PERFORMANCE AUDIT

OVERSIGHT CONTROLS AND MANAGEMENT IN THE STATE'S MANAGED CARE PROGRAM

From The Office Of State Auditor
Claire McCaskill

The Division of Medical Services needs to implement controls and procedures to improve management of the managed care program

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Office of
Missouri State Auditor
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YELLOW SHEET

Inadequate monitoring of the state's managed care program has caused potentially unnecessary program costs and results in limited assurance program costs truly reflect the healthcare services provided

This audit reviewed the Division of Medical Services' management and oversight of the state's managed care program with initial emphasis on dental services. In January 2003, the program had nearly 413,000 recipients enrolled and comprised mostly low-income families, pregnant women, children and uninsured parents. Overall managed program costs have nearly doubled since June 1999, to approximately $700 million (state and federal money) and enrollment has increased 50 percent. The following highlights the findings:

Managed care program dentists were underpaid for procedures

Dentists statewide received less than the Medicaid rate on more than 20,000 dental procedures, totaling $84,000 in underpayments, during fiscal year 2002's first quarter. Auditors also found several dentists received more than the Medicaid rate for certain procedures. For example, while some dentists received Medicaid's rate of $34 for pulling a tooth, others dentists received from $6 to $126 for the same procedure. The inconsistent compensation occurred due to special pay arrangements and the type of reimbursement methods used. Division officials improved payment non-compliance by January 2003, which occurred during our review and following public complaints, but some underpayments continued due to reimbursement methods. (See page 5)

Incomplete claims data leaves state unable to measure overall healthcare costs

Division officials did not place a high priority on complete and accurate encounter claim data, leaving state officials unable to measure the true cost of providing healthcare services. Federal Medicare and Medicaid officials state accurate claims data is critical to evaluating program use, provider performance, program access and quality of care. Limited audit tests identified numerous duplicate encounter claim records and showed about 10 percent of the sampled pharmacy claims had no associated medical claim recorded on the state computer systems. Other states have implemented procedures that assure all claims data is at least 90 percent accurate and consider it a critical tool to monitor the program. (See page 8)

Recipient eligibility inadequately evaluated

Ineligible and potentially ineligible recipients remain in the program. Audit tests showed more than $1.5 million in capitation payments during fiscal year 2002 went for 990 managed care recipients without social security numbers in the state's computer system. Federal rules require Medicaid recipients to provide their social security numbers to the

state to be eligible for benefits or maintain eligibility. In addition, capitation payments were made for recipients with out-of-state addresses and invalid social security numbers. Officials took necessary action on the out-of-state address and invalid social security number recipients we reported to them. (See page 10)

Limited fraud detection work leaves program vulnerable to higher costs

The division does not perform fraud detection activities in the managed care program despite a federal Medicaid rule requirement to do so. Division officials said lack of resources and unreliable encounter claim data limit their fraud detection work. Federal officials said without fraud monitoring, division officials cannot be sure payments reflect true service costs, and could result in higher costs to the state. (See page 11)

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TABLE OF CONTENTS

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Honorable Bob Holden, Governor
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Approximately 400,000 children and adults were enrolled in the state's managed care program in fiscal year 2002. Program costs have grown by 83 percent, to nearly $700 million (state and federal share), along with a nearly 50 percent increase in enrollment, since fiscal year 1999. To determine the extent to which the Division of Medical Services (division) is effectively administering the managed care program, we initially focused on dental services provided to these recipients. We also reviewed other controls and procedures to determine whether, overall, division officials provided effective management and oversight of the program.

We found division officials did not adequately monitor contracted managed care health plans and did not obtain complete and accurate data on services provided to recipients. In addition, the department did not ensure recipients remained eligible resulting in potentially unnecessary program costs. These situations occurred because division officials placed less emphasis on procedures to adequately monitor the managed care program, but focused efforts on the Medicaid fee-for-service program. As a result, there is limited assurance managed care program costs truly reflect the healthcare services provided. We make recommendations to improve these weaknesses.

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We conducted our work in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such tests of the procedures and records as were considered appropriate under the circumstances.

Claire C. McCaskill
State Auditor

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RESULTS AND RECOMMENDATIONS

Management and Oversight of the Managed Care Program Needs Improvement

The Division of Medical Services[1] (division) did not ensure dental procedures with mandated codes were paid at least the Medicaid rate when funding was appropriated for this purpose. This situation occurred because the division did not adequately monitor operations of the health plans providing healthcare benefits to recipients in the managed care program. Overall, oversight of the managed care program was weak. Concerns identified include officials not placing a high priority on complete and accurate encounter claim data, and not effectively monitoring costs and identifying ineligible recipients or potential fraud. As a result, the state does not know if total managed care program costs are a true measure of providing healthcare services. In addition, ineligible and potentially ineligible recipients remain in the program.

Background

Low-income families, pregnant women, children, and uninsured parents in 37 counties and the city of St. Louis receive medical assistance through a managed care delivery system. The delivery method was first used by the state in 1995. Managed care recipients include Medicaid eligible children up to age 21, uninsured parents and caregivers with family incomes up to 185[2] percent of federal poverty level, and children under age 19 not Medicaid eligible with family incomes up to 300[3] percent of the federal poverty level.[4] Healthcare benefits to the elderly and disabled, as well as recipients in counties not part of the managed care delivery system, are covered under the fee-for-service program. In January 2003, the managed care program had approximately 413,000 recipients enrolled.

