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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

September 17, 2003

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

Re: Multiple Medicaid Payments for Newborn
Services
Report 2002-S-25

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 audited the Department of Health's (Department) policies and procedures for ensuring the appropriateness of certain Medicaid payments made on behalf of newborn recipients enrolled in Managed Care Organizations (MCO) for the six-year period January 1, 1997 through December 31, 2002.

A. Background

The Department administers the State's Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the federal Social Security Act to provide medical assistance to needy people. The federal, State and local governments jointly fund the Medicaid program in New York State. The State is integrating managed care into Medicaid as a means of providing quality health care to low-income and disabled citizens in a more cost-effective manner. The Department's responsibilities include: certifying MCOs as qualified to participate in Medicaid managed care; overseeing MCO operations and quality of services; providing oversight and technical assistance to local social services districts; evaluating managed care program performance; and, developing and maintaining the necessary systems to operate and administer Medicaid and managed care.

The Department uses a fiscal agent, Computer Sciences Corporation, to operate the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and make payments to health care providers (providers) for services rendered to recipients. MMIS pays providers for these services by means of the fee-for-service (FFS) method or the capitation method. With the FFS method, MMIS pays the provider

directly for each Medicaid-eligible service rendered; with the capitation method, MMIS pays the MCO a monthly premium for managing the health care of each Medicaid recipient in the MCO, regardless of the number or types of services the recipient actually receives. The Department identifies the Medicaid recipients (including mothers and newborns) who are enrolled in MCOs on the State's automated Welfare Management System and on the Department's Electronic Medicaid Eligibility Verification System (EMEVS).

When a Medicaid recipient delivers a baby at a hospital, the hospital seeks reimbursement for the costs of newborn services from one of two sources: an MCO, if the newborn is enrolled in an MCO, or directly from Medicaid if the newborn is not enrolled in an MCO. To make sure hospitals bill the proper payer, Department billing procedures require that hospitals review EMEVS information before they bill for newborn services costs. If the newborn is not enrolled in an MCO, the hospital bills Medicaid directly for newborn services under the FFS method; if the newborn is enrolled in an MCO (infants born to Medicaid recipients who are MCO enrollees generally become members of the same MCO), the hospital bills the MCO for newborn services. Exceptions to this billing routine arise when the newborn weighs less than three pounds or has a serious disability. In these cases, hospitals can bill Medicaid for the more extensive services the newborn may require on the FFS basis. Newborn children with these special care requirements are not eligible for MCO enrollment, and they should not be listed on EMEVS as MCO enrollees.

The Department's Medicaid Managed Care Model Contract (Contract) provides for MCOs to receive a monthly capitation payment from the first day of the newborn's birth month. The Contract also states that MCOs receive a Supplemental Newborn Capitation Payment (known as a "kick payment"), a one-time fixed amount Medicaid pays MCOs to reimburse them for the cost of newborn services MCOs have already paid out to hospitals. According to Department officials, Medicaid should not pay both a FFS claim and a kick payment for the same newborn services. Further, the Contract requires MCOs to pay hospitals' bills for newborn services before obtaining reimbursement in the form of Medicaid kick payments.

For the period January 1, 1997 through December 31, 2002, Medicaid made kick payments of nearly \$421 million to MCOs for newborns enrolled in managed care.

B. Audit Scope, Objective and Methodology

We audited the Department's policies and procedures for monitoring Medicaid reimbursement for managed care kick payments during the six-year period January 1, 1997 through December 31, 2002. The objective of our financial related audit was to determine if Medicaid made appropriate payments to providers of newborn services.

To accomplish our audit objective, we interviewed officials from the Department and reviewed applicable Medicaid policies, procedures, rules, regulations and internal controls that pertain to newborn kick payment claims processing. We developed computer programs to analyze managed care kick payments and FFS hospital payments to determine if Medicaid made appropriate newborn services payments. We visited one upstate and one downstate MCO, and gathered information on their processes for billing kick payment claims.

During our audit period, there were 40 Medicaid MCOs operating in New York State. Six of the 40 MCOs accounted for 67 percent of the total value of kick payments. We judgmentally selected 75 of the most current claims for review from each of the six MCOs, for a total of 450 claims. To help assess the appropriateness of the newborn services payments, we mailed the 450 kick payment claims to the MCOs and the related FFS claims to the hospitals to determine if the MCOs paid these hospitals for the newborn services.

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 we 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 effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Internal Control and Compliance Summary

Our evaluation of the internal control structure at the Department identified internal control weaknesses over the kick payment process. As a result of these deficiencies, there is increased risk that Medicaid is making inappropriate multiple payments for certain newborn recipients enrolled in MCOs. These matters are detailed in the Result of Audit section of this report.

