Audit of Fee-for-Service Claims Incorrectly Paid for PMHP Recipients

Report Number 2021-02

October 27, 2021

Utah Office of
Inspector General

Gene Cottrell
Inspector General

October 28, 2021

To: Utah Department of Health

Please see the attached report, **Fee for Service Claims Incorrectly Paid for Prepaid Mental Health Plan Recipients**, Report 2021-02. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 5 of this report.

Sincerely,

Gene D. Cottrell
Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
Sophia Di Caro, Executive Director Governor's Office of Management and Budget
J. Stuart Adams, President of the Utah Senate
Jacob L. Anderegg, Senate Chair, Social Services Appropriations Subcommittee
Brad Wilson, Speaker of the Utah House of Representatives
Paul Ray, House Chair, Social Services Appropriations Subcommittee
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EXECUTIVE SUMMARY

Utah Department of Health (DOH) contracts with the Prepaid Mental Health Plans (PMHP) to provide services to Utah Medicaid recipients. DOH has been operating the PMHP Managed Care Plans (MCP) since 1991. Medicaid assigns recipients to receive behavioral health benefits through a PMHP, a Utah Medicaid Integrated Care (UMIC) Plan, or direct from a Medicaid Provider if assigned Fee for Service (FFS). Medicaid states most recipients receive behavioral health benefits through a PMHP.

Utah Office of Inspector General (UOIG) Program Integrity nurse investigators prior to this audit identified incorrect payments by Medicaid amounting to $1.6 million for 139 FFS claims for services covered by a PMHP during calendar years (CY) 2019 and 2020. The UOIG nurse investigators initiated recovery.

This audit initiated to identify the causes of the incorrect payments and to recommend specific controls to increase the effectiveness of the payment edits.

Audit Objective:

Determine why Medicaid paid the FFS claims for services contracted to the PMHP plans for payment.

Audit Findings:

The audit found three primary causes for the $1.6 million incorrect payment of 139 FFS Claims:

1. Approximately 70% of the incorrect payments occurred when Medicaid retroactively paid capitations without reversing the FFS claims paid previously.
2. Medicaid Management Information System (MMIS) programming bypassed the PMHP payment control edit for recipients receiving inpatient mental health services in hospital overflow beds and hospitals without psychiatric units providing psychiatric services until a psychiatric bed becomes available.
3. Medicaid inter-bureau misunderstandings caused 15 inpatient FFS Claims for $111,718 to pay incorrectly.

INTRODUCTION

BACKGROUND

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. Under the authority of Utah State Code 26-1-18, the Utah Department of Health (DOH) is designated the single state agency responsible for administration of Utah Medicaid. As the single state agency DOH is responsible for all aspects of Utah's Medicaid State Plan including administration and supervision of payment for services delivered under the State Plan.

The Utah Office of Inspector General (UOIG) under authority of Utah State Code §63A-13-201, operates as an independent entity within the Utah Department of Administrative Services soon to transition to Department of Government Operations.

The UOIG is comprised of the Audit Section, the Program Integrity Section and the Mission Support Section. Each having separate management under the Inspector General. The Program Integrity Section performs specific Medicaid oversight functions required by the Centers for Medicare and Medicaid Services.

The DOH and UOIG program integrity work together with top-level interdependencies and functions. The DOH and UOIG created a Memo of Understanding (MOU) specifying responsibilities for program integrity functions with the most recent version signed August 2017. Situations of waste and abuse enter a payment recovery process including training the provider in the use of proper billing methods. The UOIG audit section operates independently of the MOU.

The UOIG regularly assesses FFS claims, selects claims for additional research and if needed obtains supporting documentation. UOIG recovers incorrect payments in accordance with Utah Administrative Services Code Title 63A Chapter 13.

