



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Unnecessary Medicaid Payments for Children at Voluntary Agencies

Medicaid Program Department of Health



Executive Summary

Purpose

To determine if the Department of Health (Department) had adequate policies and procedures in place to ensure proper Medicaid payments for foster care children placed in voluntary agencies. The audit covered the period July 2005 through July 2011.

Background

New York State's Medicaid program provides health insurance to people who are economically disadvantaged and/or have special health needs. Many foster care children placed in private welfare agencies (known as voluntary agencies) are Medicaid eligible. For these children, the State establishes a "Daily Child Care Rate" (Daily Rate) which is the basis for Medicaid funding the Department provides to the voluntary agencies to pay for medical services provided to the Medicaid eligible children in their custody. For services not covered by the Daily Rate, providers bill Medicaid directly and are reimbursed on a fee-for-service basis. For the five years ended June 30, 2010, Medicaid paid about \$990 million on behalf of about 70,000 children placed in voluntary agencies - \$640 million of which was paid under the Daily Rate, and the remaining \$350 million was paid directly to providers on a fee-for-service basis.

Key Findings

- In many instances, payments to medical providers under the Daily Rate method far exceeded the reimbursements that the providers would be entitled to under the fee-for-service method. For example, a voluntary agency paid a laboratory \$77 for a routine cholesterol screening, while the same laboratory received only \$6 from Medicaid for the same test.
- Medicaid could save millions of dollars annually if the Daily Rate method limited voluntary agency provider reimbursements to the amounts that providers would be entitled to on a fee-for-service basis.
- On a fee-for-service basis, Medicaid paid about 1.1 million claims (totaling \$83.2 million) directly to health care providers for medical services that otherwise were covered by Medicaid's Daily Rate payments to the voluntary agencies.

Key Recommendations

- Formally assess the cost-effectiveness of the Daily Rate reimbursement method. Determine if this method should be modified or if a different reimbursement mechanism should be applied for health services for children at voluntary agencies.
- Ensure that eMedNY contains the necessary edits and file interfaces to prevent claims from being paid directly to providers when such claims are covered under the Daily Rate for voluntary agencies.

Other Related Audit/Report of Interest

[New York State Medicaid Program: Under Reporting of Net Available Monthly Income for Nursing Home Residents Causes Medicaid Overpayments \(2010-S-17\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

September 19, 2012

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls intended to safeguard assets.

Following is a report of our audit of the State Medicaid Program entitled *Unnecessary Medicaid Payments for Children at Voluntary Agencies*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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State Government Accountability Contact Information:

Audit Director: Brian Mason

Phone: (518) 474-3271

Email: StateGovernmentAccountability@osc.state.ny.us

Address:

Office of the State Comptroller
 Division of State Government Accountability
 110 State Street, 11th Floor
 Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

The Medicaid program provides health care coverage for economically disadvantaged individuals and families. Medicaid cost is shared by federal, state and local governments. The Department of Health (Department) administers the State's Medicaid program in conjunction with 58 local social services districts and other State agencies, including the Office of Children and Family Services (OCFS). Medicaid program enrollment in New York rose from 4.6 million individuals in 2007 to 5.2 million in 2010. The State's Medicaid program costs total about \$53 billion annually. The Department's eMedNY computer system processes nearly all claims and payments under the Medicaid program.

Foster care children can be placed in private welfare agencies commonly known as "voluntary agencies." There are about 90 voluntary agencies located throughout New York State, and many of the children placed in voluntary agencies are Medicaid eligible. For these children, the Department establishes a "Daily Child Care Rate" (Daily Rate) which is the basis for Medicaid funding that the Department provides to the voluntary agencies. The voluntary agencies use the Medicaid funding derived from the Daily Rate to pay for certain medical services the agencies arrange for on behalf of each Medicaid eligible child in their custody. For example, Daily Rate funding pays for physicians, psychiatrists, nurses, drugs, and other health care items. For medical services not covered under the Daily Rate, providers may use a fee-for-service method whereby they submit claims directly to Department's eMedNY system to obtain reimbursement. (Also, Medicaid eligible foster care children living in the community may be covered under a Medicaid managed care plan.)

The Department's eMedNY system should contain all necessary edits and processing capability to correctly process Medicaid payments. During the five years ended June 30, 2010, Medicaid paid approximately \$990 million for medical care on behalf of about 70,000 children placed in voluntary agencies, including \$640 million paid directly to voluntary agencies under the Daily Rate method and \$350 million paid directly to providers under the fee-for-service method.

