Department of Human Services
Division of Medical Assistance and Health Services
Fee-For-Service Payments for Managed Care Beneficiaries

July 1, 2007 to June 30, 2009
The Honorable Jon S. Corzine  
Governor of New Jersey

The Honorable Richard J. Codey  
President of the Senate

The Honorable Joseph J. Roberts, Jr. 
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Fee-For-Service Payments for Managed Care Beneficiaries for the period of July 1, 2007 to June 30, 2009. If you would like a personal briefing, please call me at (609) 292-3700.

Stephen M. Eells  
Assistant State Auditor  
December 31, 2009
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Department of Human Services  
Division of Medical Assistance and Health Services  
Fee-For-Service Payments for Managed Care Beneficiaries

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Fee-for-Service Payments for Managed Care Beneficiaries for the period July 1, 2007 to June 30, 2009. For the fiscal year ended June 30, 2009 New Jersey spent $2.3 billion on managed care for approximately 884,000 beneficiaries. This audit was performed in conjunction with our overall review of the Managed Care program. Several audit reports will be issued on selected topics relating to the Managed Care program.

Objectives

The objective of our audit was to determine whether controls are adequate to prevent inappropriate payment of fee-for-service claims for services provided to beneficiaries enrolled in managed care plans. Our review focused on fee-for-service inpatient hospital and pharmacy claims. We did not include fee-for-service claims for physician, outpatient hospital, transportation, dental, and durable medical equipment services in our review.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our audit, we studied legislation, the State Medicaid Plan, administrative code, the managed care contract, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our analysis of financial
transactions. We also interviewed agency personnel to obtain an understanding of the program and the internal controls. Fee-for-service claims for beneficiaries enrolled in managed care were sorted and analyzed and both judgmentally and randomly selected for testing.

**Background**

The Division of Medical Assistance and Health Services administers the state’s Medicaid and NJ FamilyCare programs, which provide medical assistance to needy or uninsured individuals. Medicaid pays providers by one of two methods: the fee-for-service method, in which a provider is paid for every Medicaid eligible service rendered to the beneficiary; or the capitation method, in which a Managed Care Organization (MCO) receives a monthly payment for each Medicaid beneficiary enrolled in the plan and in return is responsible for ensuring enrollees have access to quality health care and needed medical services. During our audit period there were five MCOs participating in the state’s Managed Care program which is intended to provide quality health care in a cost-effective manner. The division determines the basic package of medical services to be offered. These medical services are detailed in a standard contract with the participating MCOs. Some medical services, such as psychiatric and methadone maintenance, are excluded from the managed care contract and are paid on a fee-for-service basis. In addition, beneficiaries are allowed by federal law to obtain certain services, such as family planning services, outside their MCO’s network. Except in these certain specified circumstances, the division should not pay a fee-for-service claim for a beneficiary at the same time that it pays a capitation premium.

**Conclusions**

We found the division has controls to prevent inappropriate fee-for-service payments for services provided to beneficiaries identified as being enrolled in managed care. However, inappropriate payments may still occur when beneficiaries have multiple active recipient numbers. In addition, we found the division needs to improve its linking of newborns to their mother’s recipient number in
managed care. The division also needs to implement new procedures to ensure managed care enrollment information is updated timely and the managed care coverage is not interrupted. Finally, the division should improve its monitoring of fee-for-service payments for beneficiaries covered by managed care and recover all inappropriate payments.
Managed Care Beneficiaries with Multiple Recipient Numbers

The division's automated claims payment system has edits to identify and prevent fee-for-service payments for services for beneficiaries covered under managed care. Through an intricate multi-staged computerized data match and manual analysis, we identified 505 fee-for-service inpatient hospital claims totaling $4.8 million for the period January 2007 through March 2009 for beneficiaries with managed care enrollment at the date of service. We tested 278 of these claims totaling $4.3 million and found 101 totaling $1.1 million that should have been paid by the Managed Care Organization (MCO). These claims were paid because the beneficiaries had both a fee-for-service and a managed care recipient number open simultaneously. Hospitals may have knowledge of both numbers enabling them to circumvent managed care by billing the fee-for-service number. Included in the 101 claims were the following examples.

- A $231,000 inpatient claim for a liver transplant was inappropriately paid as fee-for-service when the procedure should have been paid by the MCO. The beneficiary had two active identification numbers: one fee-for-service and the other managed care. The hospital was paid by billing the fee-for-service number.

- A beneficiary had two active recipient numbers for one month with one being fee-for-service and the other managed care. A hospital was paid $78,000 using the fee-for-service number when the services should have been paid by the MCO.

County welfare agencies and the state's contracted enrollment broker are responsible for
determining and terminating program eligibility. The county welfare agencies and the broker are not always adequately screening individuals for currently assigned recipient numbers. Often an individual’s eligibility was established under one program and the individual re-entered under another program and a new recipient number was assigned without termination of the previous recipient number. Also, when a newborn’s birth weight is less than 1200 grams (2.6 pounds), the infant may be determined eligible for Supplemental Security Income (SSI), by the Social Security Administration, which results in a new recipient number being issued.

This weakness was noted in our audit report issued August 2, 2001. The division is aware of the multiple numbers and is trying to address the issue. As of April 2009, the division estimated there were 75,000 multiple numbers.

Separate from the data match noted above, we performed additional analysis of high dollar out-of-state inpatient hospital claims and found the following claim for a beneficiary with multiple recipient numbers inappropriately paid as a fee-for-service claim.

An MCO inappropriately denied an inpatient hospital claim for a newborn maintaining the child was not their member when, in fact, the child was enrolled in the MCO at the time of service and covered by the lump sum maternity payment. Despite the MCO claiming that the newborn was not a member, it paid approximately 280 claims totaling $38,000 throughout the newborn’s three month inpatient stay including physician services, radiology, and the cost to transport the newborn to the hospital via helicopter. The hospital resubmitted the denied claim and was paid $658,000 as a fee-for-service claim using the second recipient number. The numbers were not linked in the system due to the misspelling of the beneficiary’s last name on one of the numbers. Had the numbers been linked, the fee-for-service claim would have been denied.
Recommendation

We recommend the division review the Medicaid eligibility file to identify and link or eliminate multiple recipient numbers to prevent improper fee-for-service payments for services that should be the responsibility of a managed care provider. In addition, where appropriate, the division should seek to recoup fee-for-service payments for services that should have been covered under the managed care contract.

