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

DEPARTMENT OF HEALTH
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

FEE-FOR-SERVICE CLAIMS PAID FOR RECIPIENTS ENROLLED IN MANAGED CARE PLANS

REPORT 96-S-83

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 96-S-83

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Mr. Brian Wing
Commissioner
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Dear Dr. DeBuono and Mr. Wing:

The following is our report on Medicaid's payment of fee-for-service claims for recipients enrolled in managed care plans.

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

June 15, 1998

Executive Summary

Department Of Health
Office Of Temporary And Disability Assistance
Fee-for-Service Claims Paid For Recipients Enrolled In Managed Care Plans

Scope of Audit

The New York State Department of Health (Health) administers the State's Medical Assistance Plan (Medicaid). During most of our audit period, the Department of Social Services (Social Services) administered Medicaid, and used the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. The State's 58 local social services districts enroll Medicaid recipients in the State's Medicaid managed care plans. Social Services coordinated local districts' activities during most of our audit period. Effective August 20, 1997, the Office of Temporary and Disability Assistance (OTDA) assumed these responsibilities. 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 one of two methods: the fee-for-service method, in which a provider is paid for each Medicaid-eligible service, and the capitation method, in which a managed care plan is paid a monthly fee based on the number and types of Medicaid recipients enrolled in the plan. The managed care plan must provide health services to enrolled recipients when services are needed. However, 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. For the two-year period ended September 30, 1996, Medicaid paid about $1.9 billion to managed care providers in New York State.

Our audit addressed the following question regarding the payment of fee-for-service claims for managed care recipients for the period October 1, 1994 through November 20, 1997:

- Were Medicaid payments of fee-for-service claims for managed care recipients appropriate?

Audit Observations and Conclusions

We found MMIS potentially overpaid managed care plans and fee-for-service providers a total of $38.5 million because of delays in updating enrollment and plan benefit information and in developing a policy to recover duplicate payments.

Local districts enroll and disenroll recipients in managed care plans. MMIS uses this information to pay managed care and fee-for-service claims. Therefore, delays in updating this information can result in MMIS incorrectly paying a managed care or fee-for-service claim. As a result of delays in updating enrollment and disenrollment information to MMIS, we identified $12.3 million in fee-for-service claims that were paid on behalf of recipients covered by managed care plans. We recommend that Health investigate and recoup overpayments from either fee-for-service or managed care providers, and that OTDA ensure that districts update enrollment transactions in a timely manner. (See pp. 4-6)

Health maintains a benefit file which it updates to add new providers or to account for changes to an existing provider's contract. However, we found that Health does not have controls needed to ensure that the benefit file reflects services agreed to in the provider's managed care contract. These controls are intended to ensure that Medicaid does not pay for the same service in both the managed care plan's rate and in a fee-for-service claim. We found that, because Health did not update this file timely, MMIS paid over $500,000 in fee-for-service pharmacy claims for services included in the managed care plan's rate. Health officials agreed that a delay occurred in updating the scope of benefits file in this instance, but indicated that no funds could be recovered because the managed care plan provided pharmacy services for any enrollee who used an in-plan pharmacy and the out-of-plan pharmacies billed fee-for-service Medicaid for those services provided to the managed care plan enrollees. However, this example demonstrates the importance of accurate and timely updates to the benefit file. (See pp. 5-6)

Since Federal law prohibits any restriction on Medicaid recipients' access to family planning services, Health allows managed care recipients to obtain their family planning services from either the managed care plan or a fee-for-service provider. However, Health developed this policy without adjusting managed care plans' rates, or adding contract language to allow Health to recover payment from plans for claims which MMIS paid on a fee-for-service basis. We identified over $26.2 million in family planning claims paid on a fee-for-service basis for recipients enrolled in managed care plans during the two-year period ended September 30, 1996. Since Health did not develop a policy to prevent or to allow the recovery of duplicate payments for family planning services, Health will be able to recover only $.9 million of this amount. Although Health has since added language to contracts with managed care plans to allow recovery of such duplicate payments, we recommend that Health develop more specific guidelines to ensure such reimbursement is appropriate. (See pp. 6-8)

Comments of Officials

Department of Health officials generally agree with our recommendations and indicated that steps are being taken to implement many of them.

