Appointment Availability Studies (Studies) to the Department, listed on a county-by-county basis. (MCOs are also required to send each district their own results from such Studies.) These Studies evaluate appointment availability in various categories for adults and children, measured separately. The Department informed us that the purpose of having MCOs measure and report this information is to monitor MCOs' compliance with established access standards. In addition, contract reporting ensures the MCOs have monitoring techniques capable of identifying this information so MCO management follow up on related issues internally. The MCOs contracting in counties where Medicaid Managed Care is voluntary are required to submit the Studies six months from the effective date of the contract, and semiannually thereafter. In districts with mandatory programs, MCOs must submit these Studies annually.

Our audit found that MCOs did not submit Studies to the Department within the time frames and/or format specified in the contracts. We determined that 19 MCOs that were required to submit Studies for calendar year 1998 were noncompliant for one or more of the following reasons:

- did not submit Studies at all;
- submitted annual Studies when semiannual Studies were due;
- did not submit results by county; and
- submitted member satisfaction survey results in place of the Studies.

(In response to our draft report, Department officials stated that there were three MCOs that were in the process of transitioning members out of their plans in specific counties during 1998, because they were no longer participating in the Medicaid Managed Care program. During the period covered by our audit, Department officials provided us with a list of four MCOs that transitioned out of the Medicaid Managed Care program in 1998. However, two MCOs submitted Studies for 1998, although the reports were not county-specific. We did not include the remaining two MCOs in our analysis.)

We believe this noncompliance occurred because the Department did not have an effective process in place to follow up on missing Studies. For example, the Department's method of accounting for the Studies identifies the effective date of the contract, which allows staff to know when Studies are due. The Department also sent the MCOs guidelines for conducting and submitting the Studies. However, the Department did not formally follow up on missing or incorrect Studies due between June 30 and December 31, 1998 until May 14, 1999. On that date, the Department sent the MCOs letters that required them to respond by May 24, 1999. More than two months later, the Department was unable to provide us with any documentation of responses from MCOs in response to the inquiry about missing or incorrect Studies.

The model contract authorizes local districts to levy fines against MCOs for non-submission of required reports. Further, when the Department does not receive required reports, it could direct the local district to levy a fine. However, it is our understanding that Department and local district officials are reluctant to sanction MCOs because they don't want to discourage MCO participation in the Medicaid Managed Care program.

As a result of its insufficient monitoring of these required Studies during our audit period, the Department did not have the assurance that would have resulted from monitoring these Studies that Medicaid Managed Care enrollees were able to get appointments with providers within established time frames. In addition, since many of the reports the Department did receive did not contain county-specific data, as they should, the Department was unable to determine if it should have focused resources on certain districts, or on individual MCOs within districts, to help ensure appointment availability standards were met.

(In response to our draft report, Department officials stated that neither the Department or the contract requires county-specific data and, in many cases, county-specific measures don't make sense and are not useful. However, our audit identified that the voluntary managed care contract that was in effect during the period covered by our audit for counties that had not implemented the Department's December 1997 contract amendment, did

require county-specific reporting for Studies and 24-Hour Access Reviews. In addition, officials from 18 of the 19 counties we surveyed indicated that county-specific reporting is a useful monitoring tool.)

24-Hour Access Reviews

The model contracts also require MCOs to send the Department the county-by-county results of 24-Hour Access Reviews (Access Reviews), and to send each district its own Access Review results. The Department uses the Access Reviews to evaluate whether MCOs provide recipients with access to health care services around the clock, as the Medicaid Managed Care program requires. The Access Reviews report compliance with established standards and help identify problems that should be addressed by MCO management.

We determined that 20 MCOs had not submitted the Access Reviews within the required time frames (annually for mandatory programs and semiannually for voluntary programs), in the proper format, and/or on a county-by-county basis. As with Studies above, we found that MCOs' noncompliance occurred because the Department did not have a process to follow up on missing Access Reviews in a timely manner. Since the Department did not monitor these Access Reviews during our audit period, it did not obtain assurance from this process that recipients had adequate access to 24-hour medical services.

Department officials told us they have an integrated approach to evaluating Medicaid Managed Care, which includes annual access and availability studies performed by an external contractor. While the contractor's studies may be helpful in assessing MCOs' services, we believe the Department should monitor MCOs' compliance with the terms of the contracts, which include the submission of Access Reviews. During our audit period, both Studies and Access Reviews were required by these contracts. The new model contract in effect as of October 1999 eliminated the requirement for MCOs to self-report the results of Studies and Access Reviews. In addition, each MCO will now be allowed to use either the district or the MCO's entire service area as the area reported on. The Department claims it will review these studies during annual operational surveys, if warranted.

Primary Care Provider Auto-Assignment Reports

When the MCO first contacts a newly enrolled Medicaid recipient, the MCO must offer the enrollee a choice of at least three Primary Care Providers (PCP). The enrollee has 30 calendar days from the date of enrollment in which to select a PCP. The Department prefers that enrollees choose their own PCPs. However, if an enrollee does not select a PCP within 30 days, the MCO must assign a PCP (an "auto-assignment") and inform the enrollee of the assignment. In assigning a PCP, the MCO must take into consideration factors such as the enrollee's geographic location and any known special health care or language needs. MCOs are required to provide local districts with up-to-date listings of PCPs, including each provider's specialty, office location, office hours, telephone number and wheelchair accessibility status. The listings should also note any languages other than English spoken in the provider's office. MCOs must allow enrollees the freedom to change PCPs, without cause, once every six months and any time when cause to do so exists.

Contracts for MCOs in both voluntary and mandatory districts require that MCOs report their percentage of PCP Auto-Assignments twice a year. Both the Department and local districts should receive these reports. A high percentage of PCP Auto-Assignments may indicate that recipients were not appropriately educated during enrollment on the importance of their selecting a PCP, or that recipients were unable to find an acceptable PCP due to a limited selection on the MCO provider listing, their own geographic location, or their requirements for wheelchair or language accessibility. The Department is responsible for monitoring the submission and analysis of the PCP Auto-Assignment reports for all local districts in the State except for the New York City district, for which NYCDOH has responsibility.

Our audit found that, while NYCDOH properly tracked PCP Auto-Assignment data for the New York City district in 1998, the Department did not ensure that MCOs outside New York City submitted this data for 1998. In fact, we determined that only three MCOs contracting with local districts outside New York City had submitted these required reports. In addition, we found the Department did not evaluate the PCP Auto-Assignment reports it did receive. We believe the Department's insufficient monitoring of contract compliance is again attributable to the lack of a process to collect and analyze PCP Auto-Assignment reports. Without appropriate contract monitoring of these reports, the Department has no assurance that recipients in MCOs outside New York City are appropriately assigned to PCPs.

The Department's annual operational survey of MCOs has some processes that help assess whether MCOs ensure that enrollees have PCPs, as well as a choice in selecting a PCP. However, the Department had not integrated

monitoring of MCOs' compliance with the reporting requirement into these processes at the time of our audit. Department officials told us they have begun developing a process to ensure the monitoring and analysis of PCP auto-assignment reports, which would also incorporate on-site follow up during annual operational surveys.