Audit Findings and Recommendations

We conclude that in many instances Medicaid is paying significantly more by using the Daily Rate rather than a fee-for-service arrangement for medical care provided to children placed at voluntary agencies. Moreover, the Department could save millions of Medicaid dollars annually by assessing and modifying certain policies and practices that drive the costs of such medical care. In addition, from July 1, 2005 through June 30, 2010, Medicaid paid medical care providers \$83.2 million directly (on a fee-for-service basis) for services and drugs that should have been paid using the Daily Rate.

Program Policies and Related Cost Considerations

During our audit, we compared Medicaid program costs for drugs and services under the Daily Rate method with the same costs covered under the Medicaid fee-for-service provider reimbursement method. We concluded that payments to providers under the Daily Rate method in many instances far exceeded the reimbursements the providers would be entitled to under the fee-for-service direct provider billing method. In fact, millions of dollars of annual Medicaid costs could be saved if the Daily Rate method limited voluntary agency provider reimbursements to the amounts that providers would be entitled to under the fee-for-service method. The following table illustrates the substantial additional cost that sometimes resulted for certain services under the Daily Rate when compared with the costs for the same services billed directly by the providers to eMedNY under the fee-for-service method.

Claim Description	Amount Agency Paid	Medicaid Fee	Difference	Percent Above Medicaid Fee
Test for Antibiotic Effectiveness	\$313.75	\$6.59	\$307.16	4,661%
Culture – Bacteria or Other	113.00	8.15	104.85	1,287%
Cholesterol Test	77.00	6.04	70.96	1,175%
Thyroid Test	96.75	9.00	87.75	975%
Breast Ultrasound	300.00	67.53	232.47	344%
Oral Evaluation Problem Focus	55.00	14.00	41.00	293%
Office Consultation	73.33	20.00	53.33	267%
Dental Panoramic X-ray	85.00	40.00	45.00	113%
Office Visit – Complex	225.00	108.35	116.65	108%

As the table illustrates, voluntary agencies sometimes paid several times the normal Medicaid rates for services. For example, a voluntary agency paid a laboratory \$77 (the amount charged by the laboratory) for a routine cholesterol screening, while the same laboratory received only \$6 from Medicaid for the same test. Thus, the voluntary agency paid more than 12 times the standard Medicaid fee rate for the screening.

In addition, we found that voluntary agencies often paid significantly more than Medicaid normally paid for pharmaceuticals. For the five years ended June 30, 2010, voluntary agencies reported about \$46 million in pharmacy costs, which were included in the calculations of the agencies' Daily Rates. Based on our review, we believe the Department should consider certain steps to help minimize Medicaid's costs for these drugs.

For example, each voluntary agency has its own pricing agreements with pharmacy suppliers. Thus, some voluntary agencies paid significantly more for certain drugs than others. Moreover, the voluntary agencies often paid more for drugs (through the Daily Rate program) than the drugs would have cost if Medicaid paid pharmacies directly for them. One voluntary agency, for example, routinely paid 10 to 20 percent more for several common drugs than Medicaid would have paid directly to the pharmacy. For a drug to treat attention deficit hyperactivity disorder, this agency paid a pharmacy \$156 when Medicaid would have paid only \$132. Thus, the agency paid \$24 (18 percent) more than Medicaid for the prescription.

Further, the Federal government established a Medicaid Drug Rebate Program (Rebate Program) which requires drug manufacturers to reimburse the states significant portions of amounts Medicaid paid for the drugs. For the three years ended December 31, 2009, the Department recovered, through the Rebate Program, about 35 percent of the amounts Medicaid originally paid for drugs. Currently, however, the costs of drugs procured under the Daily Rate are not subject to the Rebate Program. If the costs for such drugs were included in the Rebate Program, Medicaid could have saved about \$16 million (\$46 million times 35 percent) during the five years we analyzed.

