ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

September 14, 2005

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

Re: Controls Over Supplemental Maternity Payments
Report 2004-S-67

Dear Dr. Novello:

According 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 applicable controls at the Department of Health (Department) for ensuring Medicaid appropriately paid supplemental maternity payments on behalf of eligible women enrolled in managed care. Our audit covered the period October 1, 2001 through December 31, 2004.

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 Department's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and pay providers for medical services they render to eligible Medicaid recipients. In New York, the Federal, State and local governments jointly fund the Medicaid program.

The Department administers two plan based programs: Family Health Plus and Medicaid Managed Care. Under these programs, eligible recipients are enrolled in a participating managed care organization (Plan). The plan ensures the recipient has access to covered health services on an as-needed basis and pays all providers. In return, the plan receives a flat monthly premium, based on the recipient's county of residence, regardless of actual usage during the month.

For the most part, the monthly premium is expected to pay for the costs of providing covered health services. However, plans may submit additional claims for supplemental payments. These

additional payments are intended to cover the costs of enhanced services. One such supplemental payment is the supplemental maternity capitation payment (maternity payment), which is a one-time payment intended to cover the costs of pre-natal care, delivery, and post-partum care for a woman enrolled in either Family Health Plus or Medicaid Managed Care at the time of delivery.

The Department has developed a model contract, which lays out the terms and conditions for plans that participate in the Medicaid program. Family Health Plus and Medicaid Managed Care have their own model contract, but the terms and conditions for the maternity payments are identical for both programs. In both programs, plans are responsible for paying the costs of all birth related health services provided to the mother. The plan receives the maternity payment only if the pregnancy results in either a live or still birth; pregnancies that end in termination or miscarriage are considered to be covered by the regular monthly premium.

The maternity payment is due only to the plan of record at the time of delivery; it is not prorated if a pregnant woman switches plans prior to the delivery. Once the plan has paid the provider (usually a hospital) for the delivery, the plan may submit a maternity payment claim to the Department. Evidence of payment and of the services provided does not have to be submitted with the claim, but supporting documentation must be retained by the plan and are subject to audit by Department staff. The Department may recover any unsupported maternity payments.

Both Family Health Plus and Medicaid Managed Care pay the same amount for a maternity payment. Like the monthly premium, the payment is based on the recipient's county of residence. However, each program has a separate rate code, which the plan notes on its claim. The plan submits the claim for a maternity payment directly to MMIS for processing. Unless an edit check prevents payment, the claim is approved and paid without review by Department staff. Originally, the costs of both Family Health Plus and Medicaid Managed Care were allocated the same: 50 percent was paid by the Federal government, 25 percent by the State, and the remaining 25 percent by the recipient's county of residence. However, in January 2005, the State began assuming responsibility for the local share of Family Health Plus, an arrangement that will be completed over a two year period, when the costs will be allocated evenly between the Federal and State government.

For plans participating in Family Health Plus, the maternity payment has been available since October 1, 2001, when the program began. For plans participating in Medicaid Managed Care, the maternity payment has been available only since April 1, 2003. The following table shows the number and amount of maternity payments made from October 1, 2001 through December 31, 2004 under both Family Health Plus and Medicaid Managed Care.

Period Covered	Family Health Plus		Medicaid Managed Care	
	Number of Maternity Payments	*Amount Paid*	*Number of Maternity Payments*	*Amount Paid*
10/01/01 to 03/31/02	0	$0	N/A	N/A
04/01/02 to 03/31/03	132	639,303	N/A	N/A
04/01/03 to 03/31/04	2,694	12,051,871	41,571	$183,773,965
04/01/04 to 12/31/04	3,352	15,272,064	52,415	241,063,847
Total	6,178	$27,963,238	93,986	$424,837,812

