

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FEE-FOR-SERVICE PAYMENTS
FOR SERVICES COVERED BY
CAPITATED MEDICAID MANAGED
CARE**



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Inspector General

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Office of Inspector General

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E X E C U T I V E S U M M A R Y

OBJECTIVE

To determine the extent to which Medicaid programs in five States paid noninstitutional fee-for-service claims for services provided to beneficiaries enrolled in capitated Medicaid managed care plans during the first quarter of fiscal year (FY) 2005.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) estimates that over 65 percent of the Nation's Medicaid beneficiaries received all or some of their health or mental health services through managed care in 2006. In capitated managed care arrangements, State Medicaid programs pay managed care plans a fixed rate per Medicaid beneficiary in exchange for services included in the plan. Except in limited circumstances specified by the State (e.g., the beneficiary receives services outside the managed care plan coverage area), Medicaid programs should not pay claims for services that are included in capitated Medicaid managed care plans on a fee-for-service basis. Otherwise, Medicaid programs pay twice for the same service—once through the fee-for-service claim and once as a portion of the capitated payment. We selected five States for this review based on the percentage of the States' Medicaid populations enrolled in managed care.

FINDINGS

In the first quarter of FY 2005, Medicaid programs in four of the five States that we reviewed erroneously paid nearly \$864,000 for fee-for-service claims. We identified 16,621 fee-for-service claims totaling \$863,664 paid in error for capitated Medicaid managed care covered services in California, Missouri, New York, and Wisconsin during the first quarter of FY 2005. The Federal share of these claims paid in error was \$462,087. Manual overrides of Medicaid automated payment system edits and faulty system logic contributed to the claims paid in error.

An additional \$974,006 was potentially paid in error in two States in the first quarter of FY 2005. We identified an additional 23,069 fee-for-service claims totaling \$974,006 that appeared to be for services covered by capitated Medicaid managed care plans in California and Pennsylvania. However, State staff indicated that determining

whether the claims were paid in error would require resource-intensive reviews of these claims, which could involve researching the Medicaid automated payment system edits applied to each claim, identifying any manual overrides of system edits, reviewing the claims payment history, and tracking systems processing logic. Without this type of review, neither the Office of Inspector General nor State Medicaid agency staff could definitively determine whether these fee-for-service claims were paid in error.

RECOMMENDATIONS

When Medicaid programs pay fee-for-service claims for services covered by capitated Medicaid managed care plans in error, they are essentially paying twice for the same services. We identified approximately \$1.8 million (i.e., State expenditures and Federal financial participation) in total Medicaid claims paid or potentially paid in error during a single quarter in the five States that we reviewed. State Medicaid agency staff either acknowledged that these claims were paid in error, describing faulty system logic, edits, and manual overrides as reasons for these errors, or explained why determining whether claims were paid in error was not feasible. These challenges point to vulnerabilities in claims processing. Therefore, we recommend that CMS:

Work with all States to reduce the vulnerability for erroneous fee-for-service Medicaid payments for services covered by capitated Medicaid managed care plans. CMS should issue guidance to States addressing Medicaid payment systems' vulnerabilities, identifying erroneous payments, and developing payment systems to prevent payment errors. CMS could accomplish this through disseminating information to State Medicaid agencies regarding the vulnerabilities that we identified; encouraging every State to examine existing Medicaid claims payment systems to identify potential errors and to determine whether errors identified are associated with State automated payment system logic, edits, and manual overrides; and providing technical assistance and information to State Medicaid agencies regarding the importance of developing Medicaid claims payment systems that will enable State Medicaid agency staff and external reviewers to more easily identify and prevent fee-for-service payments for services covered by capitated Medicaid managed care plans.

Take appropriate action to collect overpayments associated with Medicaid claims paid in error from States. OIG will forward to CMS the identified erroneous fee-for-service claims information needed to take appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments, CMS agreed with the recommendation contained in the draft report. CMS recognized the importance of ensuring that erroneous payments are eliminated to the fullest extent possible. CMS offered as context the small amount of erroneous claims that we identified and the complexity of the States' Medicaid managed care programs that we reviewed. However, the claims paid in error demonstrate how these complex programs can lead to the vulnerabilities identified. CMS noted in its comments that for many situations cited in the report, States should have been able to control erroneous payments with edits in their payment systems. OIG is now recommending that CMS collect overpayments associated with the claims paid in error from the States.

