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OFFICE OF THE STATE COMPTROLLER

August 4, 1999

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

Re: Report 99-F-7

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 officials of the Department of Health (Health) as of July 6, 1999, to implement the recommendations contained in our audit report, *Fee-for-Service Claims Paid For Recipients Enrolled In Managed Care Plans* (Report 96-S-83). Our report, which was issued on June 15, 1998, assessed Health's payment of the fee-for-service claims for managed care recipients for the period October 1, 1994 through November 20, 1997. In addition to issues included in Report 96-S-83, we provided Health officials with a letter communicating matters of lesser significance.

Background

During most of our audit period (until October 1, 1996), the Department of Social Services (Social Services) administered the Medicaid Management Information System (MMIS). MMIS is a computerized payment and information reporting system, operated by a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and pay providers for medical services rendered to eligible Medicaid recipients. After October 1, 1996, Health assumed responsibility for MMIS. Effective on August 20, 1997, Social Services was abolished and the Office of Temporary and Disability Assistance (OTDA), a component of the newly created Department of Family Services, assumed responsibility for the coordination of local social service district activities.

The New York State Department of Health (Health) 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. Health has overall

responsibility for setting Medicaid payment policy and monthly premium payments to managed care plans, and OTDA is responsible for ensuring local districts update enrollment information to MMIS.

MMIS pays Medicaid providers by two methods: the fee-for-service method and the capitation method. In Medicaid managed care plans, the medical services needed by plan participants are arranged by a single service provider, who receives a flat monthly capitation fee for each program participant. MMIS pays fee-for-service claims for some enrolled recipients who require services not provided by the plan, or who choose to receive certain services outside the plan, as allowed by Federal law.

New York State's 58 local social services districts enroll Medicaid recipients in the State's Medicaid managed care plans. Health uses a computerized benefit file to help ensure the accuracy of all fee-for-service claims paid for recipients enrolled in managed care plans. The benefit file contains specific information detailing which services are provided by the managed care plan. MMIS uses this information to determine whether it is appropriate to pay a provider on a fee-for-service basis for a service rendered to an enrolled recipient. The proper payment of all claims is dependent on accurate managed care enrollment and benefit information.

Summary Conclusions

In our prior audit, we found that MMIS potentially overpaid managed care plans and fee-for-service providers a total of approximately $38.5 million during our October 1, 1994 through November 20, 1997 audit period. Of this total overpayment amount, we identified $12.3 million in fee-for-service claims that were paid on behalf of recipients covered by managed care plans as a result of delays in recording enrollment and disenrollment information on MMIS. The remaining $26.2 million related to family planning claims paid on a fee-for-service basis for recipients enrolled in managed care plans, which resulted because Health officials did not develop a policy to recover duplicate payments.

In addition to the matters discussed in Report 96-S-83, we provided Health officials with a letter relating to matters of lesser significance, in which we recommended that Health take further steps to improve controls over the payment of Medicaid claims for recipients enrolled in managed care plans.

In our follow-up review, we found that Health officials have made progress in implementing the recommendations contained in our prior audit report and in the letter on matters of lesser significance. Health officials have established policies which should prevent some of the potential Medicaid overpayments from occurring in the future. However, Health is in varying stages of recovering the Medicaid overpayments identified by our prior audit.

Summary of Status of Prior Audit Recommendations

Of the six prior audit recommendations, Health officials have implemented five recommendations; one recommendation was deleted from the report. Of the four recommendations contained in the letter on matters of lesser significance, Health officials have implemented two recommendations, have partially implemented one recommendation, and have not implemented one recommendation.

Follow-up Observations re: Report 96-S-83

Recommendation 1

Investigate and recoup inappropriate payments from managed care, inpatient or clinic providers.

Status - Implemented

Agency Action - Health officials have initiated their investigation of the potential Medicaid overpayments we identified in our prior audit. Our audit identified overpayments resulting from delays in recording enrollment and disenrollment information on the managed care enrollment files and benefit file. Health officials have requested repayment of Medicaid overpayments from managed care providers based on delays in disenrolling recipients.

Recommendation 2

Develop procedures for ensuring timely updates of benefit file information and local district's recipient enrollment information.

Status - Implemented

Agency Action - Health officials have developed and implemented procedures to monitor and instruct the local districts on the importance of timely updates of the enrollment information. Also, Health officials have established procedures to improve the timeliness of updates of the benefit file information. They are in the process of incorporating procedures for the update of benefit file information into a written manual.

Recommendation 3

Develop a policy to address all retroactive enrollments and disenrollments.

Status - Implemented

Agency Action - Health's policy is that retroactive disenrollments of recipients from a managed care plan should occur only in emergency situations. Health has also established a policy to allow for recovery of Medicaid payments made to managed care providers for retroactive disenrollments of recipients who have been in institutions, moved out of the provider's service area, or are deceased. Further, Health has established a policy to recover Medicaid payments made to managed care providers for the delivery costs of newborns where retroactive enrollments were a factor.

Recommendation 4

Deleted

Recommendation 5

Investigate and recoup inappropriate payments from managed care plans for the amounts Medicaid paid in fee-for-service claims for family planning services provided to enrolled recipients.

Status - Implemented

Agency Action - Health officials are in the process of recovering Medicaid payments for family planning claims paid to fee-for-service providers on behalf of recipients enrolled in managed care plans.

Recommendation 6

Develop detailed procedures relating to the family planning recovery process and incorporate these procedures into the contract language.

Status - Implemented

Agency Action - Health officials have modified the language of the contracts between the managed care providers and the local districts to clarify issues pertaining to the family planning charge-back process. The contract details the recovery process and explains that managed care providers will be responsible to reimburse Medicaid (based at the applicable Medicaid fee or rate), for all family planning charges paid by Medicaid on their behalf.

Follow-up Observations re: Letter on Matters of Lesser Significance

Recommendation 1

Develop formal policies and procedures to ensure that the benefit file is updated in a timely and accurate manner and supervisory review of the update process is documented.

Status - Partially Implemented

Agency Action - Health has develop internal policies to ensure the timely and accurate update of the benefit file. However, Health officials are still developing a procedure manual to formalize these policies and other practices regarding the benefit file.

Recommendation 2

Develop a standardized method for supporting exclusions from all managed care plans.

Status - Implemented

Agency Action - Health has established the contract between the managed care provider and the local districts as the standardized approach they will follow to support exclusions from all managed care plans.

Recommendation 3

Investigate and recoup all inappropriate payments, including claims paid before and after our audit.

Status - Implemented

Agency Action - Health officials have investigated the claims in question, and have determined that the potential inappropriate payments are not recoverable. Health officials reached this conclusion based on their policy of not recovering potential overpayments if the managed care provider is at financial risk for any of the payment period.

Recommendation 4

Investigate and determine why MMIS made managed care payments on behalf of recipients not enrolled in managed care. Recover all inappropriate payments.

Status - Not Implemented

Agency Action - Health officials stated their belief that, based on the lower dollar value of the claims in question and a lack of staffing resources, it would not be cost effective to investigate these claims.

Major contributors to this report were Lee Eggleston, Donald Paupini, Paul Alois 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 wish to thank management and staff for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Mr. Charles Conaway