Local District Monitoring Efforts

According to responses we received to our survey of 20 local districts, there is significant variation in the levels of MCO compliance with the reporting requirements stated in their contracts. Our visits to six districts confirmed that some districts, such as New York City, have achieved good compliance from their MCOs, while others receive very few of the reports they should be getting. Within districts, some MCOs submit most of the reports due, while other MCOs submit virtually none. To help ensure MCOs provide services required by the Medicaid Managed Care program, we believe the Department should instruct local districts in more effective ways to:

- ensure MCOs comply with these contract requirements;
- follow up on delinquent MCOs; and
- use the reported information to monitor the quality of care and availability of services at the MCOs they oversee.

Required Managed Care Reports

We surveyed a judgmental sample of 20 local districts (all 12 districts with mandatory programs, 4 districts with voluntary programs and 4 districts with voluntary exempt programs) and visited 6 local districts (3 mandatory and 3 voluntary). Based on survey information obtained from the 20 local districts we surveyed, and the results of our observations and reviews during our visits to local districts, we concluded that MCOs often failed to comply with the contract requirement to submit managed care reports to local districts during our audit period. We received responses to our survey which indicated that, among the 20 districts we contacted, the mandatory districts had a higher likelihood of receiving MCO reports than did the voluntary districts. As shown in Exhibit A, the survey responses also showed there was a lot of variability among districts regarding the numbers of reports they received from MCOs. For example, 9 of 12 mandatory districts reported receiving the PCP Auto-Assignment report from MCOs, but only 4 of 8 voluntary districts reported receiving this required report.

During our visits to local districts, we found that districts outside New York City did not receive large numbers of reports from MCOs at all. For the six districts we visited, the relevant MCOs should have submitted, collectively,

a total of 63 reports to be in compliance with their contracts in 1998. We determined that these MCOs submitted only 36 of these reports (57 percent), as shown in Exhibit B. Districts that do not adequately monitor MCO contract compliance have no assurance from the reporting process that the MCOs they oversee are providing recipients with the quality of care and access to services required in the Medicaid Managed Care program.

Our visits also confirmed the variability in districts' efforts to enforce contract compliance, as shown in Exhibit C. For example, New York City, with 20 MCOs under contract during our audit period, had consistently high submission rates for reports it considered essential for its monitoring operations. We found NYCDOH had report submission rates of 93 percent or higher for 7 of these reports. Sullivan County, with only one MCO, received only 1 of the 11 different types of reports required in its contract. Our visits also identified significant differences in report submission among the MCOs in a single local district. For example, in Suffolk County, one MCO submitted no reports at all to the district, while another MCO submitted 30 of 36 required reports (83 percent).

We found that most local districts lack a formal process or system to track the Medicaid Managed Care reports they receive from MCOs, and to follow up on the reports that MCOs do not submit. Of the six local districts we visited, only New York City and Albany County had such a system in place during 1998. New York City's system consisted of a calendar showing when MCO reports are due and a log for each MCO's report submissions. Albany County maintains a log to determine when and if reports have been received from an MCO. If the reports are not received within 30 days, district officials send a letter to the MCO requesting the information. The high rate of MCO report compliance in New York City during 1998 demonstrates the effectiveness of the report tracking system.

Columbia, Onondaga and Sullivan counties had no report tracking system. However, the managed care coordinators in each of these counties stated that such a system would be beneficial. Suffolk County officials told us that, while they had no report tracking system during our audit period, they were working to implement a tracking system.

Monitoring Operations

As previously stated, the model contracts assign the Department and local districts the responsibility of reviewing MCO performance data to ensure that MCOs are achieving targeted local level initiatives and goals. However, our review of survey information and our site visits to district offices led us to conclude that, even when they do receive the required reports from MCOs, local districts are inconsistent in performing and documenting their

monitoring of contract compliance. For example, although the NYCDOH was generally effective in performing and documenting contract monitoring work in the New York City district, NYCDOH officials could not provide documentation of follow up regarding seven MCOs that had reported relatively high rates of voluntary disenrollment in one or more quarterly reports. Voluntary disenrollment occurs when a recipient chooses to leave an MCO to enroll in another MCO or return to fee-for-service Medicaid. A high level of voluntary disenrollment from an MCO is an indicator that many recipients are experiencing problems with the MCO. This kind of indicator should prompt the local district to closely examine the MCO's operations to identify the reason(s) why recipients are leaving the plan.

Another cause of inconsistent monitoring among districts throughout the State could be available resource levels. We found that, although local districts must perform similar tasks to maintain appropriate oversight of the MCOs under contract within their respective counties, the resources available to carry out this oversight objective vary from county to county. For example, in Columbia and Sullivan counties, district officials told us there are no staff working on Medicaid Managed Care on a full-time basis; in Onondaga County, there are 9.5 full-time equivalent staff to monitor this program. By contrast, the NYCDOH's Division of Health Care Access has a staff of 19 people dedicated to monitoring the Medicaid Managed Care program in New York City.

The Department is not required to specify the administrative process local districts use to do contract monitoring. However, we believe the Department can assist local districts in obtaining better reporting compliance from MCOs and help ensure consistent documentation and appropriate follow up of the information districts do receive by adding to and expanding the use of a recently developed oversight tool. As noted earlier in this report, the Department established a Local District Managed Care Program Review (Review) evaluation form in January 1999 for Department personnel to use in reviewing operations at districts with mandatory programs. The Department uses the Review process to determine whether mandatory districts are effective in monitoring MCO operations. Department officials share the results of the Review with local district officials. Through this process, districts can determine what monitoring duties are essential, where monitoring improvements should be made and the most efficient way to make these improvements. However, at the time of our audit, the Review evaluation form did not include all contract reporting requirements. Further, the Department performed Reviews only in local districts with mandatory programs. Without complete program reviews of all districts with Medicaid Managed Care programs, the Department will not be assured that local districts are appropriately monitoring their managed care programs to ensure that MCOs are providing Medicaid recipients with access to quality health

care. Department officials told us they are planning to implement the Reviews in voluntary local districts as well.

Recommendations

1. Recommendation deleted.

2. Implement a process to monitor the submission and content of PCP Auto-Assignment reports.

   (In response to recommendation 2, Department officials stated that, in cooperation with plans and counties, it is considering New York City's benchmark in combination with other data, as a starting point for evaluation and analysis of the information provided in the reports.)

3. Instruct local districts to establish formal managed care report tracking systems to monitor MCO report submission and to follow up on late or missing reports. Advise districts to consider modeling their systems, to the extent possible, on New York City's report tracking system.

4. Expand the Local District Managed Care Program Review process to include all local districts (both mandatory and voluntary) with Medicaid Managed Care programs.

5. Expand the Local District Managed Care Program Review evaluation to include all local district managed care contract reporting requirements. Add steps, as necessary, to ensure local districts are effectively using MCO reports.

Recommendations (Cont'd)

(In response to recommendations 3, 4 and 5, Department officials stated they were not required to implement the recommendations, but indicated the steps they were taking to do so.)