To address the OIG recommendations, CMS will remind States of the importance of eliminating erroneous payments and recommend that States make any necessary edits to their payment systems at the next Medicaid Managed Care Technical Advisory Group call. Additionally, CMS will work with States to voluntarily collect the overpayments associated with erroneous fee-for-service payments.



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OBJECTIVE

To determine the extent to which Medicaid programs in five States paid noninstitutional fee-for-service claims for services provided to beneficiaries enrolled in capitated Medicaid managed care plans during the first quarter of fiscal year (FY) 2005.

BACKGROUND

States and the Federal Government jointly fund medical and health-related services for low-income individuals, families, the elderly, and disabled who meet State and Federal eligibility criteria through State Medicaid programs. States have the option to provide Medicaid services to eligible beneficiaries solely on a fee-for-service basis, through managed care arrangements, or through both fee-for-service and managed care arrangements. Over the past 10 years, beneficiary enrollment in Medicaid managed care plans has increased.¹ The Centers for Medicare & Medicaid Services (CMS) estimates that over 65 percent of the Nation's Medicaid beneficiaries received all or some of their health or mental health services through managed care in 2006.²

In capitated Medicaid managed care arrangements, State Medicaid programs pay managed care plans a fixed rate per Medicaid beneficiary in exchange for services included in the plan.³ Except in limited circumstances specified by the State (e.g., the beneficiary receives services outside the managed care plan coverage area), Medicaid programs should not pay claims for services that are included in capitated Medicaid managed care plans on a fee-for-service basis.

¹ "2006 Medicaid Managed Care Enrollment Report," Managed Care Trends, p. 3. Available online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp#TopOfPage. Accessed on June 1, 2007.

² "2006 Medicaid Managed Care Enrollment Report," Medicaid Managed Care Penetration Rates, p. 5. Available online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp#TopOfPage. Accessed on June 1, 2007.

³ Although States utilize a variety of managed care arrangements to provide Medicaid services to eligible beneficiaries (e.g., capitated managed care, primary care case management), this evaluation focused strictly on services provided through capitated Medicaid managed care.

Otherwise, Medicaid programs pay twice for the same service—once through the fee-for-service claim and once as a portion of the capitated payment.

Medicaid programs are responsible for ensuring the integrity of all Medicaid paid claims.⁴ In processing claims for services provided to Medicaid beneficiaries, States' automated claims payment systems should first determine whether beneficiaries are enrolled in capitated Medicaid managed care plans. For beneficiaries enrolled in capitated Medicaid managed care plans, States' automated claims payment systems should determine whether the beneficiaries' plans cover the services or whether the claims are appropriate for fee-for-service payments. States' Medicaid automated payment systems should deny fee-for-service claims for services covered by the capitated Medicaid managed care plans unless beneficiaries and services meet State-specified conditions that allow the beneficiaries to receive the services outside of the managed care plans.

Prior Office of Inspector General Work

An Office of Inspector General (OIG) study published in February 2003 identified approximately \$4 million in erroneous fee-for-service Medicaid payments in the State of Florida for services covered by a capitated Medicare managed care plan. These errors occurred because the State's Medicaid automated payment system was not updated to reflect the enrollment of dually eligible Medicaid beneficiaries in managed care.⁵ A September 2003 OIG study found that the State of Ohio made fee-for-service Medicaid payments for services that capitated Medicaid managed care plans covered.⁶ The study revealed that systems processes designed to prevent fee-for-service payments for managed care enrollees had been bypassed, resulting in \$1 million in erroneous payments between July 2000 and June 2001.

⁴ Social Security Act § 1902a(37)(B), 42 U.S.C. § 1396a.

⁵ "Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees," A-04-02-07007, February 2003.

⁶ "Review of Medicaid Fee-for-Service Payments for Beneficiaries Enrolled in Medicaid Managed Care," A-05-02-00079, September 2003.