Federal regulations require states participating in the Medicaid program to provide healthcare services to Medicaid eligible individuals at no cost to the family. Although federal regulations do not require states to provide healthcare benefits to individuals not eligible for Medicaid, Missouri began providing benefits to children without health insurance in 1998 by creating the State Children's Health Insurance Program. These children receive medical assistance, but their families may have to pay health insurance premiums and co-payments, depending on family size and income levels.[5] In January 2003, approximately 46,000 of 81,000 children enrolled in this insurance program received services through managed care. State Children's Health Insurance Program children represent about 11 percent of total managed care program enrollment.

Under managed care, recipients select a health plan and a primary care provider within the plan to access healthcare services. The state pays the health plans a per person amount each month to cover all health and dental benefits (capitation payment); as such, the state is not at risk for healthcare costs beyond the monthly capitation payment, which is paid even if recipients do not

[1] Part of the Department of Social Services.
[2] Annual income of $34,044 for a family of four.
[3] Annual income of $55,200 for a family of four.
[4] For more information on program categories and income levels see the division's website at http://www.dss.mo.gov/pr_health.htm.
[5] See Appendix II, page 20, for eligibility requirements for the State Children's Health Insurance Program.

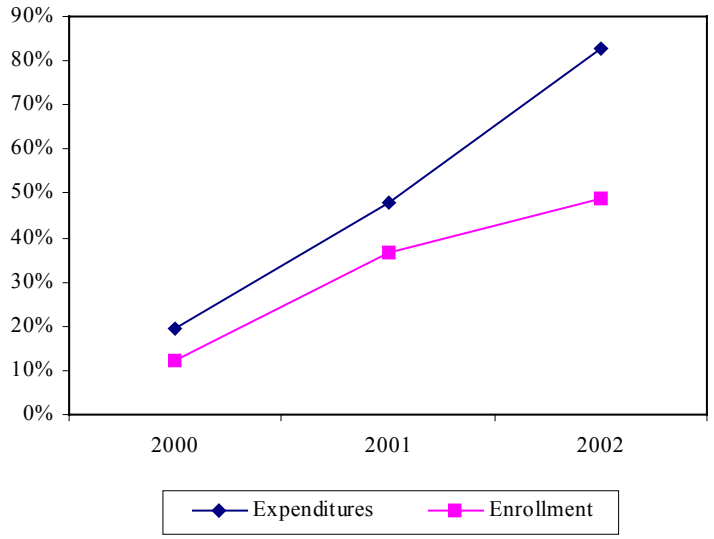
receive services. Health plans must ensure each enrollee has access to a comprehensive benefits package and 24-hour access to necessary covered services. The health plans contract with doctors, hospitals, pharmacies and other providers, but usually not dentists. Instead, the plans often contract with dental networks and pay the dental networks a monthly capitation payment for dental services. Like the state, the health plans are not at risk for dental costs beyond the monthly capitation payment to the dental networks. Dental networks then contract with individual dentists and dental groups for services. The health plans and the dental networks pay providers and must submit records of services provided, called encounter claim data, to the division monthly.

During fiscal year 2002, the division contracted with nine health plans to provide health and dental benefits to managed care recipients in the three state regions where managed care is offered. An actuarial firm contracted by the state determined the capitation amounts paid to the health plans. The capitation rates, which varied by the age and gender of the managed care recipients, were not broken out by the various covered services (dental, medical, etc.). Eight of the health plans contracted with dental networks to provide dental services to managed care recipients and paid the dental networks a negotiated capitation fee monthly. The dental networks then contracted with dentists and dental providers to provide services. One health plan in the eastern region contracted directly with dentists. Non-participating dentists were compensated at negotiated rates, which were their usual and customary charges, a percent of their usual and customary charges, or another amount. Examples of non-participating dentists include orthodontists, endodontists, oral surgeons or general dentists. Participating dentists were compensated under the global budget reimbursement method, which was used by each of the three dental networks that contracted with the health plans.[6]

Managed care program costs have nearly doubled since June 1999. The program costs have grown 83 percent, to approximately $700 million (state and federal share),[7] while enrollment has increased nearly 50 percent, to more than 400,000 recipients in fiscal year 2002. Figure 1 illustrates the growth of the managed care program for the last three years since fiscal year 1999.[8]

[6] See Appendix III, page 21, for an explanation of the global budget reimbursement method.
[7] Medicaid and State Children's Insurance Program costs are approximately 61 and 72 percent, respectively paid from federal funding. All dollar amounts presented in this report represent both the state and federal share.
[8] See Appendix IV, page 22, for additional information on managed care costs and enrollment.

Figure 1: Managed Care Cost and Enrollment Growth



Source: Prepared by SAO based on data provided by the division.

Methodology

We obtained health plan payment records to determine if dentists were paid Medicaid rates for procedures with mandated codes.[9] We analyzed this financial data and identified the number of dental procedures paid under the Medicaid rate, total payments to dentists, and administrative costs charged by the dental networks.

We obtained recipient enrollment and encounter claim records for fiscal year 2002 from the division to determine whether division officials provided effective oversight and management of the managed care program. We conducted testing on inpatient hospital and pharmacy encounter claims. We also conducted a limited review of managed care recipients who had no encounter claim records on the state's computer systems during the fiscal year.[10]

Better management controls needed to monitor payments to dentists

Statewide, 21 percent of dental procedures with mandated codes were paid less than the Medicaid rate during the first quarter of 2002, with underpayments to dentists totaling approximately $84,000. Table 1 shows more than half of all mandated code procedures occurred in the eastern region, which also had the most underpaid procedures and the largest underpayment amount.

[9] Dental procedures with mandated codes required reimbursement at the Medicaid rate, effective January 1, 2002.
[10] See Appendix I, page 18, for additional information on methodology.

