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June 12, 2001

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

Re: Report 2001-F-6

Dear Dr. Novello:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have reviewed the actions taken by the Department of Health (Health) as of April 4, 2001, to implement the recommendations contained in our audit report, *Assessing Medicaid Managed Care Provider Networks* (Report 97-S-59). Our report, which was issued on June 3, 1999, assessed Health's process for determining the maximum number of Medicaid recipients that can be served by managed care organizations (MCOs) without compromising the quality of services provided.

Background

Health administers New York's Medical Assistance program (Medicaid) to provide medical assistance to needy people. The Medicaid Managed Care program was established under the Statewide Managed Care Act of 1991. Under Medicaid Managed Care, each county is responsible for developing its own Medicaid Managed Care program. Local social services districts contract individually with MCOs to provide medical services to enrolled Medicaid recipients. The MCOs receive a monthly capitation payment for each enrolled recipient. In return, the MCOs must ensure that each enrollee has a primary care provider, adequate access to quality health care, and 24-hour access to emergent and urgently needed services.

A provider network consists of physicians or groups of physicians; specialists; and service centers - i.e., hospitals, pharmacies, and clinics - that contract with MCOs to provide enrollees with all of the health care services they may require. The success of an MCO often depends on how well the provider network is structured, and how efficiently and effectively it responds to patients' needs.

As of April 2001, Health reported that about 698,466 Medicaid recipients were enrolled in MCOs throughout New York State.

Summary Conclusions

In our prior audit, we noted that Health routinely assessed the capacity of the MCOs that serve Medicaid recipients. However, these assessments did not consider the number of non-Medicaid patients in a physician's panel, and did not fully consider whether an MCO's primary care providers were easily accessible to its patients.

In our follow-up review, we found that Health officials have taken steps to improve the process for determining the maximum number of Medicaid recipients that can be served by an MCO. This improved process should aid Health in assessing the ability of MCOs to provide quality medical care to Medicaid recipients.

Summary of Status of Prior Audit Recommendations

Health officials implemented all three of the recommendations in our prior report.

Follow-up Observations

Recommendation 1

Enhance the process of analyzing the capacity of Medicaid Managed Care provider networks by considering the number of non-Medicaid patients and the location of health care providers.

Status - Implemented

Agency Action - Health commissioned a study by New York University of primary care practitioner's (PCP's) patient capacity in New York City. The study report is dated January 8, 2001. The methodology used in the study considered the number of non-Medicaid patients seen by physicians. Additionally, Health officials indicated that during quarterly reviews of the provider network data system (PNDS), formerly known as the Network System, when staff identify physician panel sizes approaching 1,500 Medicaid enrollees, commercial panel size information is also examined to assess the overall impact to the physician's panel. To date, no PCPs have reported panels that exceed 1,500 Medicaid patients.

Regarding analysis of location, Health implemented a geo-access function on the Health Provider Network (HPN) for use by local district staff when enrolling recipients, to identify the location of physicians nearest the recipient by matching address and/or zip codes. This function is also used to identify physician specialists, as well as those physicians speaking languages other than English.

Recommendation 2

Develop a procedure for verifying and ensuring that information submitted to the Network System is accurate.

Status - Implemented

Agency Action - Health implemented validity and reliability tests within the PNDS to ensure the accuracy of submitted provider information. In 1999 and 2000, Health contracted with the Island Peer Review Organization (IPRO) to conduct audits of the PNDS. IPRO is scheduled to perform another audit of the PNDS in 2001. In addition, Health implemented a process to ensure the accuracy of provider license numbers on the PNDS through a match of the network information to the professional license file maintained by the State Education Department.

Recommendation 3

Develop and implement general control policies and procedures over the development and acquisition of microcomputer applications.

Status - Implemented

Agency Action - Health established a process to update and test microcomputer application programs, as well as ensure accurate reports on data submitted by managed care plans through the HPN.

Major contributors to this report were Lee Eggleston, Gabriel Deyo and Sally Wojeski.

We would like to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Charles Conaway