Utah Medicaid utilizes two payment methodologies

Utah Medicaid utilizes two payment methodologies for Medicaid services covered under the State Plan: capitation and FFS. Under the capitation method, the PMHPs receive a fixed monthly capitation payment to provide behavioral health (mental health and substance use disorder) services covered under the State Plan to eligible recipients. The PMHPs receive capitation payments regardless of treatment required—or not required—during the month of capitation coverage.[1] The PMHPs compensate providers for delivering contracted behavioral health services. Under capitation methodology, providers submit their claims for

[1] Managed Care, 42 C.F.R. § 438.2 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.

reimbursement to the PMHP. Under the FFS payment method a provider bills Medicaid directly for mental health services covered by the State Plan.

DOH Delivery System for Behavioral Health Services

Medicaid reports most recipients receive behavioral health services through one of the PMHPs located throughout the state, one per county except for Wasatch County. Wasatch County provides mental health services on a FFS basis only. DOH in January 2020 contracted with four Manage Care Organizations (MCO) to provide physical and behavioral health services in the same MCP and these are the UMIC Plans. The UMIC Plans provide services only to recipients eligible for services under Adult Expansion Medicaid living in five urban counties. See Appendix three for a listing of the PMHPs by county.

DOH has been operating the PMHP MCPs since 1991. Medicaid recipients in all counties except Wasatch County enroll in a PMHP. Foster children and children with subsidized adoption Medicaid may enroll only for inpatient hospital services and receive ancillary and outpatient mental health services from Medicaid FFS providers.

Enrolled recipients choose a provider from a panel of providers unless approved by the PMHP for a non-network provider.

Medicaid may pay capitations up to 12 months retroactively

Medicaid may retroactively enroll a recipient to a PMHP back to the date of Medicaid eligibility. The time period of retroactive enrollment may exceed 12 months, however, the Department pays up to 12 months of retroactive capitation payments and the PMHP is responsible for covered services *during the retro-enrollment*.[2]

The retroactive enrollment up to 12 months prior is unique to the PMHP contracts. For example, Utah Medicaid contracts with four Accountable Care Organizations (ACOs), four UMICs and both the ACO and UMIC contracts only allow retro-enrollment back to the first day of the current month.[3, 4]

Medicaid recipients prior to retroactive enrollment in the PMHP receive mental health coverage on the FFS delivery system.

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[2] For example contract #1727205: Salt Lake County Health Dept. Attachment B 3.3.3 Retroactive Enrollment, The Contractor shall provide Covered Services to Enrollees dating back to the month in which a Potential Enrollee is determined to be eligible for Medicaid. This time period of retroactive eligibility may exceed 12 months, however, the Department shall pay up to 12 months of Capitation Payments to the Contractor and the Contractor shall be responsible for providing Covered Services during those 12 months.

[3] For example: ACO contract Select Health Update Attachment B Effective January 1, 2019, Article 3.3.1 Enrollee Choice (D) Medicaid enrollees made eligible for a retroactive period prior to the current month are not eligible for Contractor enrollment during the retroactive period.

[4] For example: UMIC contract Select Health Integrated Care: Attachment B Effective January 1 and updated July 1, 2020: Article 3.3.1 Enrollee Choice (D) Enrollees made eligible for a retroactive period prior to the current month are not eligible for Contractor enrollment during the retroactive period. (SAME AS ACO)

UOIG identified $1.6 million incorrect payment of FFS Claims for PMHP Recipients for Dates of Service (DOS) 2019-2020.

UOIG nurse investigators prior to this audit identified incorrect payments amounting to $1.6 million for claims paid FFS for services covered by a PMHP during CY2019-2020. See Appendix one for listing of FFS inpatient claims paid incorrectly by DRG and year. Appendix two lists by Current Procedure Terminology (CPT) the FFS ancillary claims for mental health services paid incorrectly for the same recipients listed in Appendix one.[5] The nurse investigators initiated the recovery of the incorrect payments.