B. Audit Scope, Objective and Methodology

We audited the Department's oversight policies and procedures relating to the payment of supplemental maternity capitation payments for the period October 1, 2001 through December 31, 2004. The objective of this performance audit was to determine whether Department management established adequate controls to assure Medicaid appropriately paid supplemental maternity payments on behalf of eligible women enrolled in managed care. To accomplish our objective, we interviewed Department officials, reviewed applicable sections of State laws and regulations, and examined the terms of the model contracts for both Family Health Plus and Medicaid Managed Care plans. Using computer-assisted audit techniques, we analyzed payment information for maternity payments as well as encounter data for the recipients on whose behalf these payments were made. We also reviewed the logic of edit checks within MMIS and their status.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess the Department operations within our audit scope. Further, these standards require that we understand the Department's internal control structure and its 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 our audit provides a reasonable basis for our findings, conclusions and recommendations.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

Department management does not consider maternity payments to be a significant portion of either program. Department staff rely on the plans to submit valid, supported claims that are properly coded for the program in which the recipient is enrolled and depend on edit checks in MMIS to prevent inappropriate payments. However, they do not perform regular analyses of maternity payments to determine whether inappropriate payments have been made. As a result, plans have received duplicate maternity payments and maternity payments have been made on behalf of recipients who are male or otherwise ineligible. We also identified valid maternity payments that were incorrectly coded to the wrong program, either Family Health Plus or Medicaid Managed Care. Correct coding is important since the State is assuming the local share of Family Health Plus costs. Consequently, any miscoded payments will result in the State making payments that the counties are actually responsible for (or vice versa).

1. Duplicate Payments

Department policy restricts plans to one maternity payment for a recipient within a six-month period. To ensure this restriction is imposed, MMIS has an edit check that compares the date of service of a maternity payment claim with the date of service of any other maternity payments made on behalf of the same recipient. However, as part of our audit of Family Health Plus (2004-S-17), we found duplicate maternity payments totaling $292,507.

When we investigated the edit check in MMIS, we found it was only looking for maternity payments with duplicate dates of service or a date of services that was later than the date on the new claim. The edit did not look for dates of service that were prior to the date on the new claim, creating the situation for inappropriate maternity payments. For example, if the date of service on the original maternity payment was the date of delivery, while the second claim listed the date of discharge as the date of service, the latter claim would also be paid despite being within six months of the original claim.

We brought this issue to the attention of Department management in March 2004, as part of our audit of the Family Health Plus program (2004-S-17). Since that time, Department staff have been working with the providers to recover the duplicate maternity payments paid under both programs. As of December 21, 2004, just 21 duplicate maternity payments remained, for a total of $96,345 to be recovered - $19,367 paid on behalf of Family Health Plus recipients and $76,978 paid on behalf of Medicaid Managed Care recipients. However, this group of 21 included two duplicate maternity payments paid in November 2004 and one paid in December 2004, indicating that duplicate claims are still being approved for payment.

2. Payments on Behalf of Male Recipients

The maternity payment is intended to cover the costs of providing medical services for a pregnant woman. MMIS has an edit check intended to prevent such payments from being made on behalf of male recipients. However, we found that the recipients of 309 maternity payments made through October 31, 2004 were coded as a male - 10 by Family Health Plus and 299 by Medicaid Managed Care.

We reviewed the names of the recipients on whose behalf these 309 claims were paid. We determined that nine recipients were females who were miscoded as males. Of the remaining 300 claims, we determined that 183 were male recipients and we could not conclusively determine the gender for the remaining 117 recipients. Of these 300 claims, 256 were submitted by a single plan. Further review of the payments to that plan revealed the male recipients were newborns. The plan submitted claims for a maternity payment instead of the supplemental newborn capitation payment, which is a smaller amount. As a result, this plan was overpaid, receiving $591,278 more than it should have for the first half of 2004 alone.

When we investigated the edit check in MMIS that should have prevented such inappropriate payments, we found that it had not been turned on. In responding to this matter, Department officials indicated this edit was never completed due to systems issues they encountered during development. In addition, we did not find an edit check of the recipient's date of birth versus the claim's date of service, which would have prevented maternity payments from being made on behalf of newborns.