METHODOLOGY

Scope

We selected five States for this review: California, Missouri, New York, Pennsylvania, and Wisconsin. State selection was based on the States' Medicaid populations relative to the percentage of their Medicaid beneficiaries enrolled in managed care.⁷ Table 1 below provides an overview of Medicaid enrollment, expenditures, and number of Medicaid managed care plans in the five States.⁸ Because of the large number of fee-for-service claims processed in each State and to ensure a more manageable scope, we included only outpatient fee-for-service payments in this review. Fee-for-service payments for services provided by pharmacies, in hospitals, and in long term care and other institutional settings were excluded from this review.

Table 1: State Medicaid Facts for Fiscal Year 2005

State	Medicaid Population	Percentage of Medicaid Beneficiaries Enrolled in Managed Care	Medicaid Expenditures (in billions)	Number of Medicaid Managed Care Plans
California	3,355,339	50.49	\$33.6	46
Missouri	469,808	44.17	\$6.5	9
New York	2,606,291	61.83	\$42.7	76
Pennsylvania	1,248,390	75.35	\$15.7	29
Wisconsin	386,037	45.38	\$4.7	41
Total	8,065,865		\$103.2	201

Source: Medicaid Managed Care Enrollment Report.

⁷ "2004 Medicaid Managed Care Enrollment Report," Medicaid Managed Care Program Summary, pp. 21–54. Available online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp#TopOfPage. Accessed on May 30, 2007.

⁸ See Appendix A for an overview of Medicaid managed care enrollment and fee-for-service paid claims for Medicaid beneficiaries enrolled in managed care during the first quarter of FY 2005.

Data Collection

Beneficiaries Enrolled in Capitated Medicaid Managed Care Plans. From each of the five States' Medicaid Management Information Systems (MMIS), we obtained Medicaid eligibility data for beneficiaries enrolled in capitated managed care plans at any time during the first quarter of FY 2005. The beneficiary information included, at a minimum, each beneficiary's unique Medicaid identification number, date of birth, dates of Medicaid eligibility, county codes, managed care plan identifier, and beginning and ending dates of managed care enrollment.

Medicaid Fee-for-Service Claims. For each of the five States, we obtained the adjudicated Medicaid fee-for-service paid claims files from the State's MMIS for all services performed in noninstitutional settings during the first quarter of FY 2005. The adjudicated paid claims files included, at a minimum, each beneficiary's unique Medicaid identification number, procedure code, procedure description, provider type, date of service, service category, diagnosis code, place of service, unit of service, amount billed to Medicaid, an indication of whether the claim was paid or denied, any Medicaid paid amount, and the date of payment.

Data Analysis

Fee-for-Service Claims for Services Covered by Capitated Medicaid Managed Care Plans. For each of the five States, we identified all fee-for-service claims that Medicaid paid for services provided to beneficiaries who were enrolled in capitated Medicaid managed care plans during the first quarter of FY 2005. To do this, we identified beneficiaries enrolled in Medicaid managed care and the beginning and ending dates each beneficiary was enrolled in Medicaid managed care. We then used each beneficiary's unique Medicaid identification number to identify fee-for-service claims that fell on or between the beginning and ending dates of managed care enrollment.

We obtained information from each State about the services that the capitated Medicaid managed care plans covered. If a managed care plan excluded a service (i.e., did not cover the service), we considered fee-for-service to be an appropriate method of payment for that service and did not question the fee-for-service payment. Examples of services excluded from capitated Medicaid managed care coverage in these five States are summarized in Appendix B.

I N T R O D U C T I O N

For the remaining fee-for-service claims that fell within periods when beneficiaries were enrolled in capitated Medicaid managed care plans, we worked with multiple individuals in each State’s Medicaid agency to interpret complex eligibility and claims data, program and managed care policy, and managed care plan coverage information to identify fee-for-service claims paid:

- correctly and why,⁹ and
- in error and why.