Timely Enrollment of Newborns in Managed Care

Un timely enrollment of newborns in managed care can result in inappropriate fee-for-service payments.

The division inappropriately paid fee-for-service hospital payments for infants born to mothers enrolled in managed care. In addition to the monthly capitation, the division pays the Managed Care Organization (MCO) a supplemental payment following a pregnancy outcome. This single lump sum payment reimburses the MCO for its inpatient hospital/birthing center, antepartum (prenatal), and postpartum costs in connection with the delivery. This payment also covers the care of the baby for the first 60 days after the birth plus through the end of the month in which the 60th day occurs. During this post-partum period, the newborn is covered under the mother’s recipient number.

Our review found the division does not have adequate procedures to identify all infants born to beneficiaries enrolled in managed care. We identified $748,000 in fee-for-service payments for hospital services that should have been covered by an MCO. These inappropriate payments occurred because the division could not properly link the newborn to the mother’s recipient number indicating coverage by an MCO. Had the link been properly made, the hospital fee-for-service claim would have been denied by the Medicaid Management Information System.
Our review found that if a county does not update the eligibility file in a timely manner, or if a mother of the newborn does not report the birth to her county welfare agency as required, the child will not be enrolled and will lose coverage under managed care.

In one situation, an MCO received a lump sum maternity payment but the child was not enrolled in managed care until 4½ months after the date of birth because the mother failed to notify the county in a timely manner. This resulted in a $314,000 fee-for-service inpatient claim that should have been the responsibility of the MCO. As a result of our inquiries, the division recovered the $314,000 from the MCO.

**Recommendation**

We recommend the division review the fee-for-service claims relating to maternity and newborn services and recover all overpayments. The division needs to implement new procedures to ensure program eligibility information for newborns is updated timely. These procedures should include hospitals participating in a new process of reporting live births.

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**Procedural Disenrollment from Managed Care**

The division needs to be more conscious of maintaining managed care enrollment in certain situations such as pregnancy. Our review also found that procedural disenrollment from managed care for reasons such as a change in program status, transferring to another Managed Care Organization (MCO), or moving to another county can result in significant fee-for-service claims as noted in the following examples.
- A woman enrolled in managed care for nine months while pregnant had her eligibility and managed care terminated, per regulation, six days prior to giving birth after failing to respond to her annual eligibility redetermination. The newborn was immediately transferred to a hospital for approximately six months resulting in a fee-for-service claim of $1.1 million. After reapplying, both mother and child were re-enrolled in the same MCO less than two months after the birth.

- A child was procedurally disenrolled from managed care after a change in household composition resulted in increased income triggering a change in the child’s program status code. Although the child never lost Medicaid eligibility, her managed care was systematically terminated. Twenty-seven days after being disenrolled from managed care, the child was admitted to a hospital for approximately eight months resulting in a fee-for-service claim of $1.1 million that would have been the responsibility of the MCO had the division and the county maintained continuous managed care coverage during the change. The child was subsequently re-enrolled in a different MCO twelve days after leaving the hospital.

- A beneficiary transferring from one MCO to another can result in a gap in their managed care coverage. A beneficiary requested to switch MCOs the day before giving birth. Her enrollment in her old MCO ended the last day of the month she gave birth and began with her new MCO the first day of the next month. Despite the
original MCO receiving the lump sum maternity payment, the post-partum period was shortened by the switching of MCOs resulting in a $208,000 fee-for-service inpatient claim that should have been the responsibility of her MCO at birth. The process of transferring from one MCO to another should be seamless and not result in a gap in managed care coverage.

- A woman enrolled in an MCO for seven years lost her managed care eligibility for one month because she moved to a different county. The month before the lapse in coverage she gave birth and the MCO received a lump sum payment to cover the newborn during the post-partum period. The lapse in managed care resulted in a $50,000 fee-for-service inpatient claim for the newborn which should have been paid by the MCO. The mother and child were subsequently re-enrolled in the MCO.

**Recommendation**

The division should consider implementing procedures to prevent pregnant women from being procedurally disenrolled from managed care so close to giving birth. In addition, the division should review its procedures to ensure that transferring to another MCO, a change in a beneficiary’s program status code, or moving to another county does not result in an interruption in managed care coverage.
Maternity Claims and Newborn Drug Withdrawal Syndrome

An infant whose mother is enrolled in managed care at the time of the infant’s birth is covered by the mother’s managed care plan. When a baby is born to a mother who is enrolled in managed care, the division makes a supplemental payment to the Managed Care Organization (MCO) to reimburse them for the cost of the newborn’s delivery, inpatient hospital, and post-partum costs. The following contract references pertain to the MCO’s responsibility.

“Coverage of newborn infants shall be the responsibility of the contractor that covered the mother on the date of birth from the date of birth and for a minimum of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the contractor’s responsibility until discharge as well as for any hospital readmissions within forty-eight (48) hours of discharge for the same diagnosis...”

“The contractor shall be responsible for inpatient hospital costs of enrollees with a dual diagnosis (physical plus mental health/substance abuse condition) whose primary diagnosis is not mental health or substance abuse related.”

We found the division manually processed fee-for-service hospital claims for neonatal services provided to newborns covered under the managed care contract. The claims were manually processed by the division by overriding an existing Medicaid Management Information System edit preventing the payment of such claims for beneficiaries covered under managed care. These claims were denied by MCOs because services were provided to a newborn of a substance abuse mother.
In a July 26, 2007 letter to a children's rehabilitation hospital, the division stated that services provided by this hospital for infants diagnosed with newborn drug withdrawal syndrome were to be reimbursed fee-for-service. Some of the MCOs used this letter to deny hospital claims for intensive care services for newborns born to a substance abuse mother. For example, an MCO received the maternity payment from the division in the amount of $9,400 for a birth. The hospital claim shows charges for the delivery and hospitalization of the newborn in a neonatal intensive care unit for 52 days. The MCO paid the hospital $3,000 for only two days of the infant's hospitalization. The hospital submitted the claim to the division. The division made a $101,000 payment to the hospital for the 50 days not covered by the MCO. A review of the diagnosis codes on the claim indicated that the newborn drug withdrawal syndrome diagnosis was neither the primary nor secondary diagnosis on the claim.