3. Payments on Behalf of Ineligible Recipients

The Family Health Plus program has always included the maternity payment as a supplemental payment offered to providers. The Medicaid Managed Care program only started offering the maternity payment for deliveries on or after April 1, 2003. However, we found 219 maternity payments, totaling $1 million, made on behalf of Medicaid Managed Care recipients who delivered prior to April 1, 2003 that were inappropriately charged against the Family Health Plus program. These are invalid claims - not valid claims charged to the wrong program.

Of the 219 invalid maternity payments, 158 were submitted by a single plan. We visited this plan in July 2004, to ascertain from plan management the origin of these invalid payments. Plan management provided us with an explanation for these payments and told us they expected to void out the claims by the end of August 2004. However, as of December 21, 2004, these claims had not yet been voided out.

The edit checks in MMIS verify the recipient was enrolled in the plan at the time of the service and that the plan was participating in the program before a claim for payment was authorized although there is no verification that the recipient was enrolled in the program. Thus, if a plan participating in both programs submits a claim on behalf of a Medicaid Managed Care recipient, but uses the Family Health Plus code erroneously, the claim would be paid.

The Department allows providers - including plans - up to two years from the date of service to submit a claim for payment. Since Medicaid Managed Care began offering the maternity payment on April 1, 2003, any claims submitted after March 31, 2005 that were more than two years from the date of service would automatically be denied by the system. Therefore, there is no need to add an edit check to MMIS.

4. Miscoded Payments

Although both Family Health Plus and Medicaid Managed Care pay the same amount for maternity payments, the Department uses a different code for tracking each program's costs. The plans are expected to use the appropriate code, based on the enrollment status of the recipient. We found maternity payments were made on behalf of Family Health Plus recipients that were coded to Medicaid Managed Care and others coded for Medicaid Managed Care that should have been coded to Family Health Plus.

Department officials developed edit checks in MMIS to verify, before authorizing the claim for payment, that the recipient was enrolled in the plan at the time of the service and that the plan participates in the program. However, there is no verification of the recipient's program enrollment. Thus, even if a plan participating in both programs submits a claim for a Medicaid Managed Care recipient against the Family Health Plus code, it will be paid.

Of the maternity payments made through October 31, 2004, we found 922 were paid against the wrong code. As a result, Family Health Plus costs were overstated by $3 million while Medicaid Managed Care costs were overstated by $1.2 million. These payments are valid, but the miscoding results in a misstatement of program costs. In addition, with the State assuming the local share of Family Health Plus, any miscoded maternity payments made after January 1, 2005 would result in the State bearing costs for which the counties are responsible or the counties bearing costs that are the responsibility of the State.

Recommendations

1. *Develop procedures to prevent duplicate maternity payments. At a minimum, Department management should make certain:*

    - *system edits designed to prevent duplicate maternity payments actually accomplish this goal, and*
    - *system edits are turned on.*

    In addition, Department officials should continue to recover the duplicate maternity payments identified by this audit and their own internal review.

2. *Take action to prevent inappropriate maternity payments made on behalf of male recipients. At a minimum, Department management needs to:*

    - *make certain system edits designed to prevent maternity payments on behalf of male recipients are completed, functioning as intended and turned on,*
    - *work with local district officials to ensure recipient gender is coded properly in the system,*
    - *investigate the 309 maternity payments made on behalf of male recipients to determine if the recipient was miscoded as male, if the claim should have been submitted against the newborn supplemental capitation payment rate code, or if the claim is not valid, and*

- *recover the $591,278 in overpayments made for male newborns and any other inappropriate payments identified by Department management in its analysis of maternity payments made on behalf of male recipients.*

3. *Recover the $1 million in invalid maternity payments made against the Family Health Plus rate code.*

4. *Department management needs to take action to minimize the potential for the miscoding of maternity payments by designing and implementing edit checks to prevent such errors which ultimately impact the funding responsibilities of the State and individual counties.*

We provided draft copies of the matters contained in this report to Department officials for their review and comment. We considered the Department's comments in preparing this report and have included the comments as Appendix A. Department officials generally agree with the recommendations made in this report and indicated the steps they have taken or will take to implement them.