DEPARTMENT OF HEALTH MEDICAID MANAGED CARE CONTRACT REPORT SUBMISSION REPORTED BY SAMPLED LOCAL DISTRICTS				
REQUIRED REPORTS	**Number and Percent of Mandatory Counties that Submitted Reports (Total Counties = 12)**		**Number and Percent of Voluntary Counties that Submitted Reports (Total Counties = 8)**	
Encounter Data	**1**	**8.3 % Note 1**	**1**	**12.5 %**
QARR	**1**	**8.3 % Note 1**	**1**	**12.5 %**
MCO Financial Statements	**5**	**41.7 %**	**1**	**12.5 %**
Appointment Availability Studies	**6**	**50 %**	**2**	**25 %**
24-Hour Access Reviews	**6**	**50 %**	**2**	**25 %**
Member Satisfaction Surveys	**10**	**83.3 %**	**4**	**50 %**
Prenatal Care Tracking	**Not Required**	**N/A**	**0**	**0 %**
PCP Auto-Assignments	**9**	**75 %**	**4**	**50 %**
No-Contact Reports	**11**	**91.7 %**	**6**	**75 %**
Complaint/Grievance Summaries	**8**	**67 %**	**5**	**62.5 %**
Voluntary Disenrollment Summaries	**9**	**75 %**	**1**	**12.5 % Note 2**
Participating Provider Network Reports	**8**	**67 % Note 1**	**2**	**25 %**
Clinical Study Results	**6**	**50 %**	**2**	**25 %**
Average Number of Reports Used Per County	**7**	**56%**	**4**	**30%**

NOTES:
1. MCOs were not required to submit this report under mandatory program contracts but some counties still received them.

2. New York City was the only voluntary county to require this report in 1998.

Exhibit A

LEGEND:

Encounter Data - managed care medical service information recorded by the provider (e.g. physician), maintained by the MCO and required to be submitted to the Department monthly.

QARR (Quality Assurance Reporting Requirements) - MCO performance measurement information submitted yearly, that allows the Department to assess MCOs' ability to meet statutory requirements for quality and delivery of services, continuity of care and accessibility in caring for both the non-Medicaid (commercial) and Medicaid populations.

MCO Financial Statements - MCOs are required to submit semi-annual and annual financial statements for review of fiscal solvency and other analysis.

Appointment Availability Studies - MCOs are required to submit semi-annual studies that evaluate appointment availability in various categories that are measured separately for adults and children.

24-Hour Access Reviews - MCOs are required to submit semi-annual reviews that evaluate whether MCOs provide recipients with access to health care services around the clock.

Member Satisfaction Surveys - MCOs are required to conduct these surveys initially within 6 months of the start of the contract and every 18 months thereafter to obtain enrollee feedback on MCO and service performance.

Prenatal Care Tracking - semi-annual MCO reports identifying information such as the timing of enrollees' entry into prenatal care.

PCP Auto-Assignments - MCOs are required to report on a semi-annual basis the rate of enrollees that had their PCP selected by the MCO.

No Contact Reports - MCOs are required to report the number of new members the it was unable to contact within 90 days of enrollment.

Complaint/Grievance Summaries - MCOs are required to provide the Department and some local districts with a written summary of all complaints and grievances received during the preceding quarter, including a record of all complaints that have been unresolved for more than 45 days.

Voluntary Disenrollment Summaries - MCOs are required to submit to a quarterly report of voluntary disenrollments using report categories specified by the Department or local districts to classify the reasons for disenrollment.

Participating Provider Network Reports - MCO information identifying physicians and other medical service providers that contract with the MCO. Reports are used by the Department to ensure there are a sufficient number of medical providers to serve MCO enrollees.

Clinical Studies - MCOs are required to conduct and report on at least one internal focused clinical study each year in a priority topic of their choosing to promote quality improvement within the MCO.

DEPARTMENT OF HEALTH
MEDICAID MANAGED CARE CONTRACT REPORT SUBMISSION
REPORT VERIFICATION AT LOCAL DISTRICTS

13 TYPES OF REQUIRED REPORTS	ALBANY CNTY 5 MCOs		COLUMBIA CNTY 3 MCOs		ONONDAGA CNTY 3 MCOs		NEW YORK CITY 20 MCOs		SUFFOLK CNTY 7 MCOs		SULLIVAN CNTY 1 MCO	
	Report		Report		Report		Report		Report		Report	
	Submitted	Required	Submitted	Required	Submitted	Required	Submitted	Required	Submitted	Required	Submitted	Required
Encounter Data	---	---		X		X	---	---	---	---		X
QARR	---	---		X	X	X	---	---	X	X		X
MCO Financial Statements		X		X		X	---	---	X	X		X
Appointment Availability Studies	X	X		X	X	X	X	X	X	X		X
24 Hour Access Review	X	X		X	X	X	X	X	X	X		X
Member Satisfaction Surveys	X	X	X	X	X	X	X	X	X	X		X
Prenatal Care Tracking	---	---	---	---		X		X	---	---	---	---
PCP Auto-Assignment		X		X	X	X	X	X	X	X		X
No-Contact Reports	X	X	X	X	X	X	X	X	X	X		X
Complaint/Grievance Summary	X	X		X	X	X	X	X	X	X	X	X
Voluntary Disenrollment	X	X	X	X		X	X	X	X	X	---	---
Participating Provider Network Reports	---	---	---	---		X	---	---		X		X
Clinical Study Reports	X	X		X	X	X	---	---	X	X		X
TOTAL	7	9	3	11	8	13	7	8	10	11	1	11