D. Results of Audit

Department procedures require hospitals to determine whether Medicaid recipients who receive newborn services are enrolled in MCOs before billing Medicaid on a FFS basis for the newborn services costs. The Contract requires MCOs to pay hospitals' bills for newborn services before obtaining reimbursement in the form of Medicaid kick payments. However, this did not occur. Using computer assisted audit techniques to analyze Medicaid payments for newborn services for the six-year period ended December 31, 2002, we found that Medicaid paid about \$27.3 million in FFS payments to hospitals and \$22.1 million in kick payments to MCOs for the same newborn services. In addition, based on our testing of 450 claims for kick payments, we found that MCOs obtained kick payments from Medicaid before paying the hospitals, despite contract requirements to the contrary. In fact, we found that MCOs have kept these payments for long periods - up to five years in some instances. The result of these MCO and hospital practices, and the

Department's lax oversight of kick payment processing, is that Medicaid paid twice for the same services.

1. Hospital Billing Practices

Department billing procedures require hospitals to consult EMEVS to determine whether an eligible Medicaid recipient who has received newborn services is enrolled in an MCO before billing the costs of those services. If the mother is enrolled in an MCO, the newborn generally becomes a member of the same MCO unless it requires special care. The hospital is supposed to bill the MCO using the newborn's recipient identification number, as listed on EMEVS, and receive payment from the MCO.

In practice, though, hospitals may not always conform to Department billing procedures for billing newborn services provided to MCO enrollees, and EMEVS may not always contain the data hospitals need to bill for these services. In some instances, the newborn may not be an MCO enrollee, even if the mother is an MCO enrollee, because the infant requires special care services that the hospital will bill to Medicaid on a FFS basis. In many cases, however, a newborn who should be enrolled in his or her mother's MCO is not listed as such on EMEVS because the Department has not timely updated EMEVS with information about the infant's (or mother's) MCO enrollment. The hospitals need this information to bill the MCOs for the costs of services provided. When hospitals do not have this information, they routinely bill Medicaid on a FFS basis for services provided to MCO-enrolled recipients instead of billing MCOs for these costs. In two prior audit reports (Report 96-S-53, issued February 13, 1998 and Report 2001-S-44, issued February 7, 2003), we alerted Department officials to control weaknesses that allowed delays in enrolling recipients into MCOs and recommended that the Department correct these weaknesses. However, the Department did not correct the weaknesses we identified. In this audit, we identified about \$27.3 million in hospital FFS claims paid by Medicaid for newborn services that should have been paid by MCOs. In addition, as discussed in the following section of this report, MCOs received about \$22.1 million in kick payments for these same newborn services. These overpayments occurred in part because the Department has not implemented our prior audit recommendations.

2. MCO Kick Payments

The Contract requires that MCOs pay hospitals' claims for newborn services they provide to MCO-enrolled Medicaid recipients before seeking reimbursement from Medicaid in the form of kick payments. However, we found that some MCOs submitted about \$22.1 million in kick payment claims to Medicaid before they paid hospitals for newborn services costs. Furthermore, the MCOs kept some of the kick payments they received from Medicaid, without paying hospitals, for periods up to five years. MCOs were able to engage in these improper billing practices because the Department does not adequately monitor MCO payments to hospitals.

We reviewed 450 kick payment claims submitted by 6 of the 40 MCOs operating in the State that had the largest dollar amount of kick claims paid during our audit period. This review showed that these six MCOs submitted approximately 90 percent of their kick payment claims before they paid the hospitals for the newborn services. By submitting kick payment claims before paying

hospitals, MCOs are reimbursed without having to first pay the expense, and also get paid for some newborn services that should be paid on a FFS basis (e.g., special care newborn services).

Further, we found that MCOs delayed paying hospitals' bills for as long as five years, or did not pay them at all. For example, one MCO did not pay hospital bills for newborn services for 50 of the 75 kick claims that we reviewed. We were informed by this MCO that the legal counsel representing the Prepaid Health Services Plan (PHSP), a coalition of Medicaid MCOs, stated that the Contract does not mandate that the MCOs pay the hospital claim prior to submitting a kick claim; it merely requires that the MCO produce evidence of payment to the hospital (whether made before or after submission of the claim) upon audit. Officials at several MCOs that are members of PHSP also told us that PHSP counsel's legal interpretation of the Contract allows them to bill kick claims prior to paying the hospitals. However, we believe an MCO that obtains a kick payment reimbursement without first paying the hospital's bill is not complying with the Contract. According to a Department official, the Contract clearly states that the MCO gets paid a kick payment claim when the MCO has paid the hospital for the newborn hospital stay.

We also determined that 9 of the 40 MCOs operating in New York State are owned by their member hospitals. Of the six MCOs whose claims we reviewed, four were owned by member hospitals. In these instances, Medicaid paid both the MCOs and their owner hospitals for the same services. Medicaid paid one hospital-owned MCO more than \$7 million in kick payment claims for newborn services. Medicaid paid for the same services again when it paid more than \$6 million in FFS payments to this MCO's owner hospitals. Given the relationship between these MCOs and their owner hospitals, we believe the existence of these multiple payments raises additional concerns about the propriety of these institutions' billing practices.