Federal and State Shares of Fee-for-Service Claims Paid in Error. We calculated the Federal and State shares of fee-for-service claims paid in error for each of the five States. We calculated these amounts by multiplying the expenditures for payments determined to be paid in error in each State by the Federal medical assistance percentage (FMAP) rate established specifically for that State. The FMAP rates for the five States reviewed varied between 50 percent and 61.15 percent as specified in Table 2 on page 6.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

⁹ States used data and information not available to us to determine whether the remaining fee-for-service claims were paid in error (e.g., beneficiaries were enrolled in waivers or State programs that enabled them to receive specific services covered by managed care plans on a fee-for-service basis and State-approved manual overrides of States’ Medicaid automated payment systems).

► FINDINGS

In the first quarter of FY 2005, Medicaid programs in four of the five States that we reviewed erroneously paid nearly \$864,000 for fee-for-service claims

We identified 16,621 fee-for-service claims totaling \$863,664 for capitated Medicaid managed care covered services in California,

Missouri, New York, and Wisconsin. These claims were identified from nearly 8.5 million fee-for-service claims for services provided to beneficiaries enrolled in capitated Medicaid managed care plans during the first quarter of FY 2005. Medicaid staff from the four States acknowledged that these fee-for-service claims were paid in error because the services were included in the capitated rates paid to the Medicaid managed care plans. We analyzed the erroneously paid claims data to determine trends and/or service categories associated with the payments made in error across the four States; however, errors were not concentrated in any particular service categories (e.g., case management, dental screenings, laboratory services, organ transplants, and substance abuse treatment). A summary of the fee-for-service claims paid in error in each of the four States is provided in Table 2.

Table 2: Medicaid Fee-For Service Paid Claims Paid in Error During the First Quarter of FY 2005

State	Number of Claims	Total Payments	FMAP (percent)	State Share	Federal Share
CA	2,343	\$115,296	50.00	\$57,648	\$57,648
MO	1,657	\$270,409	61.15	\$105,054	\$165,355
NY	12,597	\$476,713	50.00	\$238,357	\$238,357
WI	24	\$1,246	58.32	\$519	\$727
Total	16,621	\$863,664		\$401,578	\$462,087

Source: Office of Inspector General analysis of reimbursed claims, 2007.

California. We identified 2,343 Medicaid claims totaling \$115,296 paid in error for medical supplies that capitated Medicaid managed care plans covered. State Medicaid agency staff acknowledged that these claims were paid in error as a result of issues in their State's Medicaid automated payment system. They reported that they had previously identified 186 of these claims paid in error, had implemented edits to

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prohibit erroneous payments for these services in the future, and were in the process of recouping the erroneous payments.

Missouri. We identified 1,657 Medicaid claims totaling \$270,409 paid in error. Of these claims, 1,573 were for dental services totaling \$267,480. These errors resulted from inappropriate manual overrides of the State's Medicaid automated payment system edit designed to prevent fee-for-service payments for services covered by capitated Medicaid managed care. Additionally, 84 claims totaling \$2,928 were paid for services provided to newborns whose Medicaid eligibility files had not been updated at the time of claims processing. State Medicaid agency staff reported that payments for services to newborns under these circumstances are not unusual and that the State has processes in place to recoup erroneous payments made on behalf of newborns. However, the edits established for detection of inappropriate claims did not reject these 84 claims. As a result of our review, the State Medicaid agency provided formal training to fiscal agent staff regarding payment of claims for dental services and instituted an additional level of review for services provided to newborns.

New York. We identified 12,597 Medicaid claims totaling \$476,713 paid in error. Although State Medicaid agency staff indicated that some of the errors were due to problems with the State's Medicaid automated payment system, they were unable to explain why other claims were paid. Our review found that 3,357 of these claims were for physical and mental health services provided in a clinic or an office and 296 were for dental services. The remaining claims were for a variety of other services. As a result of our review, the State Medicaid agency staff informed us that our evaluation better prepared them to respond to Payment Error Rate Measurement program questions.¹⁰

Wisconsin. We identified 24 Medicaid claims totaling \$1,246 paid in error. State Medicaid agency staff indicated that these claims were paid because the beneficiaries' managed care plan designations had not been updated to the appropriate file in the State's automated Medicaid payment system at the time of claims processing.

¹⁰ Beginning in FY 2007, States were required to conduct eligibility reviews of both Medicaid and State Children's Health Insurance Programs' beneficiaries and report payment error dollar amounts every 3 years.