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 the leader 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 were Ken Shulman, Ed Durocher, Jennifer Paperman, Holly Winters, Jennifer Van Tassel and Marticia Madory.

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.

Yours truly,

David R. Hancox
Director
State Audit Bureau

cc: Robert Barnes, Division of the Budget

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

July 8, 2005

David R. Hancox
Audit Director
Office of the State Comptroller
110 State Street
Albany, NY 12236

Dear Mr. Hancox:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2004-S-67) entitled "Controls Over Supplemental Maternity Payments."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure
cc: Mr. Griffin
Mr. Howe
Ms. Kuhmerker
Ms. Kutel
Mr. Reed
Mr. Seward
Ms. Shure
Mr. Van Slyke
Mr. Wing

Appendix A

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2004-S-67 Entitled
"Controls Over Supplemental Maternity Payments."

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2004-S-67) entitled "Controls Over Supplemental Maternity Payments."

Recommendation #1:
Develop procedures to prevent duplicate maternity payments. At a minimum, Department management should make certain:

- system edits designed to prevent duplicate maternity payments actually accomplish this goal, and
- system edits are turned on.

In addition, Department officials should continue to recover the duplicate maternity payments identified by this audit and their own internal review.

Response #1:
System edits related to maternity payments have been reviewed by the Office of Managed Care (OMC) and the Office of Medicaid Management (OMM). Edit updates have been identified and implemented in the eMedNY system. The Department is continuing to follow-up and recover the duplicate maternity payments identified by the OSC audit as well as its own internal review.

Recommendation #2:
Take action to prevent inappropriate maternity payments made on behalf of male recipients. At a minimum, Department management needs to:

- make certain system edits designed to prevent maternity payments on behalf of male recipients are completed, functioning as intended and turned on,
- work with local district officials to ensure recipient gender is coded properly in the system,
- investigate the 309 maternity payments made on behalf of male recipients to determine if the recipient was miscoded as male, if the claim should have been submitted against the newborn supplemental capitation payment rate code, or if the claim is not valid, and
- recover the $591,278 in overpayments made for male newborns and any other inappropriate payments identified by Department management in its analysis of maternity payments made on behalf of male recipients.

Response #2:
The Department has the following response:

- GIS 05 MA/010 "Correct Coding of Medical Applicant/Recipients' Gender" was issued to Local Departments of Social Service on February 23, 2005 (attached).
- The Department's audit staff is currently investigating the inappropriately coded male recipients and other maternity payment issues. Recoveries will be made where appropriate.
- The Department is requesting the claims that were identified in this report relating to this recommendation be shared with OMM for review, and recovery will be made where appropriate.

Recommendation #3:
Recover the $1 million in invalid maternity payments made against the Family Health Plus rate code.

Response #3:
The Department is requesting the claims identified as inappropriate in this report relating to this recommendation be shared with OMM for review. Recovery will be made where appropriate.

Recommendation #4:
Department management needs to take action to minimize the potential for the miscoding of maternity payments by designing and implementing edit checks to prevent such errors, which ultimately impact the funding responsibilities of the State and individual counties.

Response #4:
GIS 05 MA/010 "Correct Coding of Medical Applicant/Recipients' Gender" was issued to Local Departments of Social Service on February 23, 2005 (attached) and, as previously stated, appropriate edits have been implemented.

WGIUPD

GENERAL INFORMATION SYSTEM
DIVISION: Office of Medicaid Management

2/22/05
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GIS 05 MA/010

TO: Local District Commissioners, Medicaid Directors

FROM: Betty Rice
Director, Division of Consumer and Local District Relations

SUBJECT: Correct Coding of Medicaid Applicant/Recipients' Gender

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison
Upstate (518) 474-8216 NYC (212) 268-6855

This GIS message reminds local districts of the importance of correctly coding a Me dicaid applicant/recipient s (A/R s) gender in the Welfare Management System (WMS).

Failure to enter the correct gender code can result in the assignment of a duplicate client identification number and incorrect payment/non-payment to Medicaid providers for gender related care, services and supplies.