LEGEND

X - indicated report was verified to be required and/or submitted

--- - report was not required to be submitted

blank - required report was not submitted

DEPARTMENT OF HEALTH
MEDICAID MANAGED CARE CONTRACT REPORT SUBMISSION
DETAILED REPORT VERIFICATION AT LOCAL DISTRICTS

TYPES OF REQUIRED REPORTS	ALBANY COUNTY 5 MCOs			COLUMBIA COUNTY 3 MCOs			ONONDAGA COUNTY 3 MCOs			NEW YORK CITY 20 MCOs			SUFFOLK COUNTY 7 MCOs			SULLIVAN COUNTY 1 MCO		
	# of Rpts			# of Rpts			# of Rpts			# of Rpts			# of Rpts			# of Rpts		
	Sub.	Req.	%	Sub.	Req.	%	Sub.	Req.	%	Sub.	Req.	%	Sub.	Req.	%	Sub.	Req.	%
Encounter Data	---	---	---	0	12	0%	0	24	0%	---	---	---	---	---	---	0	4	0%
QARR	---	---	---	0	3	0%	1	2	50%	---	---	---	1	5	20%	0	1	0%
MCO Financial Statements	0	8	0%	0	6	0%	0	6	0%	---	---	---	5	14	36%	0	2	0%
Appointment Availabilty Studies	2	4	50%	0	3	0%	3	5	60%	39	40	98%	4	7	57%	0	1	0%
24 Hour Access Rev.	2	4	50%	0	3	0%	3	5	60%	40	40	100%	4	7	57%	0	1	0%
Member Satisfaction Surveys	4	5	80%	2	3	67%	3	3	100%	20	20	100%	4	7	57%	0	1	0
Prenatal Care Tracking	---	---	---	---	---	---	0	4	0%	0	20	0%	---	---	---	---	---	---
PCP Auto-Assignment	0	8	0%	0	6	0%	1	4	25%	37	40	93%	7	14	50%	0	2	0%
No-Contact Reports	5	48	10%	3	36	8%	11	36	31%	228	240	95%	31	69	45%	0	12	0%
Complaint/Grievance Summary	Note1 8	16	50%	0	12	0%	4	8	50%	79	80	99%	11	28	39%	2	4	50%
Voluntary Disenrollmnt	14	16	88%	1	12	8%	0	4	0%	79	80	99%	8	28	29%	---	---	---
Participating Provider Network Reports	---	---	---	---	---	---	0	8	0%	Note 2	---	---	0	15	0%	0	4	0%
Clinical Study Reports	4	5	80%	0	3	0%	3	3	100%	---	---	---	1	7	14%	0	1	0%
TOTAL	39	114	34%	6	99	6%	29	112	26%	522	560	93%	76	201	38%	2	33	6%

LEGEND

--- - report was not required to be submitted

NOTES

1. MCO contracts in Albany county did not require complaint grievance summary reports. However, two of four MCOs submitted reports.

2. NYC only had provider network reports for the portions of Brooklyn that are going mandatory first. However, they stated that they did have provider directories that are used by marketers during enrollment.

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Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 27, 2000

Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 99-S-15, entitled "Monitoring Medicaid Managed Care Contracts".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
99-S-15 Entitled
"Monitoring Medicaid Managed Care Contracts"

The following are the Department of Health's (DOH) comments in response to Draft Audit Report 99-S-15 entitled "Monitoring Medicaid Managed Care Contracts".

General Comments:

The Medicaid managed care program continued its development phase during the period of the audit. Program requirements were being refined to be more effective and efficient. Plan reporting requirements specified in the Medicaid managed care contracts have undergone and continue to undergo re-examination. Many of the reporting requirements audited by OSC were modified with the advent of the October 1, 1999 model Medicaid managed care contract currently in use. Such modifications were part of a comprehensive review and revision of the model contract which reflected input from local districts and managed care organizations on the utility and value of the reporting requirements.

Self-reported information by managed care plans is just one tool that the Department and local districts use to evaluate the effectiveness of the Medicaid managed care program. The Department's integrated approach to evaluating Medicaid managed care includes the use of an external contractor to conduct independent, uniform and standardized access and availability audits. The Department routinely evaluates plan-specific complaint data and conducts: complaint investigations, annual operational surveys, focused surveys of plans to identify access issues, and quarterly provider network reviews to ensure that plans have adequate networks available to members. The Department also conducts undercover surveillance of provider offices listed in MCO provider directories to determine whether listed providers participate with the stated MCO. Each of these activities represent tools which the Department proactively uses to monitor the Medicaid managed care program, and specifically to assess the access and availability of providers in Medicaid managed care plans.

The Department is not aware of any requirements to specify administrative mechanisms that local districts must follow in monitoring plan compliance with contractual reporting requirements, or to conduct annual program reviews of local districts implementing voluntary Medicaid managed care programs. Nevertheless, the Department has developed a tool that local districts may use to monitor the receipt of plan reports and will provide training to local districts on the use of this tool. The Department also has

amended its protocol for the annual review of local districts implementing a mandatory managed care program to include a review of how local districts monitor all contractually required plan reports. This review tool is currently being adapted for use in counties implementing voluntary programs later this year.

Specific Comments:

The Medicaid managed care contract in place during the audit period was a version of a contract and amendments in use for approximately six years. In response to issues raised by the counties and managed care plans, the Department began a process of revision of that contract in February 1999 with the goals of simplifying language, eliminating redundancy and re-examining the effectiveness of certain requirements. Part of the revision process was to assure that contract requirements, going forward, were relevant in the context of the broad range of oversight activities carried out by the Department and local districts.

Several of the health plan reporting requirements noted in the audit report have been revised due to the Department's and counties' belief that self-reported plan data, in certain areas, is of limited value in the quality improvement process given the comprehensive statewide plan monitoring activities in place. For these reasons, the Department does not agree with broad statements included in the audit report indicating that the Department and local districts are not able to ensure that MCOs are providing adequate services to recipients, track MCO performance, or follow up on problems if they do not receive reports from plans. Specifically, the Department disagrees with the following statements:

> On Page 9 – "Since the Department did not monitor these Access Reviews during our audit period, it did not have assurance that recipients had adequate access to 24-hour medical services;" and
>
> On Page 11 – "Districts that do not adequately monitor MCO contract compliance have no assurance that the MCOs they oversee are providing recipients with the quality of care and access to services required in the Medicaid managed care program."

The Department believes that other mechanisms are in place to ensure that it and local districts can monitor the operation of the managed care program and behavior of MCOs.

The draft report indicates that 33 local districts with voluntary programs are exempt from participating in the mandatory Medicaid managed care program. Since the audit report was written, one county requested that its exemption be rescinded. Therefore, at this time, 32 local districts are exempt from participation in the state's mandatory Medicaid managed care program.

The draft report is misleading as it indicates on Page 2 that "the Department amended contracts for certain voluntary programs in December 1997 to make reporting requirements the same as those for mandatory programs by October 1998 at the latest." In only one of the audited counties were these reporting requirements not effective until October 1998. As indicated previously to the OSC, it was the Department's intent that MCO reporting requirements in mandatory and voluntary counties be comparable during the audit period. An amendment to the contract in use in voluntary counties was promulgated by the Department of Health to accomplish this goal. This amendment was distributed by the Department of Health to voluntary counties and plans operating in those counties in December 1997 to be implemented in January 1998. However, the timing of the execution of these amendments varied by county accounting for differences in reporting requirements observed by the OSC during the audit period.

The draft report indicates that the Department's local district managed care program review tool is used to assess mandatory districts' monitoring effectiveness. The review tool and process is designed to review more than just how the districts monitor plans. The primary purpose of the review process is to assess local district Medicaid managed care program administration, beneficiary education and enrollment processes, exemption and exclusion processes, auto-assignment, disenrollment processes, and local district plan monitoring activities including: benefits access and availability, marketing materials and practices, contract management, complaints and appeals processes, and report monitoring. The monitoring of report submission by plans is one small component of the DOH's process for reviewing local district effectiveness.

The draft report indicates that districts with mandatory programs generally had better rates of compliance with plan report submission than those with voluntary programs. This is because prior to and during the period of the audit, primary attention by the Department was directed at ensuring that key program elements, including reporting by plans, were in place in districts implementing mandatory programs as required by the terms and conditions of New York's 1115 waiver. In keeping with federal Balanced Budget Act requirements to establish minimum requirements for Medicaid managed care, effective in October 1997, the Department put in place systems to ensure the same level of performance and contract compliance among local districts implementing voluntary Medicaid managed care programs.