Table 1: Procedures with Mandated Codes Paid Less Than the Medicaid Rate

Region	Number of Providers Underpaid	Number of Procedures Underpaid	Total Procedures Performed	Percent of Procedures Underpaid	Amount Underpaid
Eastern	73	17,092	58,810	29	$68,805
Central	14	121	10,987	1	657
Western	67	3,070	25,235	12	14,443
Total	154	20,283	95,032	21	$83,905

Source: Prepared by SAO based on data provided by the health plans.

The providers in Table 1 received less than the Medicaid rate for 20,283 procedures with mandated codes during the first quarter of 2002. The underpayments occurred because the division did not monitor mandated rate compliance. In some cases, however, dentists received more than the Medicaid rate for the same procedure. As a result, even though dentists were underpaid for more than 20,000 procedures, they received about $614,000 more than if they were paid the Medicaid rate for every mandated code procedures. For instance, pulling a single tooth was underpaid in the eastern region 51 percent of the time during January 2002. The Medicaid rate for this procedure is $34, but some dentists received as much as $126, while others received less than $6. The inconsistency in compensation for the same procedure occurred because of contracts with special payment arrangements for non-participating dentists and the effects of the global budget reimbursement method for participating dentists. The global budget reimbursement method bases compensation for dental procedures on a ratio of money available to pay dentists (after administrative charges and special payment arrangements) and the assigned value of procedures performed during a month.[11]

In January 2002 the division amended contracts with the health plans to increase capitation payments. The appropriation for the increased funding required the increase be passed onto dentists through reimbursement at the Medicaid rate for mandated code procedures. During March 2002, in response to public complaints, the division began investigating one eastern region dental network for underpayments, and eligibility and access issues. However, the division's investigation did not include potential underpayments by the other dental networks. In April 2002, the division notified health plans the dental network in the eastern region was not paying Medicaid rates for these procedures and should immediately adjust fee schedules. By November 2002, all three dental networks had adjusted their fee schedules following division notification. The division issued its final investigative report on the eastern region dental network in January 2003, stating health plans provided "minimal oversight" and "failed to adequately monitor the subcontractor's performance."

January 2003 payment records disclosed 11 percent of the eastern region's mandated code procedures were still paid at less than the Medicaid rate, while less than 2 percent of mandated code procedures in the central and west regions were paid at less than the Medicaid rate. Two factors caused these underpayments. Two networks continued to pay providers for these procedures using the global budget reimbursement method, accounting for 28 percent of all underpayments. Approximately 72 percent of the underpayments were due to dentists contracting to receive an amount lower than the Medicaid rate. One dental network, the one

[11] See Appendix III, page 21, for further explanation of the global budget reimbursement method.

investigated in 2002 by the division, paid dentists the Medicaid rate for mandated code procedures in January 2003. Representatives from the two networks with underpayments told us division notifications requiring fee schedule adjustments did not clearly state dentists had to be paid the Medicaid rate. They said payment under the global budget reimbursement method is based on total dollars in the global budget, not a network's fee schedule. In April 2003, division officials told us they have no comment on the dental networks' reason for not paying Medicaid rates.

The Missouri Commission for Oral Health Access[12] reports low reimbursement is the remaining barrier keeping Missouri dentists from Medicaid program participation. Current reimbursement offers dentists only about half the amounts normally charged. The report recommends reimbursing dentists at 75 percent of usual and customary charges.

Dental program costs not clearly identified

The actuarially determined capitation rates did not break down the component costs for services (dental, medical, etc.) provided. As a result, division officials did not know how much of the monthly capitation payment covered dental services or how much health plans retained for dental-related administrative fees. The health plans and dental networks both retained an administrative fee from state capitation payments.[13] In fiscal year 2002, dental networks retained administrative fees of approximately 78 cents per person per month, totaling nearly $3 million.

Health plan records showed dental networks received approximately $17.8 million in fiscal year 2002. Of this amount, dental networks retained administrative fees of approximately 16 percent in the eastern region, 17 percent in the western region, and 22 percent in the central region. The networks paid approximately 85 percent to dentists in the eastern region, 87 percent in the western region and 76 percent in the central region for dental services.[14] Central region dental network officials told us the higher administrative fees covered overhead costs of owning and operating dental clinics built in three cities in the 1990's to attract participating dentists.

Missouri would have saved more than $1.3 million on managed care dental administrative expenses in fiscal year 2002 using Illinois' method of providing dental services. Under a new contract effective March 2002, Illinois pays 36 cents per person per month to a fiscal administrator who recruits and enrolls providers, manages claims, makes pass-through payments to providers and performs other dental-related services. The state pays for dental services on a fee-for-service basis. According to an Illinois Department of Public Aid official, Illinois previously provided benefits by contracting with dental networks, but changed to the new method after dissatisfaction with using this approach.

The eight states we contacted used varying methods to deliver dental services. Wisconsin used a combination of fee-for-service and managed care, as does Missouri. Kansas, Illinois, Nebraska,

[12] *Oral Health in Missouri: Policy Recommendations for Prevention, Education and Access*, May 2002.
[13] Health plans or dental networks are not taking administrative fees from the January 2002 increased funding.
[14] Payments to dentists plus administrative fees do not equal 100 percent of monies paid to dental networks in each region due to positive or negative surplus pool funds and rounding. See Appendix III, page 21, for an explanation of surplus pools.

and Arkansas used only fee-for-service methods. Ohio, Pennsylvania, and Arizona used a managed care approach only. A representative from the Ohio Medicaid program said specific language was added to managed care organization contracts requiring oversight of dental network providers.