By overriding these types of claims, the division increased the risk of MCOs improperly splitting and denying claims for hospital days for newborns in neonatal intensive care units that should be covered by the managed care contract.

**Recommendation**

We recommend the division enforce contractual requirements regarding managed care coverage of newborns born to substance abuse mothers, and should not pay claims that are the financial responsibility of the managed care organizations.
Controls over encounter based supplemental payments could be improved.

Various services are carved out of the monthly capitation to the Managed Care Organizations (MCOs) and reimbursed separately. These services include maternity outcomes, certain blood clotting drugs, HIV/AIDS drugs, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) incentive payments. The MCOs are reimbursed for these services based on approved encounter claims submitted to the division.

MCOs received numerous duplicate payments for these encounters since 2005. The division became aware of duplicate payments for blood clotting drugs in 2006 and requested an audit be performed by the department’s internal auditors. In 2007, the auditors confirmed that a duplicate payment issue existed and also included maternity payments, HIV/AIDS drugs, and EPSDT incentive payments. According to the division, one MCO told the auditors that it had a $2.6 million liability on its books for unearned payments. A June 2008 letter from the MCO to the department indicated that it had previously sought guidance from the division on how to remedy the unearned supplemental payments.

In September 2008 the division’s Encounter Data Monitoring Unit began a reconciliation of the supplemental payments with the encounter claims to determine the scope and cause of the duplicate payments. In July 2009 the division recouped $3.8 million from five MCOs for 6700 duplicate payments during the period January 2005 through December 2008. Most duplicate payments were the result of MCOs voiding and resubmitting encounter claims for various reasons. We found no evidence that MCOs intentionally submitted duplicate claims. The division plans to perform a second reconciliation and recoupment after addressing the following weaknesses in the encounter processing system which contributed to the duplicate payments.
Voided encounter claims were not always processed correctly. MCOs received duplicate supplemental payments after properly voiding and resubmitting an encounter claim; however, the voided claim was not reflected on the payment system. After this processing error was disclosed by our audit, the division identified an additional $1.4 million in supplemental payments that should have been voided since January 2005. The division anticipates recouping these payments. In addition, the division discovered that MCOs may have received maternity payments for encounter claims that were not actual deliveries as well as the possibility that MCOs may not have received payments for some legitimate maternity claims. The net effect of any potential over/underpayments to the MCOs has not been determined by the division at this time.

The division did not have a timely filing rule which allowed MCOs to receive duplicate payments for older services. Prior to July 2009 the division made a supplemental payment to the MCO regardless of the encounter’s date of service. Beginning July 2009 the division, while still accepting all encounter claims, stopped making supplemental payments on claims with service dates older than one year.

Due to the limited two year retention of claims history on the payment system, when an MCO resubmitted an encounter claim with a date of service greater than two years, it failed to deny the claim as a duplicate because the original encounter and payment was archived off the system. As a result, the resubmitted encounter was approved a second time and a duplicate supplemental payment was issued. The timely filing rule should eliminate this problem going forward.

**Recommendations**

The division should continue to monitor encounter based supplemental payments to prevent or detect any overpayments. In addition, the division should continue its efforts to determine the net effect of any potential
The division should revise edits to deny fee-for-service claims for contraceptives that are submitted by pharmacies participating in a managed care plan.

Pharmacy Claims for Contraceptives

Our review of encounter data noted that Managed Care Organizations (MCOs) paid claims totaling $5.4 million for contraceptives from January 2008 through March 2009. Family planning drugs such as contraceptives are covered under the managed care contract. We identified an additional $900,000 in claims paid as fee-for-service for contraceptives for beneficiaries covered under managed care. Most beneficiaries enrolled in managed care obtain care and services from managed care providers affiliated with their plans. A federal statute makes an exception for family planning services and supplies. Beneficiaries have the right to choose any family planning provider regardless of whether the provider is participating in their MCO.

In New Jersey’s managed care contract, family planning services may or may not be covered by the contract depending on whether the provider is in or outside of the MCO’s provider network. The contract allows family planning services and supplies to remain in the fee-for-service program when furnished by a non-participating provider. Our review found that at least 86 percent of the fee-for-service claims for contraceptives should have been paid by the MCO because the pharmacies were participating in all five MCO provider networks. This occurred because the state’s Medicaid Management Information System (MMIS) managed care edit is bypassed for family planning drugs and instead allows these claims to be paid as fee-for-service. Beneficiaries would still be able to retain their freedom of choice even if the division denied these fee-for-service claims and directed the pharmacy to submit the claims to the MCO.
By continuing to allow pharmacy claims for these drugs to be paid as fee-for-service when a beneficiary is covered by managed care, the risk of fraud and abuse is increased. We found 281 pharmacies submitted claims totaling $21,000 where both the MCO and the program were billed for the same prescription. Some of these claims were partially billed and $12,000 in claims appeared to be double billed. These claims will be referred to the Medicaid Inspector General for further review. In addition, we found the division paid 198 fee-for-service claims for prescriptions totaling $10,000 for female contraceptives billed to male beneficiaries.

**Recommendations**

We recommend that the division review MMIS edits and make revisions to prohibit in-plan pharmacies from submitting claims for contraceptives as fee-for-service for beneficiaries that are covered by managed care. These prescriptions should be covered by the MCOs.

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**Inappropriate Managed Care**

**Enrollments of Beneficiaries in Psychiatric Hospitals**

During our review of fee-for-service claims for beneficiaries in managed care, we found twelve beneficiaries in one inpatient psychiatric hospital facility that were enrolled in managed care. Beneficiaries who are institutionalized in an inpatient psychiatric facility are excluded from managed care enrollment. Their enrollment and continued coverage in managed care results in the overpayment of services since their medical care is provided by the psychiatric facility. The managed care contract states the following.

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The division should improve its monitoring over managed care enrollments to ensure beneficiaries hospitalized in a psychiatric facility are precluded from managed care.
"Capitation payments for a full-month of coverage shall be recovered from the contractor (MCO) on a prorated basis when an enrollee is admitted to a nursing facility for long term care services, psychiatric care facility or other institution including incarceration and the individual is disenrolled from the contractor’s plan on the day prior to such admission."