Appointment Availability and 24 Hour Access Reviews:

The draft report indicates that the Department did not ensure timely or properly submitted Appointment Availability Studies, 24 hour Access Reviews, or Primary Care Auto-assignment Reports by MCOs. The audit indicates that 19 managed care organizations that were required to submit reports during calendar year 1998 were non-compliant for a variety of reasons. As indicated previously to OSC, there were 3 MCOs that were in the process of transitioning members out of their plans in specific counties during 1998 because they were no longer participating in the Medicaid managed care program. The Department disagrees with page 8 of the audit noting that reports should

contain county-specific data. As discussed with OSC in a previous audit, neither the Department nor the contract requires county-specific data and in many cases county-specific measures don't make sense and are not useful. There were a number of MCOs that did not conduct the surveys on a county specific basis because the membership in the counties and the number of providers were small which allowed them to combine these counties' results. This was particularly true in rural areas. The Department believes that there is a greater degree of validity in certain surveys if the unit of measure was the entire service area of the MCO due to the limited number of providers and enrollees. Therefore, MCOs grouped several counties together to complete this survey.

As the report indicates, the Department has since modified the new model Medicaid managed care contract by giving the MCOs greater flexibility to use the county or service area as the unit of measure. The new model contract was also revised to eliminate the need for MCOs to submit these reports to the Department. Although the Department provided guidance to the MCOs on the elements that needed to be included in these studies, during the period of the audit a specific data collection process was not prescribed as long as valid results were produced. The use of satisfaction surveys to ascertain whether or not the requirements for appointment availability and 24-hour access were being satisfied was deemed a valid method.

The Department does not agree that it could not evaluate whether Medicaid members had access to care within established time frames. This reporting requirement was only one approach to getting at this information, and is an approach which has limitations. As stated in the general comments above, the Department utilizes an integrated approach to evaluate Medicaid managed care including the use of an external contractor to conduct independent, uniform and standardized undercover access and availability audits, the evaluation of complaint data, the conduct of complaint investigations, the conduct of annual and focused surveys which would identify access issues, QARR access measures and the conduct of quarterly network reviews to ensure that plans have adequate networks available to members. The audit report should have mentioned all of the methods that the Department uses to monitor access and appointment availability in Medicaid managed care plans.

Lastly, the appointment availability and 24-hour access studies performed by the Department's external review agent are conducted annually and evaluate a greater number of physicians than the studies performed by each MCO. The Department determines from these standardized reviews if there is a problem with access, and directs MCOs to correct identified problems. If problems are identified, a plan of correction is provided to the Department and a follow-up survey is conducted to ensure that the problem is corrected.

Primary Care Provider Auto-Assignment Reports:

As previously indicated to the OSC, the statement that MCOs must allow enrollees the freedom to change PCPs without "cause" at least twice in a 12-month period, or for "cause" at any time is incorrect. MCOs must allow enrollees the freedom to change PCPs, without "cause", once every six months and any time when "cause" to do so exists.

As the OSC's report indicates, the model contract includes a requirement that health plans report PCP auto-assignment. However, there is no consensus in the health care industry, among other states and among the counties of the State as to the best way to evaluate this plan reported data. It is widely believed that other tools, such as a periodic review of encounter data, may be more effective in monitoring whether plan members have PCPs. The encounter data system provides the Department with information as to the numbers of Medicaid managed care enrollees linked to PCPs and also provides details of encounters with PCPs and the Department monitors plans' contact rates by providers. The new model contract, as revised on October 1, 1999, allows plans to assign members to PCPs after written notice of the enrollee by the plan, but in no event later than thirty days after enrollment, and only after the plan has made reasonable efforts to contact the enrollee and inform him/her of his/her right to choose a PCP.

On behalf of some counties, the Department implemented a process in 1998 to monitor PCP auto-assignment report submissions and to analyze the data. The Department mailed letters in September to the plans that had not submitted their reports for certain periods as required by the Section 18.1 of the model contract. The Department, in cooperation with the plans and the counties, is considering New York City's benchmark for monitoring PCP auto-assignment data in combination with other data as a starting point for evaluation and analysis of PCP assignment.

Local District Monitoring Efforts

As indicated in the general comments above, there is no requirement that the Department specify the administrative processes to be used by districts in the monitoring of their contracts. Also, HCFA has approved the Department's oversight of local districts including the contract process. Local district program reviews conducted by the Department and HCFA in counties implementing mandatory Medicaid managed care programs address local district monitoring of disenrollment reasons, the use of QARR and encounter data and plan complaint reports. Also, the annual operational site visits to each MCO in which local districts participate serves to check for MCO compliance with all Medicaid managed care contract requirements, including reporting requirements.

The audit report indicates that mandatory districts had a higher likelihood of receiving MCO reports than did voluntary districts, and that there was variability among the districts in the number of reports received from MCOs. The OSC report also indicates that among the districts, New York City achieved consistently high submission rates from its MCOs during the period of the audit. The OSC report expresses the view that the high rate of MCO report compliance in the City is a result of the effectiveness of New York's report tracking system. As the audit report indicates, lack of staff resources may also account, in part, for the variability in compliance observed among some counties. Additionally, prior to and during the audit period, the Department's primary focus was on ensuring that key elements of the managed care program were being implemented properly in districts implementing mandatory programs as required by the terms and conditions of the 1115 waiver. The Department did follow up consistently with each MCO participating in the Medicaid managed care program with respect to encounter data, QARR data, and network data report submissions. Contractually required reports are only one of several mechanisms the local districts use to monitor health plan compliance with the contract, and the effectiveness of the managed care program. Also as indicated earlier to OSC, the differences in reporting compliance observed by OSC may also have been related to the timing of the implementation of amendments to contracts by plans in the counties audited.

While the Department is not required to assist local districts in obtaining better reporting by plans, the Department believes technical assistance and consultation can be offered to local districts to assist them in ensuring more consistent documentation and appropriate follow up of the information reported to them by plans.

Recommendation 1:

Improve the process to track missing and incorrect Appointment Availability/24-Hour Access Studies.

Response 1:

The Department does not agree with this recommendation, since there are other better measures to evaluate whether Medicaid members have access to care within established time frames.

The October 1, 1999 model contract currently in use between local districts and plans no longer requires MCOs to submit appointment /availability and 24-hour access and availability surveys to the Department and to local districts. MCOs must still conduct a county specific or service area specific review of appointment availability and 24-hour access and availability annually and maintain the studies on file for review by local districts and the Department.

Response 1 (cont'd)

The Department uses an integrated approach to evaluate Medicaid managed care including the use of an external contractor to conduct undercover independent, uniform and standardized access and availability audits. The Department also routinely evaluates complaint data and conducts complaint investigations, annual operational surveys, focused surveys which identify access issues, QARR access measures and quarterly provider network reviews to ensure that plans have adequate networks available to members.

