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

DEPARTMENT OF HEALTH AND OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

ACCURACY OF MANAGED CARE CLAIMS PROCESSING

REPORT 96-S-53

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 96-S-53

Barbara A. DeBuono, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Mr. Brian Wing
Commissioner
Office of Temporary and Disability Assistance
40 North Pearl Street
Albany, NY 12243

Dear Dr. DeBuono and Mr. Wing:

The following is our report on Medicaid payments for monthly premium claims for managed care providers.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this report are listed in Appendix A.

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

February 13, 1998

Executive Summary

Department Of Health And Office of Temporary And Disability Assistance
Accuracy Of Managed Care Claims Processing

Scope of Audit

The New York State Department of Health (Health) administers the State's Medical Assistance Plan (Medicaid). Providers are reimbursed through the Medicaid Management Information System (MMIS), which is a computerized payment and information reporting system. Eligibility for Medicaid is determined by local social services district offices (local districts) located throughout the State. During our audit period, the Department of Social Services (Social Services) coordinated the activities of the State's 58 local districts. These activities include enrolling Medicaid recipients into managed care programs. In addition, Social Services developed the Welfare Management System (WMS) to serve as a central registry containing information about all New York State beneficiaries of the various social welfare programs available in the State. As of August 20, 1997, the Office of Temporary and Disability Assistance (OTDA) assumed responsibility for coordinating local districts' activities and for managing WMS.

In managed care programs, the medical services needed by program participants are arranged for by a single service provider. Because such providers generally receive a flat fee for each program participant, rather than a fee for each service provided, they have an incentive to control costs. During the period covered by our audit, enrollment into the State's Medicaid Managed Care program was on a voluntary basis. However, effective July 15, 1997, the Federal government approved a Medicaid waiver to allow the State to enroll about 2.4 million of New York's Medicaid recipients in managed care. For the two year period ended September 30, 1996, Medicaid paid premiums of about $1.9 billion to managed care providers in New York State.

Our audit addressed the following question regarding the payment of monthly Medicaid claims from managed care providers for the period October 1, 1994 through June 6, 1997:

- Were Medicaid payments for managed care monthly premium claims appropriate?

Audit Observations and Conclusions

We found that Health, which administers MMIS, and OTDA, which now manages the WMS, need to take additional steps to ensure the accurate payment of managed care claims. We determined that Medicaid may have overpaid managed care providers by as much as $7.4 million for the two year period ended September 30, 1996.

MMIS has computer controls that check providers' claims against managed care enrollment information maintained by WMS. These controls are intended to ensure that managed care providers are paid only for recipients enrolled in their plan, and that the claimed service dates are consistent with the date of a recipient's enrollment in the Medicaid Managed Care program. If WMS is not updated timely with managed care enrollment and disenrollment information, MMIS may incorrectly pay managed care providers. (See p. 4)

Under certain circumstances, Medicaid recipients enrolled in a managed care plan can lose their eligibility to participate in the Medicaid Managed Care program. Health's managed care policy allows local districts to retroactively disenroll Medicaid recipients from a managed care plan. Retroactive disenrollments occur when there is a delay of a month or more in updating WMS. When a payment has been made for the time period subsequent to the disenrollment, the managed care plan must return that payment. However, we found adequate controls were not in place to ensure such overpayments were identified and recovered. (See pp. 4-5)

Using computer-assisted audit techniques, we compared all paid managed care claims with managed care enrollment records available on WMS, for the two years ended September 30, 1996. We determined that MMIS may have potentially overpaid 46,025 managed care claims by as much as $7.4 million. These potential overpayments occurred because WMS was not accurately and timely updated. We found that there are generally two reasons why WMS does not reflect accurate managed care enrollment data: (1) delays in updating WMS with disenrollments of Medicaid recipients who became institutionalized or deceased; and, (2) data entry errors. (See p. 5)

We recommend that officials investigate the potential overpayments we identified and seek recoveries where appropriate. We also recommend that officials develop procedures to periodically identify and monitor monthly payments made subsequent to a Medicaid recipient's disenrollment from the Medicaid Managed Care program and recover any inappropriate payments. We made additional recommendations to further ensure the accuracy of managed care claims. (See p. 6)

Comment of Officials

Department of Health officials generally agreed with our recommendations.