Also, we determined that Medicaid's costs for foster care children are significantly higher under the Daily Rate program than they are under managed care (wherein a monthly premium is paid to a managed care plan that arranges for a comprehensive package of medical services). Excluding New York City, the average monthly cost of medical services under the Daily Rate is about \$908 per child - compared to \$326 per month for a child in managed care. Thus, outside of the New York City, it costs \$582 (179 percent) more per month to provide health care through the Daily Rate than through managed care. (Note: We excluded New York City from our analysis because relatively few New York City children are enrolled in managed care. We also excluded children who were part of special programs, such as those for hard to place children, who normally have higher health care costs than typical foster care children.)

Department officials had not formally evaluated the cost-effectiveness of the Daily Rate program, and consequently, they lacked analysis of the cost of health services under that program compared with those for managed care plans and fee-for-services payments. Further, the Department had not provided voluntary agencies with formal guidance on how to obtain medical services and drugs economically. Consequently, there was (and continues to be) a high risk of unnecessary Medicaid costs for children placed in voluntary agencies. As a result of our audit, we conclude that the Department should formally assess (with OCFS as needed) the cost-effectiveness of the Daily Rate program and determine if less costly options should be used to provide health care to children placed in voluntary agencies.

In response to our findings, the Department has begun work with OCFS to modify the Daily Rate program. Since annual Medicaid expenditures for children in voluntary agencies approach \$200 million annually, Department officials should expedite such modifications to ensure that unnecessary costs are prevented.

Recommendations

1. Formally assess the cost-effectiveness of the Daily Rate reimbursement method. Determine if this method should be modified or if a different reimbursement mechanism should be applied for health services for children placed in voluntary agencies. This assessment should also include consideration of alternatives for paying the costs of pharmaceuticals for such children.
2. Provide voluntary agencies with formal guidance for the cost-effective acquisition of medical care for children in their custody.

Payments to Providers for Services Covered by the Daily Rates

For the five years ended June 30, 2010, Medicaid incorrectly paid 1.1 million claims (totaling \$83.2 million) submitted by providers, under the fee-for-service method, for drugs and medical services for children in voluntary agencies. These Medicaid payments (made directly to providers) were incorrect because the drugs and services associated with the claims were covered by the Daily Rate method - and, accordingly, the voluntary agencies should have paid the providers using their Medicaid Daily Rate funding. In these instances, the providers should not have sought and obtained reimbursement under the fee-for-service direct provider billing method.

In total, 714,941 provider claims were reimbursed \$56.7 million in fee-for-service payments for various medical procedures that were included in the Daily Rate method. For example, eMedNY directly paid a provider \$190 for the cost of a child's physical therapy when that medical service was already covered under the Daily Rate for the voluntary agency. In addition, 346,252 claims that were reimbursed \$26.5 million were to pay pharmacies for drugs when funding for the drugs were already included in the voluntary agencies' Daily Rates. For example, eMedNY directly paid a pharmacy \$435 for a 30-day supply of common behavioral control drug that was already covered under Daily Rate funding.

The incorrect payments that we identified resulted from the following factors:

- eMedNY lacks adequate computer edits to detect when a provider claim for medical or drug service to children under the care of a voluntary agency is already covered by the Daily Rate.
- eMedNY's Principal Provider File, which shows the identity and dates of placement for foster care children at voluntary agencies, is often not kept up to date and accurate by case workers in local social services districts. Unless this file is accurate, eMedNY will be unable to determine which provider claims are reimbursable under the Daily Rate method and, thus, should not be paid under the fee-for-service reimbursement method. When we followed up with three upstate local social services districts, we learned that districts

were not always aware of the need to update the Provider File or rarely used the file as check on proper Medicaid payments for children placed with voluntary agencies.

- While Department officials have been aware of the eMedNY limitations for several years, these issues remain unresolved.

In response to our observations, Department officials explained that the eMedNY problems could be very difficult to correct due to the complexity of the necessary computer logic and data file interfaces that need to be in place. However, Department officials acknowledged the need for corrective actions to prevent unnecessary and incorrect Medicaid payments in the future. Further, officials advised us that they will ensure that the Daily Rate program requirements are clearly stated and that providers and local social services districts are adequately informed of the Medicaid eligibility and reimbursement requirements for children in voluntary agencies. Officials also plan to strengthen oversight by making efforts to modify the eMedNY with edits that are intended to prevent the problems that we identified.