Contents

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) administered Medicaid and 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]

Individuals apply for Medicaid assistance in 58 local districts located throughout the State. During our audit period, Social Services relied on the local districts to enroll Medicaid recipients into the State's Medicaid managed care plans, and to update enrollment information to MMIS. [2] The local districts enter into contracts with managed care plans to provide medical care to recipients within their districts. Health, which has overall responsibility for the Medicaid managed care program, sets Medicaid payment policy and monthly capitation premiums.

Two different methods are used to pay Medicaid providers: fee-for-service or capitation premiums. Under the fee-for-service method, a provider is paid every time a recipient receives a Medicaid-eligible service. Under the capitation method, which is used by managed care providers, a provider is paid a monthly payment based on the number and types of Medicaid recipients enrolled in its managed care program. In exchange for this payment, the managed care provider is responsible for providing various medical services to the recipients. However, there are some medical services (e.g., methadone maintenance) which MMIS pays for on a fee-for-service basis because the services are not provided by any of the Medicaid managed care plans.

During most of the period covered by our audit, recipient enrollment into the program was on a voluntary basis. However, effective July 15, 1997, the Federal government approved a Medicaid waiver which requires New York State to enroll about 2.4 million recipients into managed care on a

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

[2] On August 20, 1997, the Governor signed legislation which abolished the Department of Social Services and created a new agency in its place: the Department of Family Services. The Office of Temporary and Disability Assistance (OTDA), a component of this new agency, assumed responsibility for coordinating local districts' activities.

mandatory basis. As of September 1997, there were approximately 650,000 Medicaid recipients enrolled in managed care plans. For the two years ended September 30, 1996, Medicaid paid managed care plans $1.9 billion in monthly capitation premiums.

Audit Scope, Objective and Methodology

We audited the policies and procedures relevant to the payment of Medicaid fee-for-service claims for managed care recipients during the period October 1, 1994 through November 20, 1997. The objective of our performance audit was to determine whether the fee-for-service payments for managed care recipients 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. In addition, we developed computer programs to compare the service dates on managed care and fee-for-service claims for the two-year period ended September 30, 1996. The purpose of matching this data was to identify any fee-for-service claims for services which occurred in periods for which MMIS made monthly managed care capitation payments.

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 structure 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 report and are included as Appendix B and Appendix C, respectively.

In addition to the matters discussed in this report, we provided Department of Health officials with detailed comments on other matters. Although these matters are of lesser significance, our recommendations relating to these matters should be implemented to improve operations.

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 Fee-For-Service Payments

Health officials are responsible for establishing and maintaining a system of controls to ensure the accuracy of all Medicaid payments. To receive payment, providers must submit claims to MMIS. MMIS will pay a managed care claim when the recipient is Medicaid-eligible and is enrolled in a managed care plan. MMIS will pay a fee-for-service claim if the recipient is Medicaid-eligible and is not enrolled in a managed care plan, or if the medical service is not provided by the managed care plan. However, because of delays in updating enrollment and benefit data, and delays in developing policy adjustments for recouping certain payments from managed care plans, we found that MMIS made potential overpayments to managed care plans and fee-for-service providers totaling $38.5 million during our audit period.

Delays in Updating Recipient Enrollment and Contract Benefit Information

Local districts enter managed care enrollment information for Medicaid recipients in a computerized enrollment file, and OTDA is responsible for ensuring districts properly update such enrollment information. Health uses a computerized benefit file to 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 accurate payment of all claims is dependent on accurate managed care enrollment and benefit information. However, we found that local districts and Health are not making timely updates to enrollment and benefit file information. As a result, MMIS made potential overpayments of $12.3 million to both managed care and fee-for-service providers.

