



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

Report Number: A-05-02-00079      September 22, 2003

Tom Hayes, Director  
Ohio Department of Job and Family Services  
30 East Broad Street, 32<sup>nd</sup> Floor  
Columbus, Ohio 43215

Dear Mr. Hayes:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicaid Fee-For-Service Payments for Beneficiaries Enrolled in Medicaid Managed Care" for the period July 2000 through June 2001.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me or David Shaner, Senior Auditor at (614) 469-2544. To facilitate identification, please refer to report number A-05-02-00079 in all correspondence.

Sincerely yours,

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures - as stated

**Direct Reply to HHS Action Official:**

Associate Regional Administrator for Medicaid  
Centers for Medicare & Medicaid Services, Region V  
U.S. Department of Health and Human Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601-5519

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICAID FEE-FOR-  
SERVICE PAYMENTS FOR  
BENEFICIARIES ENROLLED IN  
MEDICAID MANAGED CARE**



**September 2003  
A-05-02-00079**

# *Office of Inspector General*

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## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **OBJECTIVE**

Our objective was to determine whether Ohio's Medicaid fee-for-service (FFS) payments were allowable for beneficiaries also enrolled in Medicaid managed care.

### **FINDING**

We developed a computer match of Medicaid FFS claims paid during fiscal year 2001 for beneficiaries who were also enrolled in Medicaid managed care organizations (MCO). The data match identified \$1,030,416 in FFS payments for the managed care enrollees, and we selected transactions totaling \$554,246 for detailed review. We concluded that Ohio made unallowable payments totaling \$34,168 (Federal share \$20,165). Section 447.45(f) of 42 CFR requires States to conduct prepayment claim reviews to verify that a claim does not duplicate or conflict with a previously reviewed claim.

Duplicate coverage of Medicaid beneficiaries under both FFS and MCO programs caused the unallowable payments identified in our review. In April 2000, the Centers for Medicare & Medicaid Services mandated that State Medicaid plans reinstate beneficiaries who had improperly lost their medical coverage when they left various cash assistance programs. Ohio reinstated these beneficiaries to the Medicaid FFS program during the period January through March 2001. The reinstated beneficiaries included individuals who had already re-entered the Medicaid program by enrolling in MCOs. Other reinstated beneficiaries enrolled in managed care during the reinstatement period while their FFS coverage remained active. Claims processing edits meant to prevent duplicate payments were bypassed for the reinstated beneficiaries.

### **RECOMMENDATIONS**

We are recommending that Ohio:

- Refund unallowable payments of \$34,168 (Federal share \$20,165).
- Review the remaining \$476,170 in FFS payments for beneficiaries enrolled in MCOs and refund any additional unallowable payments.
- Improve internal controls to prevent FFS payments for beneficiaries enrolled in managed care and payments to MCOs for beneficiaries enrolled in FFS.

Ohio officials did not concur with our recommendations. We have summarized their comments at the end of this report and included the full text of the comments as Appendix A.

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## INTRODUCTION

### Background

Title XIX of the Social Security Act created the Medicaid program to provide medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965, as a jointly funded cooperative venture between the Federal and State governments, and was intended to assist States in providing adequate medical care to eligible needy persons.

The Ohio Department of Job and Family Services is the single State agency with responsibility for implementation and administration of the Medicaid program. Since 1978, the State agency has incorporated the use of managed care organizations (MCOs) to cover Medicaid beneficiaries in the Covered Families and Children program, which includes Healthy Start and Healthy Families.

As of January 2002, the State agency had seven Medicaid MCOs providing services to 340,348 beneficiaries. This was approximately 37 percent of the statewide enrollment in the Covered Families and Children program. Enrollment in MCOs is classified as mandatory, voluntary, or preferred option, depending upon the county of the beneficiary's residence. Voluntary enrollment counties offer a choice of MCOs or the traditional fee-for-service (FFS) program. In preferred option counties, beneficiaries are automatically enrolled in an MCO, if FFS is not selected.

### OBJECTIVE, SCOPE, AND METHODOLOGY

**Objective.** The objective was to determine whether Ohio Medicaid FFS payments were allowable for beneficiaries enrolled in Medicaid managed care.

**Scope.** Medicaid FFS claims paid in FY 2001 were reviewed to determine whether any of the claims were for beneficiaries enrolled in Medicaid managed care. Our review of internal controls was limited to procedures for preventing payment of FFS claims for beneficiaries enrolled in MCOs.

