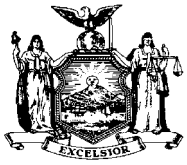
H. CARL MCCALL
STATE COMPTROLLER



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ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 8, 1999

Mr. Dennis Whalen
Executive Deputy Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 99-F-3

Dear Mr. Whalen:

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 officials of the Department of Health (Health or Department) as of April 5, 1999, to implement the recommendations contained in our audit report, *Accuracy of Managed Care Claims Processing* (96-S-53). Our report, which was issued on February 13, 1998, assessed whether Medicaid payments for managed care monthly premium claims were appropriate.

Background

Medicaid is a Federally aided, State-operated and administered program that provides medical benefits for certain low-income persons in need of health and medical care. The program is authorized by Title XIX of the Social Security Act. Subject to broad Federal guidelines, each state determines how the Medicaid program will be administered, including the benefits covered, the rules for eligibility, and the rates of payment to providers. Health administers the Medicaid program in New York State. Health contracts with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and make payments to providers. The fiscal agent processes claims and pays providers for services rendered to eligible Medicaid recipients through the Medicaid Management Information System (MMIS), a computerized payment and information reporting system.

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. In managed care programs, the medical services needed by program participants are

arranged for by a single service provider. Providers are paid monthly fees (capitation premiums) for each Medicaid recipient enrolled in their managed care programs. In exchange for this monthly fee, the managed care provider is responsible for providing various medical services to the recipients when services are needed. Health's Office of Managed Care administers the Medicaid Managed Care program.

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 the Welfare Management System (WMS), which is a central registry containing information about all New York State beneficiaries of the various social welfare programs. Local districts update and use the WMS to track Medicaid recipients' enrollment in the Medicaid Managed Care program. Health relies on local districts to accurately update WMS with Medicaid eligibility and managed care enrollment information. At the end of our audit period, September 30, 1996, about 646,000 Medicaid recipients were enrolled in managed care programs. As of February 29, 1999, about 626,000 recipients were enrolled in managed care programs.

Summary Conclusions

In our prior audit, we found that Medicaid may have overpaid managed care providers by as much as $7.4 million for the two year period ended September 30, 1996. These potential overpayments occurred because WMS was not accurately and timely updated. Under certain circumstances, Medicaid recipients enrolled in a managed care plan can lose their eligibility to participate in the Medicaid Managed Care 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 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. However, if recipients' disenrollment information is not updated correctly or timely, payments may be made for recipients who are no longer in the managed care program. Our audit found that Health needed to take additional steps to ensure the accurate payment of managed care claims.

In our follow-up review, we found that Health officials have made progress in implementing the recommendations contained in our prior audit report. Health has taken actions to investigate and recover the potential overpayments we identified in the prior audit. In addition, Health has developed and implemented policies to identify and recover inappropriate monthly capitation payments made subsequent to Medicaid recipients' disenrollment.

Summary of Status of Prior Audit Recommendations

Of the four prior audit recommendations, Health officials have implemented three recommendations and partially implemented one recommendation.

Follow-up Observations

Recommendation 1

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

Status - Implemented

Agency Action - Health officials have initiated their investigation of the potential overpayments we identified in our prior audit. In September of 1998, Health began informing managed care providers of overpayments they may have received under the Medicaid program. Health officials sent letters to these providers explaining the Department's intention to recover overpayments and the process followed by Health to recover overpayments in accordance with the Department's regulations (18 NYCRR 518.3).

Recommendation 2

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

Status - Implemented

Agency Action - Health officials have developed procedures to periodically identify and recover monthly capitation payments made subsequent to a Medicaid recipient's disenrollment from the Medicaid Managed Care program. Initially, Health officials proposed to identify and capture such payments on a quarterly basis. However, depending on the results of their investigation and recovery efforts relating to the overpayments we identified during our prior audit, Health officials may propose a different timetable. In addition, Health officials amended their model contract with managed care providers to include the State's right to recover payments made to managed care providers for recipients who are determined to have been in an institution, or to have moved out of the managed care provider's service area, or to have been deceased.

Recommendation 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.

Status - Partially Implemented

Agency Action - Health officials have not yet developed on-line edits that test the reasonableness of managed care disenrollment dates entered by local district workers. Health has postponed development of these edits because of other competing projects and resource constraints. Health is currently in the process of selecting a contractor to design and implement the Replacement Medicaid System (RMS). The RMS will replace the existing MMIS and other Medicaid support systems. Until the new contractor is selected, Health will not be initiating extensive changes to existing systems. However, as an interim measure to check the appropriateness of local district workers' updating practices, Health officials are providing local districts with monthly computer reports which list all disenrollment transactions. This information will enable local districts to detect disenrollment dates that appear inconsistent with the date the transaction was updated.

Recommendation 4

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

Status - Implemented

Agency Action - Health officials have developed and implemented procedures to monitor and instruct local districts on the importance of timely updates to WMS. Subsequent to the completion of our audit, Health conducted training at each local district on WMS updating procedures and Department policies regarding retroactive transactions. In addition, Health has drafted a new procedures manual for local districts which, among other things, instructs local districts that retroactive disenrollments should be used only when absolutely necessary - such as when a Medicaid recipient is placed in a long term care facility. The manual further instructs districts that managed care organizations should be instructed to void their claims for the retroactive period.

Major contributors to this report were Lee Eggleston, Donald Paupini, Warren Fitzgerald, and Lisa Rooney.

We would appreciate your written response to this report in 30 days, indicating any actions planned or taken to address any unresolved matters discussed in this report. We also thank management and staff of the Office of Managed Care for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Mr. Charles Conaway