Using computer assisted audit techniques, we compared all managed care claims to fee-for-service claims for the two-year period ended September 30, 1996. We determined that Health and the local districts do not always update benefit information and process managed care enrollment transactions in a timely manner. For this period, we identified over $3.5 million in inpatient and clinic claims which MMIS paid on a fee-for-service basis for recipients whose enrollment in managed care plans had not been processed timely. For example, one recipient was enrolled in a managed care plan effective July 1, 1995, at which time Health became responsible for the recipient's monthly premium payments. However, the managed care transaction was not recorded on MMIS until March 1996 -

eight months later. Since MMIS had no information indicating plan enrollment during this eight-month period, it paid the fee-for-service claims for this recipient. When the managed care plan later billed MMIS for monthly premium payments incurred since enrollment on July 1, 1995, MMIS also paid the plan.

We also found that MMIS paid managed care premium payments and approximately $8.3 million in inpatient and clinic claims for dates of service which occurred after recipients had disenrolled from managed care plans. These potential overpayments occurred because local districts did not update the disenrollment information to MMIS in a timely manner. Health needs to determine whether the managed care or the fee-for-service claims are appropriate. Medicaid should not pay for the same service twice: once as part of the managed care plan's capitation payment and again in a fee-for-service claim.

The information in the benefit file determines whether a fee-for-service claim should be paid for a Medicaid recipient who is enrolled in managed care. Health updates the benefit file to add a new provider or to account for changes to an existing provider's contract. We found that Health has not fully established the controls necessary to ensure that the benefit file reflects the services agreed to in the provider's managed care contract. When Health does not update such information in a timely way, MMIS can make inappropriate payments to fee-for-service providers.

To evaluate Health's system of controls over updates to the benefit file, we selected a sample of 12 managed care contracts on a judgmental basis from about 150 contracts within the State's managed care program. We compared the contracts to the information in the benefit file. We found that the benefit file for one of these providers was not updated in time to prevent inappropriate fee-for-service payments. The managed care plan began to include pharmacy services in its benefit package effective September 1, 1996. However, because of a delay in approving the provider's contract, the revised benefit package was not updated to the benefit file until April 1, 1997 - seven months after the effective date of the contract. MMIS paid approximately $500,000 of pharmacy claims on a fee-for-service basis during just one month of this delay (September 1996). Since our analysis included only one month of the seven-month delay period, the total inappropriate pharmacy payments could be greater than the $500,000 we identified. We did not quantify the impact of this delay after our audit period. These pharmacy claims should have been the financial responsibility of the managed care plan, since its rate included pharmacy services. As a result, Medicaid paid for these pharmacy

services twice: once as part of the managed care provider's capitation payment and again in fee-for-service claims.

In responding to our draft report, Health officials agree that a delay occurred in updating the scope of benefits file for the above noted managed care plan, but disagree with our recommendation to recoup all pharmacy claims that were paid inappropriately on a fee-for-service basis. According to Health officials, the managed care plan provided pharmacy services for any enrollee who used an in-plan pharmacy. Similarly, the out-of-plan pharmacies billed fee-for-service Medicaid for those services provided to the managed care plan enrollees. Consequently, we have deleted our recommendation to the Department to recoup the inappropriate fee-for-service overpayments. However, this example demonstrates the importance of accurate and timely updates to the benefit file.

Family Planning Services Paid on a Fee-For-Service Basis

Managed care plans are responsible for providing various medical services for Medicaid recipients enrolled with the plan. The monthly capitation rate is based on the services which the plans provide. Plans that provide comprehensive coverage would typically charge a higher rate than those that cover only limited services. Some medical services (e.g., methadone maintenance) are not provided by any of the Medicaid managed care plans. Consequently, MMIS will appropriately pay for these services on a fee-for-service basis. Health will pay for certain other services (e.g., family planning) on a fee-for-service basis, even if the service is included in the plan's capitation rate. When MMIS pays for an enrolled recipient's family planning services on a fee-for-service basis, it should recover these amounts from the plan so it does not pay twice for the same services.