The twelve beneficiaries had capitation payments totaling $144,000 that were improperly paid by the division. In one example, a beneficiary enrolled in the managed care program since July 2001 entered a psychiatric hospital in May 2004. The division has continued to pay capitation premiums for the beneficiary for the last 67 months. Overpayments for this beneficiary totaled $32,000. It was unclear whether the MCO was aware that their member was in a psychiatric hospital.

**Recommendations**

We recommend the division develop an edit in the Medicaid Management Information System to identify capitation payments and concurrent inpatient psychiatric hospital claims for beneficiaries enrolled in managed care. In addition, the division should seek to recover the monthly capitation paid to MCOs for these beneficiaries. The division should develop periodic reports to identify and disenroll beneficiaries from managed care who are institutionalized in an inpatient psychiatric hospital.
December 31, 2009

Thomas M. Meseroll  
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Dear Mr. Meseroll:

This is in response to your letter dated December 11, 2009 to Commissioner Velez concerning the draft audit report titled “Department of Human Services, Division of Medical Assistance and Health Services, Fee-For-Service Payments for Managed Care Beneficiaries”. Your letter provides an opportunity to comment on the draft audit. This response should be considered a partial response. Due to the limited time provided to respond, the numerous cases and issues presented in the report and the demands and constraints on available resources, the Division of Medical Assistance and Health Services (DMAHS) has not yet been able to completely review all the issues and cases included in the draft audit report.

The draft audit report concludes that DMAHS has controls to prevent inappropriate fee-for-service payments for services provided to beneficiaries identified as being enrolled in managed care. However, inappropriate payments may still occur when beneficiaries have multiple, active recipient numbers. In addition, the Division needs to improve its linking of newborns to their mother’s recipient number in managed care. The Division also needs to implement new procedures to ensure managed care enrollment information is updated timely and the managed care coverage is not interrupted. Finally, the Division should improve its monitoring of fee-for-service payments for beneficiaries covered by managed care and recover all inappropriate payments.

As noted by the auditor, DMAHS has controls in place to prevent inappropriate payments for managed care enrollees. Additionally, the Division has procedures to connect multiple recipient numbers. However, the systems used to apply these procedures are not optimal and the procedures cumbersome and are

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constrained by concerns for continued client coverage for critical medical services.

The numerous intake pathways and complexities of program coverage present significant difficulties in restricting client eligibility to a single coverage method in every case. There are several conduits for clients to enter the Medicaid program such as the Social Security Administration, County Welfare Agencies, the contracted enrollment vendor and the Department of Children and Families. Clients often interact with several of these agencies as their circumstances and needs change. Therefore, clients may be enrolled in the program more than once. Slight variations in client demographic information will preclude a systemic connection of the resulting multiple recipient numbers. Also, the Division must be sure of an exact match before a connection can be established. Any errors in the linking process have the potential to deny coverage for necessary medical services to an unrelated individual.

DMAHS has been working to reduce the frequency of multiple recipient numbers and the other issues cited by the auditor. The Division is implementing a sophisticated automated matching process to connect client demographic information. The master client index being developed to support electronic health information will provide simultaneous matching of client information from numerous sources and at various levels. When implemented, this system is expected to connect nearly all related client eligibility records. Additionally, DMAHS is participating in the implementation of a new automated eligibility determination system that will further support the linking of client records. The Consolidated Assistance Support System (CASS) will enhance the eligibility determination process at the County Welfare Agencies and quickly link client data to existing records. DMAHS has also expanded collection of Social Security numbers and implemented automated matches with other agency data such as earnings and tax information which help link client information.

The Division is concerned about the continuity of coverage and managed care enrollment for all clients especially newborns and pregnant women. The Division always notifies clients of pending program terminations before any changes are made. Additionally, cases are reported to the managed care organization for outreach. To support continued enrollment, new streamlined application and redetermination processes are being developed and implemented to reduce the burden on clients. However, the Division's operations are ultimately impacted by applicable State and federal statutes and regulations and available resources. DMAHS is obligated to terminate program coverage for individuals that fail to assist with or support continued eligibility. Obviously, such eligibility terminations result in disenrollment from the managed care organization. This process precludes numerous capitation payments to MCOs for ineligible individuals.
Also, eligibility operational enhancements including connecting duplicate recipient information require extensive manual efforts or significant technological investments.

The insight provided by the auditors related to some fee-for-service payments is appreciated and will be used to implement additional oversight and recovery procedures. It was noted that the Division needs to exercise additional control over managed care network pharmacies and hospitals and their classification of substance abuse or mental health services.

The auditor's findings and recommendations and the Division's responses based on the limited analysis conducted to date are provided below:

Finding:

The Division's automated claims payment system has edits to identify and prevent fee-for-service payments for services for beneficiaries covered under managed care. Through an intricate multi-stepped computerized data match and manual analysis, the auditor identified 505 fee-for-service inpatient hospital claims totaling $4.8 million for the period January 2007 through March 2009 for beneficiaries with managed care enrollment at the date of service. The auditor tested 278 of these claims totaling $4.3 million and found 101 totaling $1.1 million that should have been paid by the Managed Care Organization (MCO). These claims were paid because the beneficiaries had both a fee-for-service and a managed care recipient number open simultaneously. Hospitals may have knowledge of both numbers enabling them to circumvent managed care by billing the fee-for-service number. Included in the 101 claims were the following examples:

- A $231,000 inpatient claim for a liver transplant was inappropriately paid as fee-for-service when the procedure should have been paid by the MCO. The beneficiary had two active identification numbers: one fee-for-service and the other managed care. The hospital was paid by billing the fee-for-service number.

- A beneficiary had two active recipient numbers for one month with one being fee-for-service and the other managed care. A hospital was paid $78,000 using the fee-for-service number when the services should have been paid by the MCO.

County welfare agencies and the state's contracted enrollment broker are responsible for determining and terminating program eligibility. The county welfare agencies and the broker are not always adequately screening individuals
for currently assigned recipient numbers. Often an individual’s eligibility was established under one program and the individual re-entered under another program and a new recipient number was assigned without termination of the previous recipient number. Also, when a newborn’s birth weight is less than 1200 grams (2.6 pounds), the infant may be determined eligible for Supplemental Security Income (SSI), by the Social Security Administration, which results in a new recipient number being issued.