Better controls needed to ensure the managed care program operates as intended

Encounter data is not complete or accurate

Division officials cannot measure the utilization of covered services provided to managed care recipients and do not know if the state's total cost truly measured healthcare costs. This situation exists due to incomplete and inaccurate encounter claim data. An encounter claim is a record of any service for which a claim could be paid under the fee-for-service system. According to the federal Department of Health and Human Services - Centers for Medicare and Medicaid Services, claim data is critical to 1) monitor service utilization; 2) evaluate access, comparability and quality of care; 3) update and evaluate capitation payment rates; and 4) monitor health plan and provider performance. Division officials have not placed a high priority on obtaining complete, accurate claim data from the health plans, and agree claim records may be incomplete and may contain duplicate claim records. Officials also told us they have not attempted to estimate the accuracy or completeness of claim records and do not have procedures to do so.

To determine the extent of incomplete medical claims, we analyzed pharmacy claims for new prescriptions to see if the health plan submitted an associated medical claim. The assumption was a medical visit would have occurred if a new pharmacy prescription was obtained. We found approximately 10 percent of the sampled claims had no associated medical claim recorded on the state's computer system. Further analysis revealed many duplicate claims with some pharmacy claims appearing on division records up to 18 times. We did not test the validity of these claims against medical records. These results support the division's admission of incomplete or duplicate claim records, but they do not evaluate the data's reliability.

Division officials cited various reasons a pharmacy claim would not have an associated medical claim: 1) the medical visit occurred but the claim was not submitted; 2) the medical claim was rejected because of errors or missing information, and was not corrected and resubmitted; 3) a medical visit occurred but payment to the provider was denied by the health plan; 4) a medical visit did not occur because the prescription was phoned in to the pharmacy or 5) the prescription was not written by a participating provider. Providers paid on a fee-for-service basis have an incentive to submit all claims since payment is contingent on submitted claims; however, providers reimbursed on a capitated basis have less incentive to submit claims or correct and resubmit rejected claims since they receive no additional payment for capitated services. All paid claims, whether provided on a fee-for-service or capitated basis are required to be submitted to the division.

Our review and division records also disclosed additional concerns with the division's lack of controls over encounter claim data:

- During fiscal year 2002, division officials did not analyze rejected claims and had no procedures, incentives or sanctions in place to encourage health plans to make corrections and resubmit rejected claims.
- During fiscal year 2002, 29 percent of all claims were rejected and 55 percent of dental claims were rejected as status 6 errors.[15]
- Faulty computer system edits allowed $440,000 in duplicate inpatient hospital payments since 1999.[16]

We reviewed monthly reports of rejected claims, which included the number of claims submitted, the number accepted, the number rejected and the reasons for rejection. Examples of conditions that caused claims to be rejected as status 6 errors include: ineligible recipient or recipient was not a member of the billing health plan; ineligible provider; and a missing place of service code, admission date or admission type code. The division returned rejected claims to the health plans with error codes explaining why the claims were rejected, but no further procedures were in place to ensure the claims were corrected and resubmitted.

System edits designed to prevent payment of inpatient hospital claims by the state for managed care recipients were faulty, resulting in both the state and the health plans paying claims totaling nearly $440,000 since 1999. Division personnel detected the faulty computer edit concurrent with our review and investigated claims likely to be affected. They told us the faulty edits will be corrected and the state will attempt to recoup the duplicate payments.

Accurate and complete encounter data is achievable

Wisconsin and Arizona have policies and procedures in place to ensure encounter claim data is at least 90 percent accurate and complete. These states consider encounter claim data to be a critical tool to monitor the managed care program and have developed procedures that assure; claim data is submitted timely and reflects actual services provided to managed care recipients; and rejected data is corrected and resubmitted. As a result, these states can use the data to measure health plan performance, set capitation rates, implement quality improvement initiatives and conduct fraud analysis and reporting. Wisconsin and Missouri have a similar percentage of Medicaid recipients in managed care and number of provider health plans. Wisconsin officials told us improving encounter claim data to its present state of reliability has been a long process and required the state to work closely with the health plans to ensure accurate complete data was submitted timely. Wisconsin also increased the penalty for rejected, incorrect encounter data from $100 to $1,500 per day to encourage health plans to comply with accuracy and completeness requirements. Missouri has no sanctions or penalties to encourage health plans to correct and resubmit rejected data. As a result of their efforts, Wisconsin officials told us their claim data is reliable, based on validation studies and medical record reviews. Wisconsin officials indicated they plan to use encounter claim data in the capitation rate-setting process in the near future.

[15]Claims accepted for processing and later rejected are called status 6 errors.
[16]Duplicate payments occurred when the division and the health plan both paid a provider for the same services occurring on the same day for a recipient.

New federal requirements to use encounter claim data for rate setting

An actuary calculates the program monthly capitation rates using health plan financial data and pre-1995 fee-for-service claim data. The pre-1995 data is trended forward and adjusted, and used as a secondary information source.

However, effective August 2003, a new federal rate setting process requires states to set capitation rates using fee-for-service data less than five years old from a population that mirrors the managed care population. States will also have to continue to use health plan financial data, but show more reliance on encounter claim data in the rate setting process within two years. Because Missouri's managed care program has been in operation longer than five years, the division does not have the fee-for-service claims data required. As a result of the new requirement, the division will have to begin relying on encounter claim data as a secondary source in the capitation rate setting process within the next two years.

Limited procedures to evaluate recipient eligibility

The division did not profile the managed care population to determine if capitation payments were made for potentially ineligible recipients, or if the absence of encounter claim records was an indication of problems with access to medical services. We performed a limited review of approximately 25,000 recipients enrolled the entire fiscal year 2002, who had no encounter claims. Capitation payments were made each month for these recipients. We found the division paid:

- over $1.5 million in capitation payments during the fiscal year for 990 managed care recipients who did not have social security numbers recorded on the state's computer systems,
- nearly $48,000 in capitation payments for 40 recipients with out-of-state addresses, and in April 2003 the division identified an additional $85,000 in capitation payments paid for 33 recipients with out-of-state addresses in previous years, and
- over $91,000 in capitation payments since enrollment for 32 managed care recipients with invalid social security numbers recorded on the state's computer systems.