Recommendations

3. Formally remind voluntary agencies to inform health care providers to submit claims directly to the voluntary agencies for medical services and drugs which are covered by the Daily Rate.
4. Formally remind local social services districts to ensure that the Principal Provider File is maintained in a complete, accurate and timely manner for all children placed in voluntary agencies. Monitor the Principal Provider File to the extent practical and cost effective to help to ensure its reliability.
5. Ensure that eMedNY contains the necessary edits and file interfaces to prevent claims from being paid directly to providers when such claims are covered under the Daily Rate for voluntary agencies.

Audit Scope and Methodology

We conducted our audit to determine if the Medicaid program properly paid the medical costs for foster care children placed with voluntary agencies. Our audit period was July 1, 2005 through July 11, 2011.

To accomplish our objective, we interviewed personnel from the Department, OCFS, and 10 voluntary agencies selected judgmentally to represent a geographic cross section of the State (see Exhibit). We also reviewed Department guidelines, the OCFS Program Manual of Standards for Foster Care of Children as well as other documentation pertaining to Medicaid payments for children in voluntary agencies. In addition, we reviewed and analyzed eMedNY payment data for the period July 1, 2005 through June 30, 2010. We also requested and examined Medicaid program payments and related medical information pertaining to the 10 selected voluntary agencies.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. 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 (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed 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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments (which include comments from OCFS) in preparing this report, and we have included those comments in their entirety at the end of the report. In their response, Department officials generally agreed with our recommendations and indicated the actions they have taken and will take to address them. Also, our rejoinders to certain statements in the Department's response are included as State Comptroller's Comments.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the 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 why.

Contributors to This Report

Brian Mason, Audit Director
Ed Durocher, Audit Manager
Paul Alois, Audit Supervisor
Michele Turmel, Examiner-In-Charge
Connie Walker, Staff Examiner

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Elliot Pagliaccio, Deputy Comptroller
518-473-3596, epagliaccio@osc.state.ny.us

Jerry Barber, Assistant Comptroller
518-473-0334, jbarber@osc.state.ny.us

Vision

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Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Exhibit

List of Voluntary Agencies Contacted During Audit

<u>Agency Name</u>	<u>County</u>
Abbott House	Westchester
Astor Home for Children	Dutchess
Childrens Aid Society	New York
Childrens Village	Westchester
Good Shepherd Services	New York
Hillside Childrens Center	Monroe
Jewish Child Care Association (JCCA)	New York
Office of Children and Family Services	Albany
Parsons Child and Family Center	Albany
St. Christopher-Ottillie	Nassau

Agency Comments

Nirav R. Shah, M.D., M.P.H.
Commissioner

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

August 10, 2012

Mr. Brian E. Mason
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street - 11th Floor
Albany, NY 12236-0001

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments regarding Office of the State Comptroller Draft Audit Report 2010-S-47 on "Unnecessary Medicaid Payments for Children at Voluntary Agencies."

Thank you for the opportunity to comment.

Sincerely,



Michael J. Nazarko
Deputy Commissioner for Administration

Enclosure

cc: Sue Kelly
Robert W. LoCicero, Esq.
James C. Cox
Jason A. Helgersen
Diane Christensen
Stephen Abbott
Dennis Wendell
Stephen LaCasse
Ronald Farrell
Barry Benner
Irene Myron
John Brooks
Kevin Mahar, OCFS
Ralph Timber, OCFS

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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2010-S-47 on
"Unnecessary Medicaid Payments for
Children at Voluntary Agencies"**

The following are the Department of Health's (Department) comments in response to Office of the State Comptroller (OSC) Draft Audit Report 2010-S-47 on "Unnecessary Medicaid Payments for Children at Voluntary Agencies", including general comments followed by responses to the specific recommendations in the report.

General Comments:

The Department furnished the Office of Children and Family Services (OCFS) with a copy of OSC's draft audit report. OCFS' response to the Department commenting on the report is appended hereto.

The Department is committed to ensuring that programs it administers operate efficiently and effectively, and that Medicaid eligible children in foster care receive appropriate care to address their medical and psycho-social needs.

The Department offers the following clarifications following review of the draft audit report.