The UOIG Data Scientists and Nurse Investigators performed the following process:

Risk Based Identification of Incorrect Payment

The UOIG Mission Support Data Scientists query the Medicaid Data Warehouse for in-patient FFS claims on recipients for whom Medicaid paid a PMHP capitation covering the same dates of service. The Data Scientists remove Medicare crossover claims and export the linked records to a spreadsheet for Utah OIG nurse investigation.

The nurse investigator verifies the spreadsheet information to ensure coverage at the time of service. The nurse investigator eliminates FFS claims for services carved-out.[6] The procedures performed by the nurse investigator also include:

- Review of the recipient PMHP information on the Utah Medicaid Managed Care System to verify coverage, for example:
  - Recipient benefit history
  - Recipient capitations paid history
- Review of the FFS claims history on the Utah Medicaid Management Information System (MMIS), evaluating the paid FFS claims were within PMHP coverage by examining, for example:
  - Diagnosis Codes and descriptions
  - Diagnosis Related Group (DRG) Codes and descriptions
  - Revenue Codes
  - Dates of Service
- Review of eligibility details provided on the Utah: Electronic Resource and Eligibility Product
- Documenting the relevant supporting information.
- Reporting incorrect payments with supporting details to the supervisor.

Supervisory Review and Recovery Process

A UOIG PI supervisor reviews the results of the nurse investigators and forwards the detail to UOIG administration for recovery action. UOIG administration issue notices of recovery (NOR) to providers describing the incorrect payment, required

[5] The Current Procedural Terminology (CPT®) system was developed by the American Medical Association (AMA). The terminology provides a standard language and numerical coding methodology to accurately communicate across many stakeholders, including patients, the medical, surgical, diagnostic, and therapeutic services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865623/

[6] Carve-out refers to services stated in the PMHP contracts as not covered.

repayment and the provider's right to appeal. The NOR advises the provider to file the claim with the PMHP for reimbursement.

UOIG or Utah Medicaid performs recovery action in the absence of direct repayment or an appeal filed by the provider. Recovery action by UOIG and Utah Medicaid may consist of a financial reversal or "off-set" against provider unpaid claims on the account.

Prior Audits of Managed Care Plans

This is the third in a series of Managed Care Entity (MCE) audits relating to the Utah State Auditor's concern regarding the appropriateness of FFS payments made for Utah Medicaid members enrolled with an MCE.[7] On January 29, 2021 UOIG issued the Audit of Inpatient Fee-for-Service Claims Paid Incorrectly (2019-03) reporting Utah Medicaid incorrectly paid an estimated $4.6 million of FFS claims for inpatient services covered by ACO capitations paid during 2015-2019. On May 23, 2019, UOIG issued Audit of Dental Managed Care Organization with Fee-for-Service Billings reporting Utah Medicaid incorrectly paid an estimated $584,777 between January 2015 and June 2018.

Medicaid concurred with our recommendations regarding incorrect payment of FFS claims for MCE recipients. Medicaid requested until April 2022 to complete implementation of the corrective action.

OBJECTIVE AND SCOPE

Audit Objective:

Determine why Medicaid paid the FFS claims contracted to the PMHP plans for payment.

Audit Scope:

The audit scope focused on Medicaid's incorrect payment of FFS inpatient claims for recipients covered by PMHP capitations for Dates of Service 2019-2020, specifically:

- PMHP contract provisions for 2019 and 2020 for coverages and carve-outs.
- Medicaid's process for administering FFS claims paid prior to payment of retroactive capitation.
- MMIS PMHP payment control edits for mental health services.

METHODOLOGY

The audit relied on the work performed by the UOIG Program Integrity Nurse Investigators for incorrect payment identification totaling $1.6 million for DOS 2019-2020, and for the initiation of incorrect payment recovery.

[7] See WP104.01 State Auditor Letter, to Dr. Joseph Minor, Executive Director, August 31, 2018.

The audit process was to review for reasonableness:

- the work of the UOIG nurse investigators; and the
- Medicaid processes and procedures as of, or in effect December 31, 2020 governing and controlling payment of FFS Claims for Medicaid recipients covered by the PMHPs.