We did not review approximately 378,000 recipients with claims for potential ineligibility. Similar social security number or out-of-state address problems may exist in that population.

Social workers at the Division of Family Services (family services) determine eligibility for applicants applying for medical benefits. Social security numbers are to be obtained and recorded on the state's computer systems at the time of application, or when re-determination of eligibility is performed, which by federal and state regulation should be done at least every 12 months.[17] Family services officials told us if recipients do not or cannot provide social security numbers at the time of re-determination, they become ineligible for benefits.

[17] 42 CFR 435.916 and 13 CSR 40-2.020

In February 2003, we referred the 990 recipients with missing social security numbers to a family services official who told us the division would not take any action to review the cases of these recipients, but that normal re-determination procedures would be followed. However, the normal re-determination procedures changed over the last couple of years according to other family services officials. Those officials indicated routine eligibility re-determinations were discontinued due to increased workloads and staffing problems and are not considered a high priority. Currently, family services' social workers rely on data matches with other agencies to provide information regarding income, resources and age to determine the likelihood a recipient's eligibility status has changed. Only recipients with identified changes will have their eligibility re-determined. Since missing social security numbers will not trigger eligibility re-determination, these 990 recipients can remain enrolled in managed care with capitation payments continuing despite possibly being ineligible.

Division officials told us monitoring recipients with missing social security numbers would be a waste of time since family services generates reports of all clients with missing social security numbers and can look at this information. However, family services officials told us, although they generate a report of clients with missing social security numbers, they do not identify managed care recipients separately from other clients, and they do not track managed care recipients with missing social security numbers.

Division officials agreed identification of managed care recipients with out-of-state addresses is a valuable tool and will be used in the future to identify recipients whose cases were not properly closed when they moved from the state. The division is attempting to recoup the unnecessary capitation payments for the identified recipients with out-of-state addresses. Family services personnel could not obtain valid social security numbers for the majority of the 32 recipients with invalid numbers due to non-cooperation or inability to locate the recipient. Enrollment in managed care and the associated costs have ended for these recipients. No explanation was provided why these recipients' eligibility had not been previously re-evaluated. Federal rules require the state to verify recipient social security numbers with the federal Social Security Administration. The state's computer systems indicated these social security numbers had been reported back by the Social Security Administration as unverified.

No procedures to handle suspected cases of fraud reported by health plans or to conduct fraud analysis

Health plans contracting with the state are required to have formal procedures for detecting fraud and notifying the division of cases of suspected fraud by recipients or providers. Until 2001, the division's quality services unit handled these cases. Designated employees in the unit investigated the cases using established written procedures. Since reorganization of the unit in 2001, the division's quality assurance unit has been responsible for handling these reports; however, officials neglected to update written procedures to clearly set forth a process to record, investigate or refer these cases, or to document their eventual disposition.

A quality assurance unit official told us health plans reported a total of 19 cases of suspected fraud in 2001 and 2002, but without logs or other documentation of incoming reports, we have no assurance no other cases were reported. We reviewed five of the 19 cases to determine case

disposition. One case had been referred for further investigation, one case did not require further action, and according to the official, no investigation or further action was taken on the following cases:

- Report dated September 2002 of suspected abuse of the schedule II[18] drug Oxycontin® by a recipient who had been previously reported by a pharmacy in March 2002. Our review disclosed the recipient received daily quantities exceeding the level the manufacturer considers normal usage and had obtained the drug from several different providers while enrolled in two different health plans during fiscal years 2002 and 2003. We requested this case be referred to the division's Medicaid investigative fraud unit, which was done.
- Report dated September 2002 alleging misuse of emergency room services by a recipient in an effort to obtain drugs. Our review found a hospital claim for $1,956 was paid by the health plan and also paid by the state. We notified the division of this error and the state payment will be recouped.
- Report dated December 2002 notifying the division of possible fraudulent activity by a recipient resulting in dis-enrollment by the health plan. This recipient's case could be flagged for monitoring if he/she applies for benefits again.

The division does not perform fraud detection activities in the managed care program even though required by federal Medicaid rules. Missouri's audit liaison with the Department of Health and Human Services told us all states should perform Medicaid fraud detection work for both fee-for-service and managed care programs. According to division officials, the division's program integrity unit performs fraud detection activities in the Medicaid fee-for-service program, but does no fraud detection work in the managed care program because of a lack of resources and because the encounter claim data is not reliably complete. The federal official told us by not monitoring the managed care program for fraudulent activity, the division cannot be sure if the levels of capitation payments reflect the true cost of services, which could eventually result in higher costs to the state.

The MEDSTAT Group, Inc. identified[19] similar control weaknesses in the managed care program, and in an August 2000 report recommended the division make complete and timely encounter data reporting a high priority in managed care oversight, stating, "without this data, the oversight function is severely impaired." The report also noted managed care (as opposed to fee-for-service) fraud, waste and abuse is diffused and perhaps hidden at the plan level. If active responsibility to monitor and assist health plans is not assumed, the report stated, it could ultimately result in higher capitation payments. In April 2003, division officials said they just started developing a plan to address encounter data and its accompanying issues.

[18]The Controlled Substances Act places all substances regulated under existing federal law into one of five schedules. A schedule II drug or other substance has a high potential for abuse. Abuse of the drug or other substance may lead to severe psychological or physical dependence.

[19]At the request of the General Assembly, the MEDSTAT Group, Inc. conducted a review of the Medicaid program and issued the report *Medicaid Fraud, Waste and Abuse Risk Review* in August 2000.