- The second paragraph of the Background section on Page 4 states, "*OCFS establishes a 'Daily Child Care Rate' (Daily Rate) which is the basis for Medicaid funding that the Department provides to the voluntary agencies.*"

To clarify, OCFS does not establish foster care Medicaid per diem rates. OCFS performs an initial review of cost report data across a foster care agency's programs, and computes a separate and distinct maintenance rate that covers room and board. Any costs that should be allocated to an agency's Medicaid program are provided to the Department. This information, in conjunction with the actual cost report data submitted by the agency, is utilized by the Department to establish a daily rate for medical costs consistent with the foster care methodology. The Department sets Medicaid per diem rates (totaling approximately \$150 million in yearly expenditures) for 80 voluntary foster care agencies that serve an estimated 20,000 children in foster care annually. There is not a direct relationship between the maintenance rates set by OCFS and the medical care rates calculated by the Department.

- The paragraph under Audit Findings and Recommendations on Page 5 states, "*the Department could save millions of Medicaid dollars annually by assessing and modifying certain policies and practices that drive the costs of medical care.*"

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Comment
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* See State Comptroller's Comments, page 20.

There are several important factors that drive the cost of medical care which OSC should consider. Children enter the foster care system in a variety of ways, and the program is intended to meet the unique medical and placement needs of each child. In order to allow voluntary agencies the flexibility necessary to provide individualized care and to ensure access and availability of services, the Department has not strictly mandated business arrangements and practices. As such, each agency is able to negotiate arrangements among its subcontractors and pharmacy providers to address the specific needs of the children in its custody. The Department will encourage providers to make prudent business arrangements to the extent possible within the parameters of foster care reimbursement methodology.

Children in foster care for whom a Medicaid per diem rate is paid were previously legislatively excluded from participation in managed care. This exclusion was due, in part, to the difficulty of pricing and providing medical services as required by the foster care regulations. However, the Department recognizes that the managed care environment can provide healthcare services at substantially reduced costs. Many of the proposals in the 2012-2013 Executive Budget seek to take advantage of cost savings and improvements in the overall management of care that can be achieved by delivering health care to Medicaid recipients, including children in foster care, using a managed care approach. Consistent with the Medicaid Redesign Team's recommendations, in 2015, the Department will transition foster care Medicaid per diem children into managed care.

- The third bullet under Key Findings on Page 1 (and paraphrased elsewhere throughout the report) states, "*Medicaid paid about 1.1 million claims (totaling \$83.2 million) directly to health care providers for medical services that otherwise were covered by Medicaid's Daily Rate payments to the voluntary agencies.*" Similarly, the first paragraph under Payments to Providers for Services Covered by the Daily Rates on Page 7 states, "*These Medicaid payments (made directly to providers) were incorrect because the drugs and services associated with the claims were covered by the Daily Rate method – and accordingly, the voluntary agencies should have paid the providers using their Medicaid Daily Rate funding.*"

Costs for foster care claims billed directly to the Medicaid program are not paid through the Medicaid per diem as long as they are not included in the provider's cost report. This "leakage" (i.e., costs not included in the historical base of the Medicaid per diem) is paid through fee-for-service and is not considered duplicative billing. OSC's savings estimates may therefore be overstated.

Additionally, the Department has accelerated ongoing efforts to strengthen its oversight role by initiating a process to modify eMedNY system edits to address leakage in a more comprehensive manner. The Department is also assessing a potential policy change that would exclude pharmaceutical costs from the Medicaid per diem.

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* See State Comptroller's Comments, page 20.

Recommendation #1:

Formally assess the cost-effectiveness of the Daily Rate reimbursement method. Determine if this method should be modified or if a different reimbursement mechanism should be applied for health services for children placed in voluntary agencies. This assessment should also include consideration of alternatives for paying the costs of pharmaceuticals for such children.

Response:

The Department ensures that Medicaid foster care per diems ("Daily Rate") are set in the transparent and consistent manner required by existing guidelines and standards. These rates reflect the reasonable costs of programs that are efficiently operated in accordance with the rate reimbursement methodology established by Chapter 11 of the Standards of Payment for Foster Care of Children Program Manual.

The Department is in the process of evaluating the Daily Rate in anticipation of transitioning foster care children to managed care, as well as exploring service delivery models that enhance care coordination and case management (i.e., Health Homes). It is additionally considering alternative methods for paying for the costs of pharmaceuticals such as excluding drugs from the Daily Rate which would permit participation in federal and state rebate programs as well as implementation of utilization controls. OCFS and the Council of Family and Child Caring Agencies have expressed support for this direction.

Recommendation #2:

Provide voluntary agencies with formal guidance for the cost-effective acquisition of medical care for children in their custody.