F I N D I N G S

An additional \$974,006 was potentially paid in error in two States in the first quarter of FY 2005

We identified an additional 23,069 fee-for-service claims totaling \$974,006 that appeared to

be for services covered by capitated Medicaid managed care plans in California and Pennsylvania.¹¹ However, State Medicaid agency staff were unable to confirm whether these fee-for-service claims were paid in error without conducting a detailed, resource-intensive claims-level review. Staff from one State estimated that some claims could take up to 1 hour per claim to review. Further, State staff indicated that a review of these claims could involve researching system edits applied to each claim, identifying any manual overrides of automated payment system edits, reviewing the claims payment history, and tracking payment system processing logic. Without this type of review, neither OIG nor State Medicaid agency staff could determine the reasons fee-for-service claims were paid, or whether these payments were for services covered by capitated Medicaid managed care plans. The number of paid claims and amount of fee-for-service payments made by each State are outlined in Table 3.

Table 3: Medicaid Fee for Service Reimbursed Claims During the 3 month Period (October 1 through December 31, 2004) Requiring Claims-Level Review

State	Number of Claims	Amount Paid	FMAP (percent)	State Share	Federal Share
CA	6,789	\$453,554	50.00	\$226,777	\$226,777
PA	16,280	\$520,452	53.84	\$240,241	\$280,211
Total	23,069	\$974,006		\$467,018	\$506,988

Source: Office of Inspector General analysis of reimbursed claims, 2007.

California. We identified 6,789 Medicaid fee-for-service claims totaling \$453,554 that data indicated were for services covered by capitated Medicaid managed care plans. State Medicaid agency staff indicated that delays in entering Medicaid beneficiaries' managed care enrollment information into eligibility records may have caused the State's Medicaid automated payment system to allow these payments. State

¹¹ Medicaid expenditures reported include both State Medicaid expenditures and Federal financial participation based on the Federal medical assistance percentage for each State.

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Medicaid agency staff also indicated that some of these paid claims may have been for services provided to beneficiaries who moved or traveled outside of managed care plan coverage areas but that a “great deal of manual processing” would be required to definitively determine the reason(s) for the payments.

Pennsylvania. We identified 16,280 Medicaid fee-for-service claims totaling \$520,452 that data indicated were covered by Medicaid managed care. State Medicaid agency staff stated that these paid claims would “require service record/claims-level research to determine claim liability.” Services generally associated with these claims included clinic visits, office visits, and laboratory services. State Medicaid agency staff offered no possible reason(s) for payment of these claims.

► R E C O M M E N D A T I O N S

When State Medicaid programs pay fee-for-service claims for services covered by capitated Medicaid managed care in error, they are essentially paying twice for the same services. We identified approximately \$1.8 million in Medicaid claims paid or potentially paid in error during a single quarter in FY 2005 in five States.

- California staff identified faulty system logic as the reason for some payment errors but were unable to provide the reason(s) for other payments without conducting a resource-intensive claims-level review.
- Missouri staff identified inappropriate manual overrides of a payment system edit as the reason for payment errors.
- New York staff could not determine the reason(s) fee-for-service claims were paid in error.
- Pennsylvania staff could not definitively determine if the claims we identified were paid in error or explain why these payments were made.
- Wisconsin staff identified delays in updating automated payment system files as the reason for the payment errors. Prior OIG studies similarly identified erroneous fee-for-service payments for beneficiaries enrolled in capitated Medicaid managed care.

Because of States' responsibilities to ensure the integrity of the Medicaid program coupled with the vulnerabilities identified in this review, we recommend that CMS:

Work With all States To Reduce the Vulnerability for Fee-for-Service Medicaid Payments for Services Covered by Capitated Medicaid Managed Care Plans

CMS should issue guidance to States addressing Medicaid payment systems' vulnerabilities, identifying erroneous payments, and developing payment systems to prevent payment errors. CMS could accomplish this through:

- disseminating information to State Medicaid agencies regarding the vulnerabilities that we identified (e.g., faulty system logic, edits, and manual overrides);
- encouraging every State to examine existing Medicaid automated payment systems to identify and correct potential errors and determine whether errors are associated with State payment system logic, edits, or manual overrides of system edits; and

R E C O M M E N D A T I O N S

- providing technical assistance and information to State Medicaid agencies regarding the importance of developing payment systems that will enable State Medicaid agency staff and external reviewers to more easily identify and prevent fee-for-service payments for services covered by capitated Medicaid managed care plans.