This weakness was noted in our audit report issued August 2, 2001. The Division is aware of the multiple numbers and is trying to address the issue. As of April 2009, the division estimated there were 75,000 multiple numbers.

Separate from the data match noted above, we performed additional analysis of high dollar out-of-state inpatient hospital claims and found the following claim for a beneficiary with multiple recipient numbers inappropriately paid as a fee-for-service claim.

An MCO inappropriately denied an inpatient hospital claim for a newborn maintaining the child was not their member when, in fact, the child was enrolled in the MCO at the time of service and covered by the lump sum maternity payment. Despite the MCO claiming that the newborn was not a member, it paid approximately 280 claims totaling $38,000 throughout the newborn’s three month inpatient stay including physician services, radiology, and the cost to transport the newborn to the hospital via helicopter. The hospital resubmitted the denied claim and was paid $658,000 as a fee-for-service claim using the second recipient number. The numbers were not linked in the system due to the misspelling of the beneficiary’s last name on one of the numbers. Had the numbers been linked, the fee-for-service claim would have been denied.

Recommendation:

The Division should review the Medicaid eligibility file to identify and link or eliminate multiple recipient numbers to prevent improper fee-for-service payments for services that should be the responsibility of a managed care provider. In addition, where appropriate, the Division should seek to recoup fee-for-service payments for services that should have been covered under the managed care contract.

Response:

Based on a preliminary review of the examples contained in the report it appears the auditor’s finding is accurate. In the examples provided, multiple recipient numbers existed for the client. The multiple recipient numbers and the provider’s use of the fee-for-service identification number on the submitted claim thwarted
the Division's controls to prevent fee-for-service payments for clients enrolled in a managed care organization. However, in one example, it appears a disabled client requested and was granted an exemption or disenrollment from managed care prior to hospitalization. Clients with disabilities are permitted to voluntarily enroll or disenroll in managed care coverage at any time. Consequently, the fee-for-service payment in this case may be appropriate. Further research is needed in this and all of the cases cited by the auditor. The Division will review all of the cases and recover any inappropriate payments.

The Division will continue working to prevent the creation of multiple recipient numbers and to link or eliminate multiple recipient numbers. Additionally, the Division will review fee-for-service payments to identify any that should be recovered because they are covered under the managed care contract. However, the complexity and magnitude of the manual effort required to correctly link multiple recipient numbers while maintaining coverage for every eligible client is substantial; this manual process will be vastly improved through the implementation of technology now pending at the Division.

Because of the limitations of the current automated systems and the number of additional staff that would be required to perform the substantial manual intervention currently needed, the Division will give priority to implementing the new automated processing systems that will address the problems caused by duplicate recipient numbers. It should be noted that the technology improvements that will materialize with the master client index and CASS projects are expected to easily prevent the creation of multiple recipient numbers and identify existing multiple recipient numbers for corrective action.

Finding:

The Division inappropriately paid fee-for-service hospital payments for infants born to mothers enrolled in managed care. In addition to the monthly capitation, the Division pays the Managed Care Organization (MCO) a supplemental payment following a pregnancy outcome. This single lump sum payment reimburses the MCO for its inpatient hospital/birthing center, antepartum (prenatal), and postpartum costs in connection with the delivery. This payment also covers the care of the baby for the first 60 days after the birth plus through the end of the month in which the 60th day occurs. During this post-partum period, the newborn is covered under the mother’s recipient number.

The auditor found the Division does not have adequate procedures to identify all infants born to beneficiaries enrolled in managed care. The auditor identified $748,000 in fee-for-service payments for hospital services that should have been covered by an MCO. These inappropriate payments occurred because the
Division could not properly link the newborn to the mother's recipient number indicating coverage by an MCO. Had the link been properly made, the hospital fee-for-service claim would have been denied by the Medicaid Management Information System.

The auditor found that if a county does not update the eligibility file in a timely manner, or if a mother of the newborn does not report the birth to her county welfare agency as required, the child will not be enrolled and will lose coverage under managed care.

In one situation, an MCO received a lump sum maternity payment but the child was not enrolled in managed care until 4½ months after the date of birth because the mother failed to notify the county in a timely manner. This resulted in a $314,000 fee-for-service inpatient claim that should have been the responsibility of the MCO. As a result of our inquiries, the division recovered the $314,000 from the MCO.

Recommendation:

The Division should review the fee-for-service claims relating to maternity and newborn services and recover all overpayments. The Division needs to implement new procedures to ensure program eligibility information for newborns is updated timely. These procedures should include hospitals participating in a new process of reporting live births.

Response:

The Division has reviewed the example provided by the auditor and generally concurs with this recommendation. The continuity of program coverage for eligible newborns including managed care organization enrollment is desirable.

The available information in these cases indicates the Division's controls are compromised when a newborn is enrolled directly through the Social Security Administration (SSA) or a parent fails to timely notify the county welfare agency and apply for Medicaid coverage for the child. In these cases, a fee-for-service recipient number is established to provide coverage for the child. Based on the auditor's finding, it appears hospitals sometime submit fee-for-service claims for newborns covered by a MCO.

The SSA enrollment of low weight newborns is through a computerized data exchange that automatically establishes a fee-for-service recipient number. Since the SSA enrollment is based on a disability classification, this eligibility is exempt from immediate, mandatory managed care enrollment. The separate
SSA recipient number is subject to the linking limitations mentioned previously. This separate or multiple SSA recipient number provides the opportunity for a hospital to bypass the Division's controls and submit a fee-for-service bill and receive payment. These services are the responsibility of the mother's managed care organization that paid the hospital for the care provided to the mother.

Applicable statute and regulation requires a responsible parent or guardian to notify the county or State of the birth of a child or other changes in family composition in order to determine the eligibility of members of the family including newborns. Delays in reporting births create gaps in the eligibility and MCO coverage of the newborn. When a parent later applies for eligibility for the newborn, a fee-for-service Medicaid recipient number is needed to cover services for the child. Since the Division can not retroactively enroll Medicaid clients into managed care, a fee-for-service number is needed for the retroactive eligibility period and until prospective managed care enrollment becomes effective.