Contents

Introduction

Background 1
Audit Scope, Objective and Methodology 2
Response of Health and OTDA Officials to Audit 3

Accuracy of the Monthly Managed Care Premium Payments 4

Appendix A Major Contributors to This Report

Appendix B Comment of Department of Health Officials

Appendix C Comments of Office of Temporary and Disability Assistance Officials

Introduction

Background

The New York State Department of Health (Health) administers the State's Medical Assistance Plan (Medicaid), which was established under Title XIX of the Federal Social Security Act to provide medical assistance to needy people. During most of our audit period, the Department of Social Services (Social Services) used the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and make payments to health care providers for services rendered to recipients.[1]

Two different methods are used to pay Medicaid providers: fee-for-services or capitation premiums. Under the fee-for-service method, providers are paid every time a recipient receives a Medicaid-eligible service. Under the capitation method, which is used by managed care providers, providers are paid monthly fees based on the number and types of Medicaid recipients enrolled in their managed care programs. In exchange for this monthly fee, the managed care providers are responsible for providing various medical services to the recipients when the services are needed. State legislation was passed in 1991 encouraging the development of managed care programs in New York's Medicaid program. Because managed care providers are paid capitation premiums rather than separate fees for each individual service, State policymakers expect that they can reduce the costliness of the Medicaid program.

Individuals apply for Medicaid in 58 local district offices throughout the State. District workers in these offices also enroll Medicaid recipients into the State's Medicaid Managed Care program. During the period covered by our audit, enrollment into the program was on a voluntary basis. However, effective July 15, 1997, the Federal government approved a Medicaid waiver to allow New York State to enroll about 2.4 million of New York's Medicaid recipients in managed care.

Health has overall responsibility for the Medicaid Managed Care program, such as setting policy and the monthly capitation premiums. During our audit period, Social Services coordinated the activities of the State's 58 local social services districts (local districts) relating to various aspects of program administration. These activities include determining an individual's Medicaid eligibility, contracting with managed care providers and enrolling the individual into a managed care plan. For the two years ended September 30,

[1] The Department Social Services administered MMIS through its fiscal agent, Computer Sciences Corporation, until October 1, 1996, when the Department of Health assumed this responsibility.

1996, Medicaid paid managed care providers in New York State $1.9 billion in monthly capitation premiums.

Audit Scope, Objective and Methodology

We audited relevant policies and procedures for paying Medicaid claims from managed care providers during the period October 1, 1994 through June 6, 1997. The objective of our performance audit was to determine whether Medicaid payments for managed care monthly premium claims were appropriate.

To accomplish our audit objective, we interviewed officials from Health and Social Services, reviewed relevant records at Health and Social Services, and reviewed applicable Medicaid payment policies and procedures. We also interviewed officials from selected local districts and tested certain records of managed care enrollment information maintained by these local districts. In addition, we developed computer programs to match MMIS claims with managed care enrollment information. These programs verified the claimed service dates with the date of the recipient's enrollment in the managed care program to ensure the appropriateness of the payments for the two years ended September 30, 1996.

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 agencies that are included in our audit scope. Further, these standards require that we understand the agencies' internal control structures 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 prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Health and OTDA Officials to Audit

Draft copies of this report were provided to Health and OTDA officials for their review and comment. Their comments have been considered in preparing this draft report, and are included as Appendix B and Appendix C, respectively.

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.

Accuracy of the Monthly Managed Care Premium Payments

Agency officials are responsible for establishing and maintaining a system of controls to ensure the accurate payment of capitation premiums to managed care providers.

Social Services implemented the Welfare Management System (WMS) to increase the efficiency of local districts' determination of eligibility for the various social welfare programs available in the State and to reduce unauthorized or excessive payments. The WMS is a central registry containing information about all New York State beneficiaries of the various social welfare programs. Local districts use the WMS to track Medicaid recipients' enrollment in the Medicaid Managed Care program.[2] Health and OTDA rely on the local districts to accurately update WMS with Medicaid eligibility and managed care enrollment information. As of September 30, 1996, about 646,000 Medicaid recipients were enrolled in managed care programs.

Managed care providers must submit monthly claims to MMIS for payment. MMIS has computer controls that check providers' claims against managed care enrollment information maintained by WMS. These controls are intended to ensure that managed care providers are paid only for recipients enrolled in their plan, and that the claimed service dates are consistent with the date of a recipient's enrollment in the managed care program. If WMS is not updated timely with managed care enrollment and disenrollment information, MMIS may incorrectly pay managed care providers. Our analysis found a significant number of untimely managed care transactions that resulted in managed care providers being potentially overpaid $7.4 million.