Response:

The Department will issue formal guidance as part of the move to managed care for this population. In the interim, it will continue encouraging providers to maximize cost efficiencies and effectiveness within the parameters of the reimbursement methodology, while maintaining access to vital services and continuity of care.

Recommendation #3:

Formally remind voluntary agencies to inform health care providers to submit claims directly to the voluntary agencies for medical services and drugs which are covered by the Daily Rate.

Response:

As part of an informational webinar conducted in October 2011, the Department formally restated existing billing policies for medical services including the procedures for appropriately reporting medical and pharmaceutical costs in annual cost reports. It will issue additional guidance and technical assistance, on an as needed basis, in response to billing issues, as well as pursue eMedNY system modifications that would prevent payment of certain claims billed directly to the Medicaid program.

Recommendation #4:

Formally remind local social services districts to ensure that the Principal Provider file is maintained in a complete, accurate and timely manner for all children placed in voluntary agencies. Monitor the Principal Provider File to the extent practical and cost effective to help ensure its reliability.

Response:

The Department's Division of Health Reform and Health Insurance Exchange Integration issued guidance to local districts on the use and maintenance of the Principal Provider File. Local Districts were provided through electronic correspondence, in May 2011, with a list of the foster care agencies that receive a Medicaid foster care per diem, as well as, in June 2011, with a restatement of the appropriate use of category codes on the Principal Provider File. Referenced in, and attached to, the correspondence relating to category codes were OCFS GIS 08-002 on Foster Care and Adoption Individual Categorical Codes in MA Cases and GIS 09-008 on Chafee-Foster Care Individual Categorical Codes for Medicaid.

Recommendation #5:

Ensure that eMedNY contains the necessary edits and file interfaces to prevent claims from being paid directly to providers when such claims are covered under the Daily Rate for voluntary agencies.

Response:

The Department has initiated a systems project (EPR #1665) modifying eMedNY to prevent the payment of fee-for-service claims that are covered by the foster care Medicaid per diem.



New York State
Office of
Children & Family
Services

www.ocfs.state.ny.us

Andrew M. Cuomo
Governor

Gladys Carrión, Esq.
Commissioner

Capital View Office Park
52 Washington Street
Rensselaer, NY 12144



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August 8, 2012

Mr. Stephen Abbott, Director
Audit Unit
New York State Department of Health
Corning Tower Building
Room 2266
Empire State Plaza
Albany, NY 12237

Dear Mr. Abbott:

The Office of Children and Family Services (OCFS) appreciates the opportunity to respond to the draft audit report 2010-S-47 from the Office of the State Comptroller (OSC) entitled "Unnecessary Medicaid Payments for Children in Voluntary Agencies". The comments will consist of general and specific information that OCFS believes is important to share with OSC and the Department of Health (DOH) as part of the audit process. The first point OCFS would like to share is that the OSC use of the term "Unnecessary" to describe the payment process is inflammatory and overstates the reality of payments for services.

GENERAL OCFS COMMENTS ON AUDIT:

Voluntary agencies receive the daily Medicaid funding as part of the per diem rate for the medical expenses incurred for each child for whom payments are received. This audit is highly critical of the rates paid for pharmaceutical and laboratory fees under the Medicaid Daily Rate funding system.

SPECIFIC OCFS COMMENTS ON AUDIT:

OCFS would recommend on page 4 (page 1 of the Executive Summary) of the report that:

"otherwise were covered by Medicaid's Daily Rate payments to the voluntary agencies" be modified to

"could have been covered by the Medicaid Daily Rate payments to the voluntary agencies if the costs were part of the historical base of the Daily Rate."

Page 4 (Background):

OCFS establishes a "Daily Child Care Rate" (Daily Rate) which is the basis for Medicaid funding that the Department provides to the Voluntary agencies. *OCFS does not establish the Daily Rate, DOH does. Further, the DOH Medicaid rate is not based on the OCFS daily rate. The OCFS daily rate covers maintenance costs and the Medicaid rate covers the cost of medical care of children in residential facilities. There is no direct relationship between the two rates.*

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* See State Comptroller's Comments, page 20.

Page 5 (Audit Recommendations and Findings):

OCFS never received a specific count of the "high percentage" transactions cited in the chart. The word "sometimes" is quite vague especially in instances when the quantity of occurrences is important.