The appointment and availability study conducted by the Department's external review agent is conducted annually and within 6 months of the implementation of mandatory programs, and evaluates a greater number of physicians than the studies performed by each MCO. The Department can determine from these standardized reviews if there is a problem with access or availability of providers, and can direct MCOs to correct identified problems. If problems are identified, a plan of correction is provided to the Department and a follow-up study of the MCO's providers is conducted to ensure that the problem is corrected.

Through annual operational surveys, the Department reviews the appointment and availability studies conducted by plans to ensure that plans are carrying out self-monitoring activities that enable them to identify and act upon issues internally. The Department reviews MCO analyses and follow-up activities, as warranted.

The Department also routinely reviews complaint data to determine whether specific MCOs may have problems associated with access issues and follows up with the MCOs if needed.

Provider networks are also monitored on a quarterly basis by the Department to ensure that MCOs maintain an appropriate array of providers in their networks.

The Department also calls provider offices listed in MCO provider directories to determine whether the providers truly participate with the stated MCO. Each of these activities are proactive steps independent from the health plans, that the Department takes to monitor the access and availability of providers in managed care plans.

Recommendation 2:

Implement a process to monitor the submission and content of PCP Auto-Assignment reports.

Response 2:

The current model Medicaid managed care contract requires MCOs to submit semi-annually to the Department and local districts a report showing the percentage of PCP assignments for enrollees which were made automatically by the MCO. While New York City collects its own reports from MCOs, the Department of Health has collected and maintained these reports for some counties since 1998. The Department does monitor the receipt of PCP auto-assignment reports and sends letters to plans that do not submit reports consistent with the requirements in the current model contract. The Department, in cooperation with plans and counties, is now considering New York City's benchmark in combination with other data, as a starting point for evaluation and analysis of the information provided in the reports.

There is no consensus among industry representatives, among other states and among local social services districts as to the best way to use the information in these reports. The Department believes that other monitoring tools may be more effective in monitoring assignment of PCPs than plan self-reported data.

Recommendation 3:

Instruct local districts to establish formal managed care report tracking systems to monitor MCO report submission and to follow up on late or missing reports. Advise districts to consider modeling their systems, to the extent possible, on New York City's tracking system.

Response 3:

The Department is not required to establish administrative mechanisms for the local districts to follow in implementing their responsibilities in monitoring managed care contracts. However, the Department recognizes the oversight role and value of providing consultation and technical assistance to local districts on the importance of formal managed care report tracking systems. A draft model tracking system was developed by Department staff in collaboration with some local districts and distributed for review and comment to other districts in January 2000 (see attached copy of draft tool). The draft tool can be used to monitor the submission of reports MCOs are required to submit to local districts as well as reports mandatory local districts are required to submit to the Department. Upon finalization of this tracking tool, it will be offered, along with training on appropriate follow up, to all districts as a prototype which may be adapted for local use to assist in monitoring and following up on late report submissions.

Recommendation 4:

Expand the Local District Managed Care Program Review process to include all local districts (both mandatory and voluntary) with Medicaid Managed Care programs.

Response 4:

The Department is not required to expand the local district program review to include districts implementing a voluntary Medicaid managed care program; however, as indicated to OSC, the Department intends to implement the reviews in voluntary districts in mid 2000. The Department is currently in the process of revising the local district managed care program review tool for use in voluntary counties. A draft of this tool has been distributed at regional Medicaid Managed Care Coalition meetings (see attached copy). Voluntary local districts have been informed that such program reviews will begin in June 2000. A complete schedule for the conduct of such reviews in the voluntary counties is under development.

Recommendation 5:

Expand the Local District Managed Care Program Review evaluation to include all district managed care contract reporting requirements. Add steps, as necessary, to ensure local districts are effectively using MCO reports.

Response 5:

Again, it is not required anywhere that the Department take specified administrative steps to monitor local district efforts to monitor plan contractual reporting requirements. However, the Department's local district managed care program review tool has been revised to include optional and mandatory reports to be submitted to the local districts by MCOs as well as submission dates.

MANAGED CARE CONTRACT AND QUALITY TRACKING TOOL

Year_____

DRAFT

Plan Name_____

LDSS Name_____

Activity Report Items	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1. Annual Financial 4/1											
2. Quarterly Financial											
1st Quarter 5/15											
2nd Quarter 8/15											
3rd Quarter 11/15											
4th Quarter 2/15											
3. Clinical Studies											
Study 1											
Study 2											
Study 3											
Study 4											
4. Independent Audits											
Financial											
QARR											
5. PCP Auto Assignments											
1st Reporting Period											
2nd Reporting Period											
6. No Contact Report											
Due 1st of every month											

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1. Logs													
Complaint (monthly)													
Fair Hearings (quarterly)													
Enrollment Capacity(opt)													
Exemptions(monthly)													

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C. Internal Reports & Surveys													
1. Data Report (by 10th)													
Enroll/ Disenrollment													
Autoassigns													
2. Lock-In Report(mthly.)													
3. Surveys to enrollees													
Random handout Annual (Fall)													
Mailout Annual (Spring)													
4. Access & Availability													
Survey of Providers and Plan(phone calls)													
Semiannual:													
Spring													
Fall													
5. Observe Marketers (Four times per year)													

MCO Reports Due	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Annual Financial 4/1												
Quarterly Financial												
1st Quarter 5/15												
2nd Quarter 8/15												
3rd Quarter 11/15												
4th Quarter 2/15												
Clinical Studies												
Study 1												
Study 2												
Study 3												
Study 4												
Independent Audits												
Financial												
QARR												
PCP Auto Assignments												
1st Reporting Period												
2nd Reporting Period												
No-Contact Report												
Due 1st of Every Month												
Other LDSS Reports												

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL DISTRICT MANAGED CARE PROGRAM REVIEW

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DISTRICT STATUS

Voluntary ❒

LDSS/MC Coordinator:

_____

_____ **County**

SDOH/BIGA Rep. :

_____

CAPACITY BY PLAN

Plan	Capacity	Contract End Date	Current Enrollment Month/Year	
_____	_____	__/__/__	_____	__/__
_____	_____	__/__/__	_____	__/__
_____	_____	__/__/__	_____	__/__

PRE-SURVEY OBTAIN AND REVIEW:

ON-SITE VALIDATION

Corrective Action Updating/Submission Required:

Enrollment Pol.& Proc.	❒ Yes ❒ No	❒ Yes ❒ No
County Marketing Plan	❒ Yes ❒ No	❒ Yes ❒ No
Enrollment Packet	❒ Yes ❒ No	❒ Yes ❒ No
Consumer Survey Tool	❒ Yes ❒ No	❒ Yes ❒ No (not mandatory)
MCO Marketing Materials	❒ Yes ❒ No	❒ Yes ❒ No
Complaint Logs	❒ Yes ❒ No	❒ Yes ❒ No (not mandatory)

REVIEWERS:

DATE OF REVIEW: __/__/__

March 29, 2000

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL DISTRICT MANAGED CARE PROGRAM REVIEW DRAFT

District _____ Year_____

I. Local District Program Administration

Purpose: review of this section will allow the State to determine the ability of the local district to successfully administer and monitor various components of the mandatory managed care program.