Conclusions

Inadequate monitoring of the managed care program and the health plans resulted in dentists statewide being underpaid for over 20,000 dental procedures during the first quarter of fiscal 2002. Actions taken by the division concurrent with our review and following public complaints improved the payment non-compliance by January 2003, but some underpayments continued due to dental network reimbursement methodologies. The division does not know the true cost of providing dental services or the total cost of dental-related administrative charges retained by health plans and dental networks. Alternative methods of delivering dental services could be more cost effective for the state.

Encounter claim records, a critical management tool to help state officials make better informed decisions about the managed care program, were not reliable and could not be used to monitor service utilization; comparability and quality of care; update and evaluate capitation payment rates; or monitor health plan performance. Without complete, accurate claim data, the state cannot effectively monitor the program to control costs or ensure quality of care. No ongoing fraud detection work is performed in the managed care program. Evaluation of suspected fraud cases reported by health plans needs improvement. Eligibility of managed care recipients with unreported or invalid social security numbers and others with out-of-state addresses has not been evaluated timely, resulting in unnecessary monthly capitation costs and other potentially unnecessary costs. Procedures to improve the reliability of encounter data, and ensure eligibility of recipients will better allow the state to know the true cost of providing healthcare services to managed care recipients and control program costs.

Recommendations

We recommend the Director of the Department of Social Services require division officials:

1. Monitor health plans to ensure Medicaid rates are paid for dental procedures with mandated codes.

2. Perform a cost-benefit analysis to determine cost efficiencies of alternative methods of providing dental services.

3. Evaluate and establish "best practice" procedures to improve the quality and reliability of encounter data. Such procedures could include performing annual encounter data validation studies, working with health plans to improve the acceptance rate of submitted claims, and implementing financial penalties for rejected encounter data.

4. Work with the Division of Family Services to identify managed care recipients with missing or invalid social security numbers in the state's computer systems at least annually so eligibility can be re-determined, since current eligibility re-determination procedures will most likely miss these recipients.

5. Develop and implement fraud detection activities in the managed care program, as required by law, and implement procedures to improve evaluation of suspected fraud activity reported by health plans.

Department of Social Services Comments

1. *The Managed Care Program Performance Review, referred to hereafter as "the report," does find that DSS/DMS was investigating the issue at the time of the audit. The report does not clearly articulate that when reviewed in the aggregate, payments to dentists exceeded the Medicaid fee schedule for all codes - those to be paid at least the Medicaid rate and those with no mandate. The DSS/DMS review shared with the State Audit Team revealed that even those dentists who experienced a lower payment on certain procedure codes still received more money under the MC+ managed care program when all procedure codes were totaled and compared to what the fee-for-service program would have paid.*

   In recognition of the concerns expressed by a member of the State Audit team and subsequent discussion with MC+ health plans, DSS/DMS amended contracts effective January 2003 to recognize that mandating payment levels when networks and providers have contractually agreed to a global budget reimbursement methodology create pressures on the reimbursement levels of all other codes. Therefore, beginning January 2003, the MC+ managed care contracts require certain codes to have the fee schedule reflect a mandated level and not the payment resulting from the global budget reimbursement methodology so as not to unintentionally lower the overall reimbursement to participating dentists. DSS/DMS will monitor compliance with this contract amendment.

2. *It is important to note that the percentage paid by DMS to MC+ Managed Care health plans for administrative functions is not deducted from the amount included for provision of services; rather it recognizes the costs to the MC+ Managed Care health plans for performing administrative functions. Your report acknowledged in a footnote that health plans or their contracted dental networks are not taking their administrative fees from the increased funding for provision of dental services.*

   The DMS pays its MC+ health plans a monthly capitation payment for the provision of all services included in the benefit package. The capitation payment includes approximately 12.5% for administration, risk and contingency, and profit. This 12.5% is for the MC+ health plans to perform the administrative functions for delivering all services; not just dental. This percentage for administrative functions is in line with many other states' Medicaid managed care programs.

   We are not aware of any actuarial sound rate setting methodology that would allocate capitation payments into service lines (dental, medical, etc.) requiring a contracted health plan to follow that allocation in delivery of services or in performing the administration functions required by contract. Rather the global capitation payment allows the contracted health plan to manage the delivery of contracted services and payment for those services to meet the needs of its enrolled members in the market in which it operates. That is why DMS could not attribute the amount of capitation payment for delivery or administration of dental services.

The report's conclusion that Missouri would have saved more than $1.3 million on managed care dental administrative expenses was a simple calculation that was based on the reported $.78 per person totaling $3 million which the MC+ health plan's dental network paid for administration and Illinois' figure of $.36 per person used in their contract for administrative management of their fee for service dental program. As discussed above, DMS pays administration to the health plan based on overall capitation payment that includes dental services as only a very small percentage of expenditures. DMS does not pay a certain amount for administration of dental services. It is not correct to assume Missouri would save dollar for dollar in comparing what the MC+ health plan's dental network administration fees are compared to a very different contract that Illinois uses. There are too many differences between the two contracts to make that correlation. For example, the report indicates that some of the administrative expenses attributed to the health plans' dental networks include operation of dental clinics owned by the dental network. That is not the case in Illinois.

In May 2002 and again in September 2002, the DMS met with the dental contractor for Illinois to discuss administration management of dental services in nonmanaged care areas of the State. In October 2002, the dental contractor quoted an administrative fee of $.75/per member, per month for Missouri. The DMS does not believe this is a cost effective alternative to delivery of dental services. At the recommendation of the State Auditor Report, DMS will continue exploring cost effective ways to reimburse dental services.