The Division is aware of the benefits of coverage continuity for newborns. The Division is working with the Department of Health and Senior Services (DHSS) to collect newborn information from hospitals through a pilot program announced in October 2009. DHSS requires reporting of newborn immunizations by hospitals in New Jersey. The Division is working with DHSS to use this immunization reporting to identify eligible newborns and enroll them in the appropriate MCO. If successful, this approach should alleviate a need for separate hospital reports of births for program coverage.

The Division will review all of the cases cited by the auditor and take corrective action, as needed. The Division will recover any fee-for-service payments found to be the responsibility of the MCO.

Finding:

The Division needs to be more conscious of maintaining managed care enrollment in certain situations such as pregnancy. The auditor's review also found that procedural disenrollment from managed care for reasons such as a change in program status, transferring to another Managed Care Organization (MCO), or moving to another county can result in significant fee-for-service claims as noted in the following examples:

- A woman enrolled in managed care for nine months while pregnant had her eligibility and managed care terminated, per regulation, six days prior to giving birth after failing to respond to her annual eligibility redetermination. The newborn was immediately transferred to a
hospital for approximately six months resulting in a fee-for-service claim of $1.1 million. After reapplying, both mother and child were re-enrolled in the same MCO less than two months after the birth.

- A child was procedurally disenrolled from managed care after a change in household composition resulted in increased income triggering a change in the child's program status code. Although the child never lost Medicaid eligibility, her managed care was systematically terminated. Twenty-seven days after being disenrolled from managed care, the child was admitted to a hospital for approximately eight months resulting in a fee-for-service claim of $1.1 million that would have been the responsibility of the MCO had the Division and the county maintained continuous managed care coverage during the change. The child was subsequently re-enrolled in a different MCO twelve days after leaving the hospital.

- A beneficiary transferring from one MCO to another can result in a gap in their managed care coverage. A beneficiary requested to switch MCOs the day before giving birth. Her enrollment in her old MCO ended the last day of the month she gave birth and began with her new MCO the first day of the next month. Despite the original MCO receiving the lump sum maternity payment, the post-partum period was shortened by the switching of MCOs resulting in a $208,000 fee-for-service inpatient claim that should have been the responsibility of her MCO at birth. The process of transferring from one MCO to another should be seamless and not result in a gap in managed care coverage.

- A woman enrolled in an MCO for seven years lost her managed care eligibility for one month because she moved to a different county. The month before the lapse in coverage she gave birth and the MCO received a lump sum payment to cover the newborn during the post-partum period. The lapse in managed care resulted in a $50,000 fee-for-service inpatient claim for the newborn which should have been paid by the MCO. The mother and child were subsequently reenrolled in the MCO.

**Recommendation:**

The Division should consider implementing procedures to prevent pregnant women from being procedurally disenrolled from managed care so close to giving birth. In addition, the Division should review its procedures to ensure that transferring to another MCO, a change in a beneficiary’s program status code, or
moving to another county does not result in an interruption in managed care coverage.

Response:

The Division is currently reviewing the cases cited by auditor. Though this review is incomplete, the Division agrees that the current program eligibility requirements and MCO enrollment procedures can have undesirable results. The Division works to eliminate or reduce these consequences whenever possible and practical.

While program eligibility may be effective retroactively, managed care enrollment is established for prospective periods only. Since MCOs would not have any opportunity to manage the care provided or service costs, DMAHS can not perform retroactive MCO enrollments. Consequently, the Division can only provide fee-for-service coverage for any retroactive Medicaid eligibility periods.

The Division is constrained by a cut off date for the prospective enrollment of clients in MCOs. Due to data processing, notifications and payment requirements, the Division compiles MCO enrollment rosters approximately ten days before the start of an enrollment month. Clients added to the program after the processing cut off date must wait one month for MCO enrollment. Some of these clients will qualify for fee-for-service coverage in the meantime. This process also impacts clients that have allowed eligibility and MCO enrollment to temporarily lapse.

The Division is required to adhere to specific program eligibility requirements including periodic redeterminations. The failure of a client to assist with the redetermination process will result in the termination of program eligibility. Managed care enrollment is subordinate to program eligibility and is discontinued when eligibility is terminated. The cited case of a pregnant women terminated prior to delivery reflects an unfortunate example. The termination of Medicaid coverage for this client was secondary to the termination of cash assistance benefits when this client failed to cooperate with the redetermination process. The Medicaid eligibility determination process considers a failure to participate in a redetermination for cash assistance as a strong indication of a lack of continued program eligibility. The eligibility agency had no information indicating the client's continued eligibility or pregnancy and performed as expected. The client subsequently applied again for program eligibility which was granted with retro active Medicaid fee-for-service coverage and prospective managed care enrollment. In the absence of additional client cooperation in this case, it does not appear DMAHS had any practical opportunity to prevent the results found by the auditor.
Program eligibility and enrollment dates are dictated by the results of a formal eligibility determination. For example, eligibility may depend on the verification of household income. Additionally, family income can govern coverage limits, family contributions and whether coverage is available immediately through fee-for-service or is delayed pending MCO enrollment. The example of the child that moved to a new household illustrates the intricacies of this process. When the agency was notified the child left their current household, eligibility and MCO enrollment could not be maintained beyond the end of that month. Meanwhile, a new eligibility determination was dependent on the extensive verification of income and the other aspects of the new household. This verification was concluded after the next MCO enrollment cut off date. Unfortunately, the child was hospitalized during the intervening time when fee-for-service was the only available coverage. Because of the current eligibility requirements and extensive verification process it does not appear there was any available means to continue managed care enrollment for this client.

The Division is working to develop and implement procedures and automated systems that will expedite the eligibility process. These new processes are intended to quickly access relevant information from available data sources such as current income from the Departments of Labor and Taxation. The enhanced process should support the continuation of managed care enrollment cases like the one mentioned through an expedited eligibility determination process.

Another example cited by the auditor appears to be a case where managed care enrollment changes were enacted during the first sixty days after a birth. It seems these changes contributed to confusion about the responsibility of the MCO to cover the care provided to the newborn. This confusion, the existence of multiple recipient numbers, and the service provider’s actions circumvented the Division’s controls. The Division will review these cases to determine the appropriate coverage for the child and take corrective action as needed.