A.	Administrative Structure	Acceptable and/or Available	Comments/Recommended Action
1.	Staff/eligible ratio _____:_____ Has MC staff been added or lost since last review or in last year? explain. List positions in comments.	❒ Yes ❒ No	
2.	Local District Interface Obtain copy of staffing flowchart	❒ Yes ❒ No	
	Who provides beneficiary education (Describe).		
	Interface with other local agencies via MOU, amendments or other: (If yes, describe).	❒ Yes ❒ No	
	Who determines TPR exclusions (describe).	❒ Yes ❒ No	
3.	Training Activities -		
	Desk Reference Guides used (list those used and obtain copies) routinely and for training new staff?	❒ Yes ❒ No	
	Training sessions provided to outside agencies, providers, community organizations?	❒ Yes ❒ No	
	Copies of Training Curriculum(s) and attendees on file?	❒ Yes ❒ No	
4.	Managed Care Subcontracts/Consultants Consultants/subcontractors used to assist with local districts administration of the program. If yes, list subcontracts and specifications of subcontract in comments column.	❒ Yes ❒ No	
	Selection Process RFP	❒ Yes ❒ No	
	If no, explain process used for selection.		
	Copies of sub-contract available?	❒ Yes ❒ No	
	Contractor deliverables/monitoring plan in place.	❒ Yes ❒ No	
5.	Referral Phone Numbers Are LDSS staff familiar with SID, Atty. General, SDOH phone Numbers and when to refer inquiries?	❒ Yes ❒ No	

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL DISTRICT MANAGED CARE PROGRAM REVIEW

DRAFT

District_____ Year_____

II. Beneficiary Education/Enrollment

Purpose: review of this section will determine the ability to adequately educate potential managed care enrollees and to ensure that beneficiaries can make informed choices.

A. Beneficiary Education	Acceptable and/or Available	Comments/Recommended Action
1. Describe LDSS' enrollment and education process on back including MCO role.		
2. Educational material available for potential enrollees?	❒ Yes ❒ No	
3. Staff Training - LDSS		
Staff has been trained and understands minimum Beneficiary education components	❒ Yes ❒ No	
• General managed care	❒ Yes ❒ No	
• Exemptions/exclusions	❒ Yes ❒ No	
• Disenrollment - expedited "good cause"	❒ Yes ❒ No	
• Lock-in (if City chooses to impose lock-in)	❒ Yes ❒ No	
• Guarantee	❒ Yes ❒ No	
• MCO/PCP choice	❒ Yes ❒ No	
• ER use, referrals, FP	❒ Yes ❒ No	
All local district staff trained including MC, MA, TA and Services? Explain in comments.	❒ Yes ❒ No	
Copies of attendance sheets, agendas & curriculum available?	❒ Yes ❒ No	
Beneficiary education scripts supplied to staff (obtain).	❒ Yes ❒ No	
Routine managed care observation of workers/beneficiary education/interaction:	❒ Yes ❒ No	
4. Accommodations for beneficiaries with special requirements		
• language — Note: Reviewer to focus	❒ Yes ❒ No	
• vision — on policies and pro-	❒ Yes ❒ No	
• hearing — cedures identifying	❒ Yes ❒ No	
• mobility — how accommodations are made.	❒ Yes ❒ No	
5. Health assessment forms used	❒ Yes ❒ No	
Explain process for handling Health Assessments (comment on back)		
6. Are all calls within county to MC unit local?.	❒ Yes ❒ No	
If no, is local # available for answering beneficiary questions explain how persons can call toll-free.	❒ Yes ❒ No	

District_____ Year_____

II. Beneficiary Education/Enrollment (cont.)
Purpose: review of this section will determine the ability to adequately educate potential managed care enrollees and to ensure that beneficiaries can make informed choices.

B.	Enrollment Process	Acceptable and/or Available	Comments/Recommended Action
1.	Rosters Describe Roster Reconciliation process including use of the second roster Note: Additions are on 2nd roster, deletions are not		
2.	Beneficiary notices - Obtain copies of all notices LDSS uses	❒ Yes ❒ No	
	Content of notices, welcome letters, etc. SDOH approved?	❒ Yes ❒ No	
	Time frames available/acceptable for: • mailings • tracking • follow-up	❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No	
3.	Describe the fair hearing process		

District:_____ Year: _____

II. **Beneficiary Education/Enrollment** (cont.)
Purpose: review of this section will determine the LDSS ability to adequately educate potential managed care enrollees and to ensure that beneficiaries can make informed choices.

C. Beneficiary Education/Observation	Acceptable and/or Available	Comments/Recommended Action
1. Potential member received education materials	❒ Yes ❒ No	
2. Enrollment education session includes: A. Explanation of the difference between fee-for-service and MC	❒ Yes ❒ No	
B. Brief explanation of standard MCO benefit package (list Medicaid benefits which will continue as fee-for-service.	❒ Yes ❒ No	
C. Participation in managed care is voluntary.	❒ Yes ❒ No	
D. Exclusion process to obtain status	❒ Yes ❒ No	
E. One-on-one private and confidential counseling available on request	❒ Yes ❒ No	
F. Prospective enrollee has a choice of plans	❒ Yes ❒ No	
G. Eligible member considers whether providers are in network	❒ Yes ❒ No	
H. Member has choice of at least 3 PCPs in member's area	❒ Yes ❒ No	
I. If member does not select a PCP within 30 days, one will be selected for them.	❒ Yes ❒ No	
J. Member may only use providers & facilities in plan's network	❒ Yes ❒ No	
K. Member will almost always need to seek routine/urgent care from his/her PCP	❒ Yes ❒ No	
L. PCP will refer member to appropriate specialist	❒ Yes ❒ No	
M. If member meets qualifying conditions, may receive transitional care from his/her present provider.	❒ Yes ❒ No	
N. Member handbook, ID card will be sent within 14 days from date of enrollment	❒ Yes ❒ No	
O. How to obtain additional information about program from LDSS or MCO	❒ Yes ❒ No	
P. Disenrollment/changing of MCO discussed.	❒ Yes ❒ No	
Q. Service remaining FFS - continue to use MA ID Card	❒ Yes ❒ No	
3. Standard enrollment form was used; attestations signed.	❒ Yes ❒ No	
4.. Accommodations made for non-English speaking enrollees, persons with special needs, as applicable.	❒ Yes ❒ No	
5. LDSS implements SDOH-approved MCO monitoring policies and procedures, including follow-up actions with MCOs.	❒ Yes ❒ No	

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL DISTRICT MANAGED CARE PROGRAM REVIEW

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District_____ Year_____

III. Exclusions

Purpose: review of this section will determine if LDSS has clearly defined procedures for identifying exclusions.