Take Appropriate Action To Collect Overpayments Associated With Medicaid Claims Paid in Error From States

OIG will forward to CMS the identified erroneous fee-for-service claims information needed to take appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments, CMS agreed with the recommendation contained in the draft report. CMS recognized the importance of ensuring that erroneous payments are eliminated to the fullest extent possible. CMS offered as context the small amount of erroneous claims that we identified and the complexity of the States' Medicaid managed care programs that we reviewed. However, the claims paid in error demonstrate how these complex programs can lead to the vulnerabilities identified. CMS noted in its comments that for many situations cited in the report, States should have been able to control erroneous payments with edits in their payment systems. OIG is now recommending that CMS collect overpayments associated with the claims paid in error from the States.

To address the OIG recommendations, CMS will remind States of the importance of eliminating erroneous payments and recommend that States make any necessary edits to their payment systems at the next Medicaid Managed Care Technical Advisory Group call. Additionally, CMS will work with States to voluntarily collect the overpayments associated with erroneous fee-for-service payments. The full text of CMS's comments can be found in Appendix C.

▶ A P P E N D I X A

Totals by State of Medicaid Managed Care Enrollment and Fee for Service Paid Claims for Medicaid Beneficiaries Enrolled in Capitated Managed Care During the First Quarter of FY 2005

State	California	Missouri	New York	Pennsylvania	Wisconsin
Total Number of fee-for-service (FFS) claims	58,395,029	5,347,527	26,675,253	4,000,981	1,658,891
Number beneficiaries enrolled in Medicaid managed care	3,355,339	469,808	2,606,291	1,248,390	386,037
Percentage of FFS claims associated with beneficiaries enrolled in Medicaid managed care	4.5	5.4	11.1	50.8	36.0
Number of FFS claims for beneficiaries enrolled in Medicaid managed care	2,650,924	290,873	2,957,743	2,030,780	596,502
Number of FFS Medicaid paid claims determined appropriate for beneficiaries enrolled in Medicaid managed care	2,641,792	289,216	2,945,146	2,014,500	596,478
Number of FFS Medicaid claims confirmed paid in error for beneficiaries enrolled in Medicaid managed care	2,343	1,657	12,597	N/A*	24
Medicaid expenditures for FFS Medicaid claims confirmed paid in error for beneficiaries enrolled in Medicaid managed care	\$115,296	\$270,409	\$476,713	N/A*	\$1,246
Number of FFS claims requiring claims-level review	6,789	0	0	16,280	0
Medicaid expenditures for FFS Medicaid claims for which no determination could be made	\$453,554	0	0	\$540,452	0

Source: Office of Inspector General analysis of 2006 Medicaid Managed Care Enrollment Report and reimbursed claims, 2007.

*Pennsylvania Medicaid State Agency Staff were unable to identify claims paid in error without conducting claim-level reviews.

Examples of Services Excluded From Capitated Medicaid Managed Care Coverage in California, Missouri, New York, Pennsylvania, and Wisconsin

The following State summaries provide examples of services generally excluded from capitated Medicaid managed care plans in each of the five States during the review period. We determined that the services excluded often varied among States, by managed care plan, and by beneficiaries' counties of residence.

California

Capitated Medicaid managed care plans in California generally excluded dental services, HIV/AIDS waiver services, alcohol and substance abuse services, and services provided by the Indian Health Service or a Federally Qualified Health Center from plan coverage. Some California managed care plans also excluded other services, such as specialty mental health services, treatment for tuberculosis, major organ transplants, dental screenings, vision, acupuncture, chiropractic care, personal care, case management, education assessments, lead screening, adult day health care, and services provided in a Federal or State hospital.