Federal law prohibits any restriction on Medicaid recipients' access to family planning services. Family planning services are available from different types of providers (e.g., clinic, practitioner, pharmacy, inpatient). Health has adopted a free access policy which allows Medicaid recipients to seek family planning services from any qualified providers without having to notify or seek the approval of their managed care plans for doing so. The Federal Health Care Finance Administration's State Medicaid Manual states there are only three approved approaches regarding family planning services, and each requires that the managed care provider's rate be adjusted accordingly. However, Health developed its policy without adjusting the managed care rates, or adjusting the contract language to allow Health to recover payment when family planning services are provided by fee-for-service providers. As a result,

the Medicaid program paid for the same service twice: directly to the fee-for-service family planning provider, and indirectly to the plan in the plan's Medicaid rate.

Using computer-assisted audit techniques, we identified over $26.2 million in family planning claims which were paid on a fee-for-service basis on behalf of Medicaid recipients in managed care plans. Because Health's policy during most of our audit period did not include a method to recover potential duplicate family planning payments, Health can recover only about $.9 million of the $26.2 million from the managed care plans. Had Health implemented an adjustment process sooner, it could have recovered the remaining $25.3 million in Medicaid payments.

Health is aware of these duplicate payments, and has added new language to the contracts between managed care plans and the local districts addressing the recovery of duplicate family planning payments. These revisions began in August 1996 for several New York City managed care plans, and in October 1996 for most upstate plans. Starting with these new contracts, when the managed care plan's rate includes family planning services, the plan will be financially responsible for all family planning services. MMIS will continue to allow family planning claims to be paid on a fee-for-service basis, but will bill the managed care plan for these claims. The new contract language establishes a method of recovering these duplicate payments.

However, our audit found that the new contract language does not address all issues. For example, the contract language indicates that the plans are responsible for reimbursing the State for family planning services at the Medicaid clinic rate. However, it does not state specifically how family planning services provided by non-clinic providers will be addressed. Some non-clinic providers' rates significantly exceed the Medicaid clinic rate. Because of the material nature of family planning recoveries, we believe Health needs to develop more formal and detailed procedures regarding such recoveries from managed care plans.

Recommendations

To Health:

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

To Health and OTDA:

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

To Health:

3. Develop a policy to address all retroactive enrollments and disenrollments.

4. Recommendation deleted.

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.

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

Major Contributors to This Report

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BARBARA A. DEBUONO, M.D., M.P.H.
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May 11, 1998

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Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report (96-S-83) entitled, "Fee-For-Service Claims Paid for Recipients Enrolled in Managed Care Plans".

Thank you for the opportunity to comment.

Very truly yours,

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit 96-S-83 Entitled
"Fee-For-Service Claims Paid for Recipients Enrolled in Managed Care Plans"

The following are the Department of Health's (DOH) comments in response to the above cited Office of State Comptroller (OSC) Draft Audit Report entitled "Fee-For-Service Claims Paid for Recipients Enrolled in Managed Care Plans" (96-S-83).

Integrating the managed Medicaid Program and fee for service Medicaid claims is a complex task that requires timely enrollment data from 58 local social services districts and maintenance of a benefits file for approximately 150 managed care contracts. To ensure that claims are paid appropriately, the managed care payment system includes an edit that automatically denies payment for fee-for-service claims during a period when a Medicaid recipient is enrolled in a managed care plan. While overall this edit is effective in assuring that fee for service claims are not inappropriately paid for managed care enrollees, the audit points out that there are a limited number of situations in which the edit may not prevent payment for a fee for service claim. If a managed care enrollment or disenrollment is done retroactively, the payment system edit may not prevent payment of a fee for service claim. If the scope of benefits files that supports the payment system edit is not updated in a timely manner, fee for service claims may be paid for benefits that should be provided by the managed care plan.

Recommendation #1: Investigate and recoup inappropriate payments from managed care, inpatient or clinic providers.