The audit methodology included:

- interviewed the UOIG Lead Data Scientist and reviewed the methodology linking the inpatient FFS Claims with PMHP capitations paid for the same dates of service;
- obtained special data queries from the UOIG Data Scientist to compare original capitation paid date to the date the inpatient FFS claims for mental health services paid;
- interviewed the UOIG nurse investigator and reviewed the procedures used to review the medical history of recipients including diagnoses and treatments billed, capitations paid and suspensions if any, and removing of carve-outs;
- researched eligibility online documentation (UOIG eligibility specialist);
- reviewed supporting information of the incorrect payments identified by the nurse investigator;
- inquired and interviewed Utah Medicaid representatives;
- reviewed a judgment sample selection of the PMHP, UMIC, and ACO contracts for 2019 and 2020 regarding covered services.

CONCLUSION

Medicaid incorrectly paid $1.6 million for FFS claims for mental health services covered by capitation payment to PMHPs.

Medicaid states that they did not implement a process to monitor or correct the financial impact of paying capitations retroactively for recipients previously on FFS coverage.

FINDING 1 — UOIG identified $1.6 Million of incorrectly paid FFS Claims for PMHP Recipients Dates of Service (DOS) 2019-2020.

The UOIG identified 139 FFS inpatient claims incorrectly paid to providers for services covered by the PMHPs. Despite the PMHPs being the responsible payer, Medicaid incorrectly paid the $1.6 million of FFS Claims on the MMIS platform without detection or correction. UOIG identified the incorrect payments and initiated recovery. UOIG informed Medicaid of the incorrect payment issues by emails, copies of NORs and more broadly through the Program Integrity Committee.

Federal law states that the single state agency "must ensure that no payment is made to a network provider other than by the MCO, PIHP [Prepaid Inpatient Health Plan], or PAHP [Prepaid Ambulatory Health Plan] for services covered under the contract between the State and the MCO, PIHP, or PAHP." A PMHP is a type of PIHP.[8]

Medicaid incorrectly paid $1.6 million of inpatient claims plus $38,698 for ancillary claims covered by the PMHP contracts and paid by capitation for the same recipients. See Appendix 1 and 2 for dollar amounts incorrectly paid by DRG for inpatient claims and by CPT for the ancillary claims.

Providers submit FFS claims electronically through the Utah Health Information Network (UHIN). FFS claims received through UHIN electronically interface to MMIS for adjudication and reimbursement. Medicaid also accepts paper claims and following electronic entry to MMIS, the claims pass through the payment control edits. Medicaid relies on MMIS payment control edits to verify FFS claims are due and payable including verifying the PMHP responsibility for payment.

Utah Medicaid and the Department of Technology Services (DTS) configured a series of MMIS edit settings, payment controls that FFS claims must pass before Medicaid issues payment.

Medicaid set the MMIS PMHP edit for mental health services to reject the FFS inpatient claims *only if all* three conditions listed below *exist at the time of claim submission*:

MMIS PMHP edit for mental health:

1. A mental health capitation payment covering the range of the dates of services exists at the time the service was billed, **and**
2. A psychiatric revenue code (primary), **and**
3. A psychiatric diagnosis (primary).

[8] Managed Care, 42 C.F.R. § 438.60 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.

Causes of Incorrect Payment

1. Capitations paid retroactively without recovery of FFS claims caused duplicate payment of coverage:
   Medicaid offers various types of assistance programs. Approval for applicants to some programs can require weeks or months and Medicaid accepts the applicant to a different program on the FFS plan until approved for the recipient preferred program for example "Disability". The Medicaid program for disability can be a lengthy process and applicants often qualify in a simpler program until approved for the disability program. The hospital presumptive eligibility (HPE) is on the FFS plan and patients that qualify for the HPE FFS plan may apply for the disability program. If approved for the disability program the system automatically enrolls the recipient retroactively to a PMHP and pays capitations up to 12 months back to the original eligibility date.[9] The system automatically pays the capitations for the retroactive prior months during which the recipient was on the FFS plan.