Under certain circumstances, Medicaid recipients enrolled in a managed care plan can lose their eligibility to participate in the program. For example, if a recipient enters a nursing home or becomes institutionalized, he or she is generally disenrolled from the program. Also, Medicaid recipients may leave one managed care plan to join another. Health's managed care policy allows

[2] On August 20, 1997, the Governor signed welfare reform legislation that abolished the Department of Social Services and created a new agency in its place: the Department of Family Assistance. The Department of Family Assistance is composed of two independent agencies: the Office of Temporary and Disability Assistance (OTDA) and the Office of Children and Family Services. OTDA assumed responsibility for coordinating local districts' activities and for managing WMS.

local districts to retroactively disenroll Medicaid recipients from a managed care plan. Retroactive disenrollments occur when there is a delay of a month or more in updating WMS. When a capitation payment has been made for the time period subsequent to the disenrollment, the managed care plan must return that payment. Social Services notified local districts and managed care providers that effective December 1, 1995, Social Services would monitor and enforce this policy. In addition, Social Services planned to implement a process that would automatically identify and report such instances to managed care providers' for resolution.

Health became responsible for administering the State's Medicaid Program on October 1, 1996, and since this transition, the policy and procedures for monitoring retroactive disenrollments have not been implemented. Several local districts officials we interviewed stated their belief that the State had already implemented an automated recoupment process to identify and recover inappropriate managed care payments. However, during our audit we found that there was no automated process in place for recovering inappropriate managed care payments.

Using computer-assisted audit techniques, we compared all paid managed care claims with managed care enrollment records available on WMS for the two year period ended September, 30 1996. We determined that MMIS may have potentially overpaid 46,025 managed care claims by as much as $7.4 million. These potential overpayments occurred because WMS was not accurately and timely updated. We found a significant number of untimely or "retroactive" disenrollments updated to WMS. We reviewed the timeliness of all disenrollment transactions entered on WMS during our audit period and determined that 155,687 out of 592,369 transactions (26 percent) were entered retroactively.

Ten local districts accounted for the highest amount of overpayments and represent 86 percent of the State's Medicaid Managed Care enrollment at the time of our audit. We randomly selected and analyzed 108 retroactive disenrollment transactions entered by these ten local districts on the WMS during our audit period and found that there are generally two reasons why WMS does not reflect accurate managed care enrollment data: (1) delays in updating WMS with disenrollments of Medicaid recipients who became institutionalized or deceased; and, (2) data entry errors. For example, we identified one managed care plan that received 13 monthly payments totaling $2,838 for a deceased recipient. According to the local district's records, the Medicaid recipient died on August 29, 1995; however, the local district did not update WMS with this information until October 8, 1996. In another case, upon being institutionalized, a recipient became ineligible for managed care on June 1, 1995; however, WMS was not updated with this information until April 9, 1996. This caused MMIS to make 11 incorrect payments totaling $889 to the managed care provider. We also identified cases where

some districts entered incorrect dates when updating the WMS. At one local district, several recipients had disenrolled from their managed care plans during 1996, but local district workers incorrectly updated WMS files with disenrollment dates of 1995.

Organizations with large-scale computer systems should have procedures in place to ensure information entered into these systems is reliable and valid before the data is converted into a machine-readable format. These procedures should include testing or editing data for valid limits or reasonableness. The WMS has many of these edits, but lacks edits to check the reasonability of a recipient's disenrollment date.

Without compliance with managed care policy, as well as timely and accurate updates to WMS, Medicaid will continue to make overpayments to providers. Therefore, responsible officials need to take appropriate action to ensure the accuracy of managed care payments.

Recommendations

1. Investigate the $7.4 million in potential overpayments identified in this report, and as warranted, take steps to recover overpayments.

2. Develop procedures to periodically identify and monitor monthly capitation payments made subsequent to a recipient's disenrollment and recover any inappropriate payments.

3. Develop on-line edits that test the reasonableness of managed care disenrollment dates entered on WMS, and that prompt the local district worker to verify the information is correct in cases where the data appears to be inconsistent.

4. Instruct local districts on the importance of timely updates to WMS and monitor districts' compliance.

Major Contributors to This Report

Jerry Barber
Frank Houston
Kevin McClune
Lee Eggleston
Donald Paupini
Warren Fitzgerald
Sharon Whitmore
Ottavio Nicotina
Paul Bachman