A. Local District Process	Acceptable and/or Available	Comments/Recommended Action
Local district process complies with SDOH policies.	❒ Yes ❒ No	
1. Beneficiary questions handled by: • Local district -Staff other than MC (explain) • SDOH • LDSS MC staff	 ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No	
2. Exclusions Request log in use • tracking in place? Tickler files, etc.?	❒ Yes ❒ No ❒ Yes ❒ No	
3. How does LDSS handle exclusions transmitted by SDOH (explain)		
4 Procedures in place for identification and referral of clinical issues to SDOH for review and determination	❒ Yes ❒ No	

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL DISTRICT MANAGED CARE PROGRAM REVIEW

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District_____ Year_____

V. Disenrollments

Purpose: Review of LDSS ability to monitor beneficiary disenrollments for timeliness; monitoring procedures in place to assure disenrollment requests are handled within appropriate time frames.

A.		**Acceptable and/or Available**	**Comments/Recommended Action**
1.	MCO Monitoring procedures in place to assure disenrollment requests are handled within appropriate time frames.	❒ Yes ❒ No	
2.	Expedited disenrollment available within guidelines for beneficiaries -	❒ Yes ❒ No	
3.	Disenrollment tracking report in use for involuntary disenrollments	❒ Yes ❒ No	
4.	Plan initiated disenrollments monitored Proper client notification sent - □ by LDSS □ by SDOH reg. office	❒ Yes ❒ No ❒ Yes ❒ No	
5.	Explain enrollment procedures when - MCO of choice at capacity - PCP of choice at capacity	❒ Yes ❒ No ❒ Yes ❒ No	
6.	Are MCOs allowed to submit disenrollments Does LDSS follow-up with MCO.	❒ Yes ❒ No ❒ Yes ❒ No	

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL DISTRICT MANAGED CARE PROGRAM REVIEW

DRAFT

District_____ Year_____

VI. Local District Plan Oversight

Purpose: to review and evaluate the local districts ability to assure MCO compliance with contract provisions as appropriate.

A.	Local District Monitoring Activities	Acceptable and/or Available	Comments/Recommended Action
1.	Benefits Access and Availability		
	a. Local district staff perform periodic access and availability checks	❒ Yes ❒ No	
	Sample scripts on file	❒ Yes ❒ No	
	Survey check:		
	• 24 hr., 7 day telephone service	❒ Yes ❒ No	
	• PCP availability	❒ Yes ❒ No	
	• availability of info on free access services	❒ Yes ❒ No	
	b. Local district conducts new beneficiary surveys ☐ SDOH does marketing oversight (skip first three items in c.)	❒ Yes ❒ No	
	c. New beneficiary survey checks:		
	• marketing practices	❒ Yes ❒ No	
	• knowledge of benefits available	❒ Yes ❒ No	
	• PCP assignment/choice	❒ Yes ❒ No	
	• timely receipt of ID card	❒ Yes ❒ No	
	• timely receipt of welcome letter	❒ Yes ❒ No	
	• timely receipt of handbooks	❒ Yes ❒ No	
	d. Local district conducts client satisfaction surveys (see sample and results)	❒ Yes ❒ No	
	• Takes corrective action, as necessary (See sample C/A plan, if available)	❒ Yes ❒ No	
	e. Local district monitors plan conducted surveys	❒ Yes ❒ No	
2.	Marketing Materials and Practices		
	a. Approved, up-to-date, Marketing Plans in place for all local district MCOs	❒ Yes ❒ No	
	b. Local district staff review and approve all plan marketing materials ☐ Delegated to SDOH	❒ Yes ❒ No	
	c. All materials reviewed for compliance with low literacy guidelines (skip if delegated to SDOH)	❒ Yes ❒ No	
	c. Procedure in place to approve/monitor MCO marketing locations (i.e., in community, health fairs, etc.)	❒ Yes ❒ No	
	e. Local district staff monitor marketing practices directly	❒ Yes ❒ No	
	f. Serious marketing offenses are reported to SDOH	❒ Yes ❒ No	

District_____ Year_____

VI. Local District Plan Oversight (Cont.)

Purpose: to review and evaluate the local districts ability to assure MCO compliance with contract provisions as appropriate.

A. Local District Monitoring Activities (cont.)	**Acceptable and/or Available**	**Comments/ Recommendations**
g. Written current policies are in place and approved for ID of inappropriate marketing practices	❒ Yes ❒ No	
h. Local district has cited plan(s) within the previous year and requested corrective action	❒ Yes ❒ No	
• documentation on file	❒ Yes ❒ No	
• SDOH copied on all such actions	❒ Yes ❒ No	
3. Contract Management		
a. All local district/MCO contracts are current (explain No)	❒ Yes ❒ No	
b. Local district contracts contain the special provisions: (e.g., carve-outs)	❒ Yes ❒ No	
□ Non-emergent transportation	❒ Yes ❒ No	
□ Emergent transportation	❒ Yes ❒ No	
□ Family planning services	❒ Yes ❒ No	
□ Other(s) - Explain	❒ Yes ❒ No	
c. Local district monitors weekly enrollment by plan to ensure compliance with contract capacity	❒ Yes ❒ No	
d. Local district monitors MCO disenrollment rates and reasons	❒ Yes ❒ No	
e. Local district uses MCO QARR and MEDs data	❒ Yes ❒ No	
4. Complaints and Appeals		
a. Complaints		
1. Written policies and procedures in compliance with model contract	❒ Yes ❒ No	
2. Log sheets in use, entries are complete	❒ Yes ❒ No	
3. Summary actions are appropriate	❒ Yes ❒ No	
4. Monthly logs have been summarized (by type of complaint; timeliness of resolution) for each plan with any trends noted	❒ Yes ❒ No	
5. Policies and procedures in place for referring complaints/ grievances to SDOH, as appropriate	❒ Yes ❒ No	
6. Procedures are in place for analyzing plan submitted reports	❒ Yes ❒ No	
7. LDSS follow-up on unresolved complaints or inappropriately handled complaints	❒ Yes ❒ No	
b. Appeals		
1. Procedures are in place for tracking beneficiary appeals at LDSS level	❒ Yes ❒ No	
2. Fair hearing notices accompany all hearable decisions	❒ Yes ❒ No	
3. Communication between MC and FH units?	❒ Yes ❒ No	

District_____

VII. LDSS Reporting Requirements

	Acceptable	Comments/ Recommendations
1. Is LDSS up to date on reports required to be submitted to the LDSS by MCO's as follows:		
1. Annual Financial Statements (due 4/1 following the report closing date)	❒ Yes ❒ No	
2. Quarterly Financial Statements (due 45 days after the end of the calendar quarter)	❒ Yes ❒ No	
3. Other Financial Reports**	❒ Yes ❒ No	
4. Complaint Reports**	❒ Yes ❒ No	
5. Appointment Availability/Twenty-four (24) Hour/Access and Availability Surveys**	❒ Yes ❒ No	
6. Clinic Studies	❒ Yes ❒ No	
7. Independent Audits (due within 30 days of receipt by the Contractor)	❒ Yes ❒ No	
8. PCP Auto-Assignments (due semi-annually)	❒ Yes ❒ No	
9. No Contact Report	❒ Yes ❒ No	
10. Additional Reports**	❒ Yes ❒ No	
11. LDSS Specific Reports	❒ Yes ❒ No	

** LDSS option to require this report.

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