Missouri

Capitated Medicaid managed care plans in Missouri excluded: physical, speech, and occupational therapy; organ transplants; community psychiatric rehabilitation; comprehensive substance abuse treatment and rehabilitation; targeted case management for mental health; and mental health outpatient care for children in State custody or foster care or receiving adoption assistance.

New York

Capitated Medicaid managed care plans in New York excluded orthodontic services and the majority of mental health and alcohol and substance abuse treatment services. The State does, however, have a prepaid mental health plan that covers a limited range of mental health services.

Pennsylvania

Capitated Medicaid managed care plans in Pennsylvania generally excluded services provided through the Pennsylvania Departments of Education and Mental Retardation, medical foster care or a medical assistance waiver, early intervention services, and lead testing provided by the Pennsylvania Department of Health.

A P P E N D I X B

Wisconsin

Capitated Medicaid managed care plans in Wisconsin generally excluded family planning, prenatal care, school-based services, specific types of case management, audiology, chiropractic services, eyeglasses, hearing aids, hospice, laboratory tests and x rays, pharmaceuticals, ambulance transportation, and prosthetics.

AGENCY COMMENTS



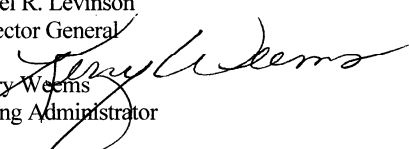
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY 30 2008

TO: Daniel R. Levinson
Inspector General

FROM: 
Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Fee-for-Service Payments for Services Covered by Capitated Medicaid Managed Care" (OEI-07-05-00320)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on the OIG draft report entitled: "Fee-for-Service Payments for Services Covered by Capitated Medicaid Managed Care" (OEI-07-05-00320). The objective of the report was to determine the extent to which Medicaid programs in five States paid noninstitutional fee-for-service (FFS) claims for services provided to beneficiaries enrolled in capitated Medicaid managed care plans during the first quarter of fiscal year (FY) 2005.

The OIG conducted this study in five States: California, Missouri, New York, Pennsylvania, and Wisconsin. These States were selected because they have large, mature, and highly complex Medicaid managed care programs with mandatory enrollment. The OIG identified total Medicaid expenditures of \$103.2 billion for FY 2005 for these five States. The OIG found erroneously paid FFS claims totaling \$864,000 in four of the five States and an additional \$974,000 that could not be verified as correctly paid for services that were provided through prepaid managed care programs. The OIG's findings represent less than 1/100 of 1 percent of the total claims paid during FY 2005.

The CMS recognizes the importance of ensuring that erroneous payments should be eliminated to the fullest extent possible. However, it is important to address these findings within the larger context of all claims paid.

OIG Recommendation

CMS should work with all States to reduce the vulnerability for erroneous fee-for-service Medicaid payments for services covered by capitated Medicaid managed care plans. CMS should issue guidance to States addressing Medicaid payment systems'

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vulnerabilities, identifying erroneous payments, and developing payment systems to prevent payment errors.

CMS Response

We agree that erroneous payments should be eliminated to the fullest extent possible. In many of the situations cited by OIG, States should be able to control this problem with edits in their payment systems.

However, we believe that the duplicate payment problem identified by OIG must be kept in perspective.

- First, based on the data provided by OIG, the amount of erroneous and potentially erroneous claims identified in the five States reviewed represented less than 1/100 of 1 percent of the total claims paid during FY 2005.
- Further, one of the issues that contribute to the possibility of erroneous FFS payments is the complexity of the State's Medicaid managed care program. The States reviewed by OIG have among the most complex programs in the country, with carved-out services, carved-out populations, different programs in different areas of the State, and different options available to beneficiaries.

To address this recommendation, at the next Medicaid Managed Care Technical Advisory Group call scheduled for June 4, 2008, CMS will remind States of the importance of eliminating erroneous payments and recommend that States make any necessary edits to their payment systems.

Further, while OIG did not recommend return of the erroneous FFS payments, CMS will work with States to voluntarily collect these overpayments. States that do not work with CMS to take corrective action will be subject to disallowances for the amounts CMS determines to be in question.

In closing, CMS again appreciates the opportunity to review and comment on this draft report.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

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