3. *The finding in the State Auditor Report implies that DMS does not have a complete understanding regarding the utilization of services because it does not rely solely on one data source--encounter data. The State Auditor Report does not reflect that DMS does measure utilization of services using data sources other than encounter data even though that information was shared during the course of the review. DMS uses data from MC+ health plans, the Department of Health and Senior Services, and the Department of Insurance.*

   The External Quality Review (EQR) processes include an annual encounter data validation. In addition, DMS staff have conferred with other state staff and participated in the Centers for Medicare and Medicaid Services (CMS)/Medstat encounter data meetings. Information regarding the programs noted in the report was presented. The CMS' "Guidelines for States to assist in the Analysis of Medicaid Managed Care Data" second edition, 1999, prepared by Medstat, indicates that Arizona, Wisconsin, Texas and Minnesota have also struggled to improve the submission process and reduce inaccurate submission of data.

   The State Auditor's analysis of the extent of incomplete encounters revealed that approximately 90% of their sample was complete. The report provides an explanation of the reasons that may account for the other 10%. This compares favorably with the states cited by the State Auditor as having "best practice" procedures. In recognition of the increased emphasis put on the use of encounter data under federal regulation, DSS/DMS began an improvement project in July 2003 for encounter data. The project has been approved by CMS.

4. *Recipient eligibility is determined by the Family Support Division (FSD). For DMS to replicate activities conducted by another agency within DSS and devote its limited resources to such activities is not a wise or prudent use of scarce resources for what can be reasonably expected to have marginal value.*

   The listing of 990 individuals provided by the State Auditor was reviewed by FSD staff, with the following findings:

   - *Some of the individuals listed have verified social security numbers in our systems. FSD is not sure whether these were added following the auditor's review, but it is an indication that FSD staff are following up on social security numbers.*

   - *Some of the individuals listed were not active Medicaid recipients, but rather were included in the assistance group for Medicaid for their children. This would explain why there was no encounter data.*

   - *Most of the individuals on the listing are children. If they were born in Missouri in recent years, they would have had a social security number applied for through the birth certificate process. While FSD should have the number reported electronically in the system, not having the number is very unlikely to result in missed opportunities for matches on wages or assets, which is the purpose of obtaining the social security numbers.*

   In the past, Missouri contracted with the Social Security Administration (SSA) to "enumerate" our clients, meaning FSD could help them apply for a number (or replacement card) and have the number automatically added to our electronic file at the same time the person received it. SSA stopped allowing states to do this practice, and it has been more difficult to maintain an electronic record of social security numbers since that time. Given this difficulty, FSD is pleased to have verified social security numbers for the large majority of its clients. FSD will use the State Auditor's recommendation as one strategy to improve this area.

5. *DMS staff participated in the CMS National Fraud and Abuse Initiative. Staff chaired two of the committees and wrote part of the "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, A product of the National Fraud and Abuse Initiative, October 2000."*

   DMS convened a Compliance Technical Advisory Group to address the identification of State and Managed Care Organization (MCO) needs for fraud and abuse detection. This group was charged with standardization of contractual fraud and abuse procedures and effective communication of Medicaid provider terminations, suspensions, or payment recoupment tracking. Compliance plans were written by the MCOs, approved by DMS and implemented. Further implementation of the compliance plans is in process. A State compliance plan is being drafted. This plan includes policies and procedures for fraud and abuse detection and reporting. MCO compliance plans are being revised to more effectively

address the evaluation of suspicious activity. "Member lock in" procedures for inappropriate utilization of pharmacy benefits are being standardized. Coordination between Program Integrity and Quality Services is being improved.

Auditor's Comment

1. The department's comments fail to note the managed care contract change decision took place in August 2003 with it being made retroactive to January 2003.

3. Utilization data received by the division is on an aggregated basis which limits its analytical usefulness. The encounter validation process for the External Quality Review (EQR) is primarily designed to look at quality of care not medical record accuracy. As of May 2003, the most recent completed EQR report (calendar year 2000) reviewed validated claims for only Early Periodic Diagnosis Screening and Treatment services which represent a very limited portion of all claims activity.

4. All recipients reviewed were active Medicaid recipients enrolled in a managed care health plan during fiscal year 2002. A department official could only provide us one instance where the department believed a recipient was part of an assistance group and not an active Medicaid recipient. During fiscal year 2002, that recipient was an active Medicaid managed care recipient with capitation payments being made totaling $1,738. The recipient lost Medicaid eligibility and was removed as an active member of his case beginning July 1, 2002.

APPENDIX I

OBJECTIVES, SCOPE AND METHODOLOGY

This appendix describes our methodology to address the reporting objective.

Objectives

Our objective was to determine whether Division of Medical Services (division) officials provided effective management and oversight of the managed care program. Specific objectives included determining whether dentists were paid Medicaid rates for dental procedures with mandated codes, and whether division officials have adequate controls and procedures in place to effectively monitor and administer the managed care program.

Scope and Methodology

The audit was initially conducted to evaluate dental reimbursement concerns reported to our office. The scope of the audit was expanded to review overall managed care program management including procedures for encounter claim data collection, and efforts to evaluate eligibility and identify fraud. Dental claims were the only medical claims looked at in detail during the audit. Some pharmacy and in-patient hospital claims were also tested.

To determine whether Medicaid rates were paid for dental procedures with mandated codes, we obtained records of payment for all dental services provided from January through March 2002, and January 2003 from the health plans. To determine the total payments to dentists for the period July 2001 through December 2002, we obtained from the health plans 1) records of capitation payments to the dental networks and 2) how the dental networks spent these monies, which the health plans obtained from the dental networks. We analyzed this financial data and identified the number of dental procedures reimbursed at less than the Medicaid rate, determined total payments to dentists, and administrative expenses retained by the dental networks.