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Comment
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Page 7 (Audit Recommendations and Findings):

The language "...Medicaid incorrectly paid 1.1 million claims (totaling \$83.2 million) submitted by providers, under the fee-for-service method, for drugs and medical services for children in voluntary agencies. These payments (made directly to providers) were incorrect because the drugs and services associated with the claims were covered by the Daily Rate method" should be modified to "...could have been covered in the Daily Rate if the costs were part of the historical base of the Daily Rate." Additionally, OCFS questions the word "incorrect".

Certain medical costs can be paid directly by an agency or charged directly to Medicaid. Either method has been allowed in practice. If costs which conceivably could have been paid through the per diem rate but are instead charged to Medicaid are excluded from the agency's cost reports, there is no rate impact. The audit results have not revealed any instances of "double billing" where an agency both charged Medicaid directly as well as reporting the cost in its own cost reports for inclusion in a rate calculation.

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Comment
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Page 7 (Audit Recommendations and Findings):

The language on page 7 "714,941 provider claims were reimbursed \$56.7 million in fee-for-service payments for various medical procedures that were included in the Daily Rate" should be modified to "...could have been included in the Daily Rate if the costs were part of the historical base of the Daily Rate."

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Comment
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IMPLEMENTATION OF RECOMMENDATIONS:

OCFS is willing to work with DOH on the implementation of all five recommendations contained in this draft audit report as practicable. As noted earlier, OCFS favors examination of different reimbursement mechanisms for paying the cost of pharmaceutical fees as described in Recommendation 1. As regards Recommendations 2 and 3, OCFS offers to work in conjunction with DOH in providing guidance on the provision of cost-effective medical care for children in foster care and proper submission of claims for medical services and drugs covered by the Daily Rate.

Recommendation 4 cites the need for monitoring the reliability and cost effectiveness of the Principal Provider File and to formally communicate with local social services districts on the need to maintain the Principal Provider File in a complete, accurate and timely manner. Recommendation 5 addresses the development of edits and file interfaces to prevent claims from being paid directly to providers when such claims are covered under the Daily Rate for voluntary agencies. OCFS has, and will continue, to offer input to DOH on these processes.

* See State Comptroller's Comments, page 20.

OCFS looks forward to the opportunity to work with DOH to implement these recommendations. Please contact Ralph Timber, OCFS Audit Liaison, via email at Ralph.Timber@ocfs.state.ny.us by phone at 473-0796 with any questions or comments you may have.

Sincerely,



Kevin W. Mahar, Director
Office of Audit and Quality Control
Room 201 South
52 Washington Street
Rensselaer, NY 12144

State Comptroller's Comments

1. We modified our report to note that the Department establishes the Daily Child Care Rate.
2. We did not characterize the \$83.2 million in question as duplicative billing. Rather, we noted that payments for certain fee-for-service items should have been covered by voluntary agencies' Daily Child Care Rate funding. Consequently, we determined such fee-for-service payments to be incorrect.
3. We support the Department's acceleration of efforts to strengthen pertinent eMedNY system edits to address fee-for-service "leakage" from the Daily Child Care Rate (per diem) method. However, as of August 2012, eMedNY continues to process significant numbers of fee-for-service claims for services that should have been covered by the per diem program. Thus, eMedNY will continue to make improper fee-for-service payments until the appropriate system controls are in place.
4. Given the extent of the incorrect fee-for-service payments (totaling \$83.2 million) we identified, we maintain that our presentation of this matter is appropriate.
5. Based on the applicable written Department guidance, the fee-for-service claim payments in question should have been covered by Daily Rate funding. Thus, we maintain that our presentation of this matter is appropriate.
6. The items detailed in the chart resulted from a limited comparison of the amounts voluntary agencies paid for certain services - to the amounts Medicaid would have paid for the same services. Consequently, we do not have counts of the "high percentage" transactions cited in the chart. Nonetheless, we believe the chart's examples help illustrate why the Department should formally assess the cost-effectiveness of the Daily Rate method.
7. Our audit scope did not include tests specifically designed to identify instances of "double billing." Further, because the daily rate methodology uses historic cost data, it could be difficult to prove conclusively that a duplicate payment (through the Daily Rate and fee-for-service process) was made for specific medical service provided to a foster care child. Moreover, as the Department acknowledges, actions are needed to minimize fee-for-service "leakage" for services normally covered by the Daily Rate method.