**Methodology.** State agency staff compiled a list of Medicaid beneficiaries enrolled in MCOs during the period July 1999 through June 2001. Using data from the CMS Medicaid Statistical Information System, we created a file containing all Medicaid FFS claims paid in Ohio during FY 2001. The two files were matched to develop a list of Medicaid FFS payments for beneficiaries enrolled in Medicaid MCOs. We identified 9,136 Medicaid FFS payments, totaling \$1,030,416, for beneficiaries enrolled in Medicaid managed care. The 9,136 charges included 19 for inpatient hospital stays, 29 for long-term care stays, 2,775 for pharmacy services, and 6,313 for other services. We selected 25 beneficiaries to determine why FFS claims were paid for beneficiaries enrolled in MCOs. The 25 judgmentally selected beneficiaries included 16 with inpatient hospital charges and nine with other services. In all, 296 charges, totaling \$554,246, were selected for review. Details are, as follows:

<b>Medicaid FFS Payments for Managed Care Enrollees</b>			
	<b>Number of Charges</b>	<b>Medicaid Charges</b>	<b>Federal Share</b>
<b>FFS Charges Identified for MCO Enrollees</b>	9,136	\$ 1,030,416	\$ 608,060
<b>FFS Charges Selected for Review</b>	296	\$ 554,246	\$ 327,165
<b>Remaining FFS Charges</b>	8,840	\$ 476,170	\$ 280,896

The audit was performed in accordance with generally accepted government auditing standards. Our fieldwork was performed during March through May of 2003 at State agency offices and our field office in Columbus, Ohio.

## **FINDINGS AND RECOMMENDATIONS**

The data match identified \$1,030,416 in FFS payments for the managed care enrollees, of which \$554,246 was selected for review. We concluded that the State agency made unallowable FFS and MCO payments of \$34,168 (Federal share \$20,165).

### **Inappropriate FFS and MCO Payments**

Section 447.45(f) of 42 CFR requires State agencies to conduct prepayment claim reviews to verify that a claim does not duplicate or conflict with a previously reviewed or currently being reviewed claim. The Medicaid claims processing system in Ohio has computerized edits to prevent payment of FFS claims, if a MCO has been paid a monthly premium to provide coverage. However, we found that these edits were bypassed and 155 FFS charges were paid for beneficiaries enrolled in Medicaid managed care. We also found that 47 of the FFS charges were correct, but unallowable payments were made to MCOs for the beneficiaries. Clerical errors had caused them to be mistakenly enrolled into the Medicaid MCOs. The claim processing system does not have computerized edits to prevent inappropriate payment of MCO premiums for beneficiaries enrolled in the FFS program.

From our computer match, identifying 9,136 Medicaid FFS charges paid in FY 2001 for beneficiaries enrolled in MCOs, State agency staff reviewed 296 of the charges and provided additional data to support the following:

- 155 unallowable FFS charges, amounting to \$31,240, for beneficiaries enrolled in MCOs.

- 92 allowable FFS charges for beneficiaries not enrolled in MCOs. We found that monthly payments to the MCOs never occurred or were reversed.
- 47 allowable FFS charges for beneficiaries incorrectly enrolled in MCOs, who received unallowable monthly MCO payments amounting to \$2,928.
- 2 allowable FFS charges for beneficiaries reaching the outlier threshold where the FFS program should cover the beneficiary's services.

The State agency made unallowable FFS and MCO payments of \$34,168 (Federal share \$20,165), as indicated below.

<b>REVIEWED FFS CHARGES/MCO PAYMENTS</b>						
<b>FFS Condition:</b>	<b>FFS Charge</b>		<b>Related MCO Payment</b>	<b>Payments</b>		<b>Unallowable Federal Share</b>
	<b>Dollar</b>	<b>Amount</b>		<b>Allowable</b>	<b>Unallowable</b>	
<b>FFS Charges/ MCO Enrollees</b>	155	\$ 31,240	NA	\$0	\$31,240	\$18,437
<b>FFS Charges/ Non MCO Enrollees</b>	92	\$ 36,924	NA	36,924	0	0
<b>FFS Charges/ Questioned MCO Payments</b>	47	\$ 8,811	2,928	8,811	2,928	1,728
<b>FFS Charges/ Outlier Threshold</b>	2	\$477,271	NA	477,271	0	\$ 0
<b>Totals</b>	<u>296</u>	<u>\$554,246</u>	<u>\$2,928</u>	<u>\$523,006</u>	<u>\$ 34,168</u>	<u>\$ 20,165</u>

In the several years prior to 2000, changes in Federal and State rules reduced the number of families receiving cash assistance. During this period, some families that had qualified for Medicaid based on participation in the cash assistance program lost their medical coverage, despite Federal law guaranteeing their Medicaid eligibility. In April 2000, CMS mandated that State Medicaid plans reinstate beneficiaries who had improperly lost their medical coverage when they left various cash assistance programs.

The State agency reinstated the beneficiaries under the FFS program for the period January through March 2001; however, the reinstated beneficiaries included individuals who had already reentered the program by enrolling in MCOs. Other reinstated beneficiaries enrolled in managed care during the reinstatement period while their FFS coverage was still active. The duplication of coverage that occurred in both cases was the major cause of unallowable FFS payments in our review. We identified 139 FFS charges paid for reinstated beneficiaries enrolled in MCOs. The remaining 16 FFS charges paid for managed care beneficiaries were unrelated to the reinstatement program.

Since monthly MCO payments never occurred or were reversed for 92 of FFS charges and an outlier threshold exception allowed FFS charges for 2 additional items, the other FFS charges reviewed were acceptable.