Finding:

An infant whose mother is enrolled in managed care at the time of the infant’s birth is covered by the mother’s managed care plan. When a baby is born to a mother who is enrolled in managed care, the Division makes a supplemental payment to the Managed Care Organization (MCO) to reimburse them for the cost of the newborn’s delivery, inpatient hospital, and post-partum costs. The following contract references pertain to the MCO’s responsibility.

“Coverage of newborn infants shall be the responsibility of the contractor that covered the mother on the date of birth from the date of birth and for a minimum
of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the contractor’s responsibility until discharge as well as for any hospital readmissions within forty-eight (48) hours of discharge for the same diagnosis…”

“The contractor shall be responsible for inpatient hospital costs of enrollees with a dual diagnosis (physical plus mental health/substance abuse condition) whose primary diagnosis is not mental health or substance abuse related.”

We found the Division manually processed fee-for-service hospital claims for neonatal services provided to newborns covered under the managed care contract. The claims were manually processed by the Division by overriding an existing Medicaid Management Information System edit preventing the payment of such claims for beneficiaries covered under managed care. These claims were denied by MCOs because services were provided to a newborn of a substance abuse mother.

In a July 26, 2007 letter to a children’s rehabilitation hospital, the Division stated that services provided by this hospital for infants diagnosed with newborn drug withdrawal syndrome were to be reimbursed fee-for-service. Some of the MCOs used this letter to deny hospital claims for intensive care services for newborns born to a substance abuse mother. For example, an MCO received the maternity payment from the Division in the amount of $9,400 for a birth. The hospital claim shows charges for the delivery and hospitalization of the newborn in a neonatal intensive care unit for 52 days. The MCO paid the hospital $3,000 for only two days of the infant’s hospitalization. The hospital submitted the claim to the Division. The Division made a $101,000 payment to the hospital for the 50 days not covered by the MCO. A review of the diagnosis codes on the claim indicated that the newborn drug withdrawal syndrome diagnosis was neither the primary nor secondary diagnosis on the claim.

By overriding these types of claims, the Division increased the risk of MCOs improperly splitting and denying claims for hospital days for newborns in neonatal intensive care units that should be covered by the managed care contract.

Recommendation:

The auditor recommends the Division enforce contractual requirements regarding managed care coverage of newborns born to substance abuse mothers, and should not pay claims that are the financial responsibility of the managed care organizations.
Response:

The Division concurs with the auditor’s recommendation and has implemented corrective action to preclude any further payments for these services. The Division previously determined that the unique services provided by a specialized hospital for newborn drug withdrawal syndrome represented substance abuse related treatment. Substance abuse related treatment is not covered by managed care and these services were reimbursed fee-for-service. More recent information indicates treatment for newborn drug withdrawal syndrome should not be considered substance abuse treatment and should be covered by the managed care organizations. Therefore, the Division will not pay fee-for-service for this treatment.

Finding:

Various services are carved out of the monthly capitation to the Managed Care Organizations (MCOs) and reimbursed separately. These services include maternity outcomes, certain blood clotting drugs, HIV/AIDS drugs, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) incentive payments. The MCOs are reimbursed for these services based on approved encounter claims submitted to the Division.

MCOs received numerous duplicate payments for these encounters since 2005. The Division became aware of duplicate payments for blood clotting drugs in 2006 and requested an audit be performed by the Department’s internal auditors. In 2007, the auditors confirmed that a duplicate payment issue existed and also included maternity payments, HIV/AIDS drugs, and EPSDT incentive payments. According to the Division, one MCO told the auditors that it had a $2.6 million liability on its books for unearned payments. A June 2008 letter from the MCO to the Department indicated that it had previously sought guidance from the Division on how to remedy the unearned supplemental payments.

In September 2008 the Division’s Encounter Data Monitoring Unit began a reconciliation of the supplemental payments with the encounter claims to determine the scope and cause of the duplicate payments. In July 2009 the Division recouped $3.8 million from five MCOs for 6700 duplicate payments during the period January 2005 through December 2008. Most duplicate payments were the result of MCOs voiding and resubmitting encounter claims for various reasons. The auditor found no evidence that MCOs intentionally submitted duplicate claims. The Division plans to perform a second reconciliation and recoupment after addressing the following weaknesses in the encounter processing system which contributed to the duplicate payments.
Voided encounter claims were not always processed correctly. MCOs received duplicate supplemental payments after properly voiding and resubmitting an encounter claim; however, the voided claim was not reflected on the payment system. After this processing error was disclosed by the audit, the Division identified an additional $1.4 million in supplemental payments that should have been voided since January 2005. The Division anticipates recouping these payments. In addition, the Division discovered that MCOs may have received maternity payments for encounter claims that were not actual deliveries as well as the possibility that MCOs may not have received payments for some legitimate maternity claims. The net effect of any potential over/underpayments to the MCOs has not been determined by the Division at this time.

The Division did not have a timely filing rule which allowed MCOs to receive duplicate payments for older services. Prior to July 2009 the Division made a supplemental payment to the MCO regardless of the encounter's date of service. Beginning July 2009 the Division, while still accepting all encounter claims, stopped making supplemental payments on claims with service dates older than one year.

Due to the limited two year retention of claims history on the payment system, when an MCO resubmitted an encounter claim with a date of service greater than two years, it failed to deny the claim as a duplicate because the original encounter and payment was archived off the system. As a result, the resubmitted encounter was approved a second time and a duplicate supplemental payment was issued. The timely filing rule should eliminate this problem going forward.

**Recommendation:**

The Division should continue to monitor encounter based supplemental payments to prevent or detect any overpayments. In addition, the Division should continue its efforts to determine the net effect of any potential over/underpayments to the MCOs related to encounter based supplemental payments and recoup any overpayments.