Response #1: The DOH agrees that inappropriate payments should be recouped from managed care plans or providers. DOH has developed an overall policy approach that capitation payments may be recoverable in instances where the managed care plan was not at any risk for provision of services for that time period. These instances are not always readily determined. We are working with the Office of Medicaid Management's Office of Quality Assurance and Audit (QA&A) to recover as appropriate.

Recommendation #2: Develop procedures for ensuring timely updates to benefit file information and local district's recipient enrollment information.

Response #2: Policies have been implemented that establish a process for contract benefit changes and scope of benefits file changes to be coordinated. In addition, we now conduct periodic validations to ensure that the benefits listed on scope of benefits file match the contract benefits.

Recommendation #3: Develop a policy to address all retroactive enrollments and disenrollments.

Response #3: The DOH is exploring various alternatives for limiting the number of retroactive enrollments and disenrollments. Achieving timely Medicaid eligibility and enrollment of newborns is a priority of the department.

Language that indicates that retroactive transactions are only appropriate in extreme circumstances was added to the Operational Protocol which governs manage care implementation. Also, local district training and HCFA readiness reviews conducted in conjunction with the Section 1115 waiver include instructions on these issues.

Recommendation #4: Investigate and recoup all pharmacy claims that were paid inappropriately on a fee-for-service basis both before and after our audit period.

* Note

Response #4: The audit reports that the scope of benefits file for one of approximately 150 contracts with managed care organizations was not updated in a timely manner. Although we agree that in this one instance a delay occurred in updating the scope of benefits file, we do not agree that recovery should be made for pharmacy claims in this instance. The scope of benefits file was not updated to reflect the inclusion of pharmacy as a capitated benefit for a specific managed care plan, allowing fee-for-service payments to be made. The managed care plan provided pharmacy services during this period for any enrollee who used an in-plan pharmacy. Thus, it would be inappropriate to recover payments from the managed care plans. Because some enrollees went to out-of-plan pharmacies, those pharmacies billed fee-for-service Medicaid. Again, because the provider actually provided a service to these enrollees, recoupment is not appropriate. To the best of our knowledge, the audit did not find that instances where the pharmacy billed both the managed care plan and Medicaid fee-for-service for the same service.

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.

Response #5: As stated in the audit report, federal law prohibits any restriction on Medicaid recipient's access to family planning services. The policy developed for the managed Medicaid program by the Department of Social Services allowed out-of-plan access to family planning, but the contracts with managed care plans did not provide that the cost of such out-of-plan services could be recovered from plans.

Subsequent to DOH assuming responsibility for the managed Medicaid program, this policy was revised and contracts with managed care plans now permit such recovery. QA&A is now preparing reports to identify out-of-plan payments for family planning. These reports will be sent to all affected managed care plans and recoveries will be generated.

*See State Comptroller's Note, Appendix B-4

Recommendation #6: Develop detailed procedures relating to the family planning recovery process and incorporate these procedures into the contract language.

Response #6: The contract language for recovering the amount of Medicaid payments made from plans has been revised to clarify that the actual rate or fee paid by Medicaid will be recovered. The procedures for recoupment are now being finalized with input from the Managed Care Plan Operational Workgroup.

* * *

State Comptroller's Note

Recommendation 4 in the draft report was deleted from the final report.

George E. Pataki
Governor

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Brian J. Wing
Commissioner

April 15, 1998

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Re: Draft Report 96-S-83
Fee-For-Service Claims Paid for
Recipients Enrolled in Managed Care Plans

Dear Mr. McClune:

This is in response to the referenced report. With the abolishment of the NYS Department of Social Services and the creation of the NYS Department of Family Assistance, the NYS Department of Health is now responsible for all Managed Care Plans relating to Medicaid. Therefore the NYS Department of Health should respond to your recommendations.

Sincerely,

David P. Avenius
Deputy Commissioner
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cc: Dennis North
Deirdre Taylor
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Appendix C