To determine whether division officials provided effective oversight and management of the managed care program, we obtained records of all enrolled recipients and all encounter claims for the fiscal year ending June 30, 2002 from the division. We analyzed the data and identified the pharmacy claims and inpatient hospital claims during the fiscal year. We conducted testing on a sample of pharmacy encounter claims for new prescriptions to determine whether an associated medical claim for an outpatient, inpatient or medical visit was also present. Other testing included reviewing the pharmacy test items to detect claims that appear multiple times in division records and a limited review of the population of managed care recipients who had no encounter claims on the state's computer system during the fiscal year. We did not assess the reliability of the encounter claim information recorded on the system.

We obtained and reviewed federal and state statutes and regulations related to Title XIX of the Social Security Act (the Medicaid program) governing Medicaid managed care programs. We obtained and reviewed the special terms and conditions and protocol documents governing the State Children's Health Insurance Program. We obtained and reviewed contracts between the

state and managed care health plans, and contracts between the health plans and dental networks. We reviewed contract amendments and applicable rate schedules.

We contacted officials at the federal Department of Health and Human Services - Office of Inspector General to obtain a federal viewpoint on Medicaid program regulations. We also reviewed:

- *Medicaid Fraud, Waste and Abuse Risk Review*, the final report by The MEDSTAT Group, Inc., dated August 2000.
- *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* published by the Centers for Medicare and Medicaid Services, dated October 2000.
- *Oral Health in Missouri: Policy Recommendations for Prevention, Education and Access* published by the Missouri Commission for Oral Health Access, dated May 2002.

We contacted officials from Arizona, Arkansas, Illinois, Kansas, Nebraska, Ohio, Pennsylvania and Wisconsin to obtain information on how they handle managed care program dental benefits. We contacted officials from Wisconsin and Arizona to obtain information about methods used to obtain complete and reliable encounter data.

We reviewed division control procedures for claims processing and analyzed division records of rejected encounter claims, by type and health plan for fiscal year 2002. We reviewed Division of Family Services internal control procedures for Medicaid eligibility and re-determination of eligibility.

We obtained written comments from the Director of the Department of Social Services to a draft of the report in a letter dated October 15, 2003. We have incorporated these comments as appropriate. We conducted our work between July 2002 and April 2003.

APPENDIX II

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

This federally funded program provides healthcare coverage for children under age 19 whose family income falls within certain guidelines. Families may have up to $250,000 in assets as long as family income remains at required levels. Family income and age eligibility requirements are:

- under age 1 186-300 percent of federal poverty level
- age 1-5 134-300 percent of federal poverty level
- age 6-18 101-300 percent of federal poverty level

Children in families with income from 185-225 percent of the federal poverty level must pay $5 per provider visit.

Children in families with income at 226-300 percent federal poverty level must be uninsured for 6 months, and depending on family income, have no access to other health insurance for less than $299 per month. These families must pay a monthly premium, ranging from a minimum of $59 to a maximum of $225 per month, based on family size and income, ensuring no family pays more than 5 percent of their income for healthcare. These families must also pay $10 per provider visit and $9 per prescription.

Table II.1 illustrates family size, monthly income and premium amounts effective July 1, 2003 for children enrolled in the State Children's Health Insurance Program.

Table II.1: Premium Amounts Based on Family Size and Income

Family Size	Monthly Income	Premium Amount
1	$1,684.01 - $2,245	$59-78
2	$2,273.01 - $3,030	$89-114
3	$2,862.01 - $3,816	$118-150
4	$3,450.01 - $4,600	$148-186
5	$4,039.01 - $5,385	$177-222
6	$4,628.01 - $5,142	$206
6 and over	$5,142.01 and over	$225

Source: Division of Medical Services

APPENDIX III

EXPLANATION OF GLOBAL BUDGET REIMBURSEMENT METHOD

Under the global budget method, after administrative charges and payment to non-participating dentists, the remaining monies each month are placed in a dental pool, and paid out based on the total value of procedures performed by participating dentists during the month and the total dollars in the dental pool. The amount placed in the dental pool to pay participating dentists is reduced when non-participating dentists are paid first, resulting in lower payments per procedure, with or without mandated codes, to participating dentists. All procedures are assigned a value, based on a fee schedule prepared by the dental network, which is then adjusted up or down depending on the amount of money in the pool.

For example, if the assigned values for all procedures performed in January totaled $100, but only $90 was in the dental pool, each participating dentist would receive 90 percent of the assigned value for each procedure performed in January. Conversely, if the assigned values for all procedures performed in February totaled $100, but $105 was in the dental pool, each participating dentist would receive 105 percent of the assigned value for each procedure performed in February. Therefore, a procedure with an assigned value of $10 would be paid at $9 in January and $10.50 in February.

The maximum dental pool payout each month is 110 percent of the assigned values for procedures performed, with the remainder, if any, considered surplus. Dental networks told us the purpose of surplus pool funds was to pay covered emergency and out-of-network services.

APPENDIX IV

MANAGED CARE COSTS AND ENROLLMENT

This appendix depicts cost and enrollment in the managed care program for the state fiscal years indicated. Table IV.1 shows total costs associated with the managed care program have increased 83 percent, and enrollment has increased 49 percent, since fiscal year 1999.

Table IV.1: Managed Care Growth Since Fiscal Year (FY) 1999

FY	Cost (in millions)	Percent Increase Since Prior Year	Percent Increase Since FY 1999	Enrollment at June 30	Percent Increase Since Prior Year	Percent Increase Since FY 1999
1999	$378			277,576		
2000	452	20	20	311,230	12	12
2001	560	24	48	378,771	22	36
2002	690	23	83	413,361	9	49

Source: Prepared by SAO from division data