Recommendations

- 1. Investigate the \$27.3 million in Medicaid payments to hospitals and recover all inappropriate overpayments. Ensure that MCOs pay these hospitals in a timely fashion for bills submitted for the newborn services addressed in this audit.*
- 2. Evaluate the \$22.1 million in Medicaid kick payments to MCOs and recover any inappropriate kick payments.*
- 3. Instruct hospitals to follow existing procedures and bill the MCOs for medical services provided to newborns enrolled in managed care plans.*
- 4. Timely update EMEVS data to enable hospitals to access current MCO enrollment information when they bill for newborn services costs.*
- 5. Revise kick claim billing instructions to clarify that MCOs must pay the hospital prior to submitting a kick claim. Include this requirement in the next Contract with the MCOs.*

6. *Perform routine reviews of MCOs to help ensure that kick claims are processed appropriately.*
7. *Assess the propriety of multiple payments for newborn services to MCOs and hospitals, especially in those instances where the MCOs are owned by their member hospitals. Make any appropriate referrals to the New York State Attorney General's Office.*

We provided draft copies of this report to Department officials for their review and comment. Their comments have been considered in preparing this report. Department officials generally agreed with the report's recommendations and identified actions planned or taken to implement them. Department officials stated they have no evidence of impropriety with respect to multiple payments for newborn services to MCOs and hospitals, including those instances where the MCOs are owned by their member hospitals, and stated that the steps they plan to take with respect to Recommendations 1 through 6 will remedy the issue of dual payments by MCOs and hospitals, regardless of affiliation. A complete copy of the Department's response is included as Appendix A.

Within 90 days after the 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.

Major contributors to the report include Ken Shulman, Bill Clynes, Don Paupini, Sally Wojeski, Paul Alois, Julie DeRubertis, Blanche Vellano, Karla Funk and Nancy Varley.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Deirdre A. Taylor



STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Dennis P. Whalen
Executive Deputy Commissioner

August 6, 2003

Kevin M. McClune
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Re: Draft Audit 2002-S-25

Dear Mr. McClune:

Attached are comments in response to your draft audit report 2002-S-25 entitled "Multiple Medicaid Payments for Newborn Services."

Thank you for the opportunity to comment at this stage in the audit process.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Department of Health's
Comments on the
Office of the State Comptroller's
Draft Audit Report
2002-S-25 Entitled
"Multiple Medicaid Payments for Newborn Services"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) draft audit report (2002-S-25) entitled "Multiple Medicaid Payments for Newborn Services."

Recommendation #1:

Investigate the \$27.3 million in Medicaid payments to hospitals and recover all inappropriate overpayments. Ensure that MCOs pay these hospitals in a timely fashion for bills submitted for the newborn services addressed in this audit.

Response #1:

The Department will recover newborn payments billed by hospitals where appropriate. Managed Care Organization (MCO) representatives have agreed that MCOs will pay hospital claims submitted by hospitals relating to this audit if not previously paid by the plan.

Recommendation #2:

Evaluate the \$22.1 million in Medicaid kick payments to MCOs and recover any inappropriate kick payments.

Response #2:

Based upon a determination that the hospital fee for service (FFS) payment may have been appropriate (i.e. newborn weighed less than 1200 grams) kick payments made to MCOs for such cases will be reviewed by the Office of Medicaid Management (OMM) in consultation with the Office of Managed Care (OMC), and recoveries pursued as appropriate.

Recommendation #3:

Instruct hospitals to follow existing procedures and bill the MCOs for medical services provided to newborns enrolled in managed care plans.

Response #3:

Hospitals have previously received specific instructions regarding newborns of enrolled moms. The Department agrees such instructions can be re-emphasized.

Recommendation #4:

Timely update EMEVS data to enable hospitals to access current MCO enrollment information when they bill for newborn services costs.

Response #4:

EMEVS is updated daily with eligibility information provided by local districts.

Recommendation #5:

Revise kick claim billing instructions to clarify that MCOs must pay the hospital prior to submitting a kick claim. Include this requirement in the next Contract with the MCOs.

Response #5:

A letter has been sent to plans clarifying that plans must pay the hospital claim prior to billing MMIS for kicks, and a draft contract amendment has been prepared with this clarification.

Recommendation #6:

Perform routine reviews of MCOs to help ensure that kick claims are processed appropriately.

Response #6:

This item will be added to routine on-site reviews of plans.

Recommendation #7:

Assess the propriety of multiple payments for newborn services to MCOs and hospitals, especially in those instances where the MCOs are owned by their member hospitals. Make any appropriate referrals to the New York State Attorney General's Office.

Response #7:

The Department has no evidence of impropriety and believes that the above steps to recommendations 1 through 6 will remedy the issue of dual payments by plans/hospitals, regardless of affiliation.