## **RECOMMENDATIONS**

We are recommending that the State agency:

- Refund unallowable payments totaling \$34,168 (Federal share \$20,165).
- Review the remaining \$476,170 of FFS payments, for beneficiaries who are on record as enrolled in MCOs, and refund any unallowable payments.
- Improve internal controls to prevent FFS payments for beneficiaries enrolled in managed care and payments to MCOs for beneficiaries enrolled in FFS.

## **AUDITEE COMMENTS AND OIG RESPONSE**

Officials from the Ohio Department of Job and Family Services provided written comments regarding the recommendations contained in the draft audit report. We have summarized the comments below and responded to each. The State agency's full comments are attached as Appendix A.

### **State Agency Comment**

The State agency indicated that most of the unallowable claims were paid on behalf of individuals, who were provided Medicaid FFS cards as part of Ohio's compliance with the April 2000 CMS mandate to reinstate individuals losing Medicaid eligibility based on the loss of cash benefits. Given this project was implemented within strict timeframes with minimal federal guidance, State officials believed that these claims should be removed from the refundable amount.

### **OIG Response**

Section 447.45(f) of 42 CFR requires State plans to conduct prepayment claim reviews to verify that a claim does not duplicate or conflict with other claims. We believe that the State agency should refund the full amount of the identified overpayments as recommended in our report.

### **State Agency Comment**

The State agency contends that reviewing the remainder of the identified claims would be resource intensive and not a productive use of time.

**OIG Response**

We believe that it would be a productive use of time for the State agency to review the remaining FFS claims. Our data indicates that more than half of the claims, not yet reviewed, were for services provided during the January 2001 through March 2001 reinstatement period. Furthermore, the expertise of the State agency staff in dealing with Medicaid claim issues will allow it to expedite the review, minimizing the utilization of scarce resources.

**State Agency Comment:**

The State agency contends that it already identified the need for an edit to prevent incorrect inpatient claims and that the edit was in place at the time of your audit.

**OIG Response**

We believe that the referenced edit was turned off or bypassed and, therefore, did not prevent overpayments. We believe that the State agency needs to improve its internal controls by preventing the bypassing of the edits, put in place to stop unallowable payments.

# **APPENDIX**

Bob Taft  
Governor



Tom Hayes  
Director

APPENDIX

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30 East Broad Street • Columbus, Ohio 43215

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July 24, 2003

Paul Swanson  
Regional Inspector General for Audit Services  
Office of Audit Services  
Department of Health and Human Services  
233 North Michigan Avenue  
Chicago, Illinois 60601

Dear Mr. Swanson:

This letter is in response to your June 16, 2003, cover letter and the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services, draft Report Number A-05-02-00079, entitled "Review of Medicaid Fee-For-Service Payments for Beneficiaries Enrolled in Medicaid Managed Care". The review determined, through a computer match developed by your office, that 9136 Medicaid FFS claims totaling \$1,030,416 (state and federal funds) were paid during the fiscal year ending June 30, 2001 (SFY 2001), for beneficiaries enrolled in Medicaid-contracting managed care organizations in Ohio.

Medicaid staff conducted an in-depth review of 296 claims selected by your office; the 296 claims accounted for \$554,246, or 54% of the \$1,030,416 identified.

Based on review of the 296 claims, your office has recommended that the Ohio Medicaid Program:

- Refund unallowable payments of \$34,368 (federal share \$20,165) for the 296 claims reviewed by Ohio, which represented 155 of the 296 claims.
- Review the remaining \$476,170 in FFS payments (8840 claims) for beneficiaries enrolled in MCOs and refund any allowable payments.
- Improve internal controls to prevent inappropriate FFS and MCO capitated payments for beneficiaries enrolled in managed care.

Of the 155 unallowable claims recommended for refund, we determined that a preponderance of claims identified in your report as unallowable were paid on behalf of individuals identified and provided Medicaid FFS cards as part of Ohio's compliance with the April 2000 Centers for Medicare and Medicaid Services mandate to reinstate individuals who lost Medicaid eligibility based on the loss of cash benefits. Given that this project was implemented within strict timeframes but with minimal federal guidance, we recommend removing these claims from the refundable amount. Ohio will refund the federal portion of the remaining allowable claim amount estimated to be \$2457 (state and federal funds).

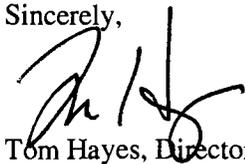
**Paul Swanson**  
**July 24, 2003**  
**Page Two**

In response to the OIG recommendation that Ohio review the remainder of the identified claims, manual review of the remaining \$476,170, accounting for a total 8840 claims would be resource intensive, and, especially in the current budget environment and in light of the outcome of the 296-claim manual review, not a productive use of time for the federal and state dollars involved in completing such a task.

We had already identified the need for an edit to prevent incorrect inpatient claims which was in place at the time of your audit. Ohio will continue to investigate and implement internal controls to prevent unallowable Medicaid payments; the success of our efforts to date is reflected in the findings of your report.

We look forward to your final report. Please do not hesitate to contact Barbara Coulter Edwards at 614.466.4443, to discuss Ohio's response to your findings.

Sincerely,



Tom Hayes, Director

c: Barbara Coulter Edwards, Patricia Martin, Cynthia Burnell  
Dick Starks