**Response:**

The Division’s process to correct the encounter based supplemental payments is continuing. The Division has provided data files for MCO review related to potential overpayments for voided encounter records and potential underpayments for maternity and other services. The Division expects to receive MCO data and complete the final reconciliation and recoupment mentioned in the report during the first three months of 2010.
Finding:

The review of encounter data noted that Managed Care Organizations (MCOs) paid claims totaling $5.4 million for contraceptives from January 2008 through March 2009. Family planning drugs such as contraceptives are covered under the managed care contract. The auditor identified an additional $900,000 in claims paid as fee-for-service for contraceptives for beneficiaries covered under managed care. Most beneficiaries enrolled in managed care obtain care and services from managed care providers affiliated with their plans. A federal statute makes an exception for family planning services and supplies. Beneficiaries have the right to choose any family planning provider regardless of whether the provider is participating in their MCO.

In New Jersey’s managed care contract, family planning services may or may not be covered by the contract depending on whether the provider is in or outside of the MCO’s provider network. The contract allows family planning services and supplies to remain in the fee-for-service program when furnished by a non-participating provider. The review found that at least 86 percent of the fee-for-service claims for contraceptives should have been paid by the MCO because the pharmacies were participating in all five MCO provider networks. This occurred because the state’s Medicaid Management Information System (MMIS) managed care edit is bypassed for family planning drugs and instead allows these claims to be paid as fee-for-service. Beneficiaries would still be able to retain their freedom of choice even if the Division denied these fee-for-service claims and directed the pharmacy to submit the claims to the MCO.

By continuing to allow pharmacy claims for these drugs to be paid as fee-for-service when a beneficiary is covered by managed care, the risk of fraud and abuse is increased. We found 281 pharmacies submitted claims totaling $21,000 where both the MCO and the program were billed for the same prescription. Some of these claims were partially billed and $12,000 in claims appeared to be double billed. These claims will be referred to the Medicaid Inspector General for further review. In addition, we found the division paid 198 fee-for-service claims for prescriptions totaling $10,000 for female contraceptives prescribed to male beneficiaries.
Recommendation:

The auditor recommends that the division review MMIS edits and make revisions to prohibit in-plan pharmacies from submitting claims for contraceptives as fee-for-service for beneficiaries that are covered by managed care. These prescriptions should be covered by the MCOs.

Response:

The Division will work to develop and implement a MMIS edit to prohibit fee-for-service payments to MCO network pharmacies for enrolled clients. The Division will review previous payments for this service and recover inappropriate payments to MCO network pharmacies. Also, the Division will assist the Office of the Medicaid Inspector General with any review they perform.

A limited review of the cited claims reflecting payments for female contraceptives prescribed to male beneficiaries indicates the drugs were not provided to male clients. Based on the name and other data on the submitted pharmacy claim the services were provided to a female relative of a male client. However, the claim from the pharmacy listed the recipient number for the male client. The twelve digit recipient numbers for various family members are identical except for the last two digits. The MMIS noted the difference between the name and number on these claims and advised the pharmacy of the discrepancy.

The Division has an MMIS edit to prevent inappropriate payments based on a client’s sex including pharmaceutical services. For prescriptions, the edit is supported by data provided from a nationally recognized organization that advises which drugs are appropriate for either or both sexes. Based on their advice, it appears these drugs have appropriate uses for both sexes.

Finding:

During the review of fee-for-service claims for beneficiaries in managed care, the auditor found twelve beneficiaries in one inpatient psychiatric hospital facility that were enrolled in managed care. Beneficiaries who are institutionalized in an inpatient psychiatric facility are excluded from managed care enrollment. Their enrollment and continued coverage in managed care results in the overpayment of services since their medical care is provided by the psychiatric facility. The managed care contract states the following.

*Capitation payments for a full-month of coverage shall be recovered from the contractor (MCO) on a prorated basis when an enrollee is admitted to a nursing facility for long term care services, psychiatric care facility or other institution*
including incarceration and the individual is disenrolled from the contractor’s plan on the day prior to such admission.

The twelve beneficiaries had capitation payments totaling $144,000 that were improperly paid by the Division. In one example, a beneficiary enrolled in the managed care program since July 2001 entered a psychiatric hospital in May 2004. The Division has continued to pay capitation premiums for the beneficiary for the last 67 months. Overpayments for this beneficiary totaled $32,000. It was unclear whether the MCO was aware that their member was in a psychiatric hospital.

Recommendation:

The auditor recommends the Division develop an edit in the Medicaid Management Information System to identify capitation payments and concurrent inpatient psychiatric hospital claims for beneficiaries enrolled in managed care. In addition, the Division should seek to recover the monthly capitation paid to MCOs for these beneficiaries. The division should develop periodic reports to identify and disenroll beneficiaries from managed care who are institutionalized in an inpatient psychiatric hospital.

Response:

The Division maintains edits to identify capitation and concurrent institutional claims. However, this edit is based on the classification of the provider and/or the type of service provided. Nursing facilities or inpatient psychiatric hospitals are distinct institutional provider types that prompt a payment edit for managed care clients. Specifically, the institutional provider will not be paid when a capitation payment has been made for the same period. The patient must be disenrolled from the MCO to allow a payment to the institutional provider.

Mental health services are not included in the managed care contract and are paid fee-for-service by DMAHS. Short term, episodic mental health services are sometimes provided by acute care hospitals. Therefore, the system edit mentioned above is not applied to claims from acute care hospitals.

The preliminary review by DMAHS indicates this finding relates to a single, unique hospital. This hospital participates in the Medicaid program through various provider types. It operates an acute care hospital including a short term specialty unit and a long term psychiatric facility at the same location. Claims submitted by the long term care psychiatric hospital will prompt the edit mentioned previously. It appears the hospital submitted acute care hospital claims for mental health services for these cases. Since the Division expects
mental health services provided by acute care hospitals to be short term and episodic, the automated payment system treats these as an exclusion from managed care and provides a fee-for-service payment. The Division will thoroughly review the cases provided by the auditor to determine the appropriate corrective actions. Any inappropriate payments identified by the Division will be recovered.

The opportunity to review and comment on this draft audit report is greatly appreciated. Unfortunately, the extensive effort required and limited time provided indicates that extensive follow-up and subsequent comments are likely. If you have any questions or require additional information, please contact me or David Lowenthal at 609-588-7933.

Sincerely,

Valerie Harr, Acting Director
John R. Guhl
Director

JRG: L

C: Jennifer Velez
David Lowenthal