   Providers correctly billed FFS claims and Medicaid correctly paid the claims, and then later changed the recipient to a different program retroactively enrolling and paying capitations to a PMHP for the periods previously approved for FFS. The payment of retroactive capitations caused the prior payment of FFS claims for the same dates of service and coverage, to be incorrect payments. The MOU includes post payment review but does not include retroactive enrollment processes to identify FFS issues.

   Effect:

   Paying capitations retroactively causes duplicate payment of services paid previously on FFS claims. Approximately 70% of the $1.6 million FFS Claims paid before the capitations paid for the same recipients and same dates of service.

   Issues:

   1.1 Medicaid did not implement a process to identify and recover FFS claims paid previously when Medicaid retro-enrolls and capitations pay retroactively.[10] As stated above, this is outside the MOU process.

   1.2 Federal law prohibits payment of FFS claims for services covered by a MCE contract.

   1.3 The providers may re-issue the claims to the MCE, however, in the absence of assistance from Medicaid the MCE may not pay.

[9] For example, Salt Lake County Health Department Contract Attachment B Section 3.3.3 Retroactive enrollment.
[10] See Email from BMHC dated May 28, 2021

2. Services covered by the PMHP do not use the regular psychiatric revenue codes for mental health services delivered in hospital overflow beds and other medical beds *used for mental health services*;
    a. Hospitals do not always have availability in the psychiatric unit and will admit patients to a medical unit for mental health services.
    b. Hospitals that do not have a dedicated psychiatric unit will admit patients for mental health services to a medical unit.

    The PMHP contract covers mental health services in a medical unit only when services are provided in lieu of being provided in a psychiatric unit and are provided to treat a mental health condition.[11]

    Issue:

    The MMIS PMHP Edit does not operate for mental health services billed not using the MMIS programmed psychiatric revenue codes described in paragraphs 2 a and 2 b. The MMIS PMHP edit only activates to stop payment when all three criteria including the programmed psychiatric revenue codes are present.

3. Medicaid Forced Payments: Medicaid operations incorrectly forced payment of 15 FFS inpatient claims amounting to $111,718 denied for payment by the payment control edits.

    Issue:
    Medicaid operations incorrectly forced payment of the claims for services covered by the PMHP contracts. Medicaid agrees the claims paid in error.

    Medicaid Bureau of Managed Healthcare (BMHC) used a Carve Out Spreadsheet that lists services not covered by the MCEs to provide criteria to the Medicaid Bureau of Operations (BMO). Certain BMO technicians have authority to force payment of FFS claims denied by MMIS payment controls. BMO incorrectly paid the claims based on the BMHC list of services not covered by the MCP. Medicaid administration has now directed BMHC to clarify the instructions.

[11]PMHP Contract Attachment C 1.1.2
(B) The Contractor shall pay for psychiatric inpatient hospital Covered Services regardless of where the service was delivered in the acute inpatient hospital.
(C) The Contractor shall be responsible for inpatient Covered Services for Enrollees regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder/intellectually disability, an organic disorder or a substance use disorder.

Recommendations

1 We recommend Medicaid develop, test and implement processes for the following:

1.1 Review and document the benefits and costs of paying capitations retroactively. Modify the PMHP contracts for retroactive capitation payment to the same retroactive term as the UMIC contracts.

1.2 Identify FFS claims paid during the same DOS covered by retroactive capitation payments.

1.3 Recover the paid FFS claims for recipients for whom capitations retroactively issue in compliance with 42 C.F.R. § 438.60 to avoid duplicate payment of FFS for services paid by capitation.

1.4 Add a provision to the PMHP contracts requiring PMHPs to repay providers for the FFS claims recovered by Medicaid for the retroactive period covered by the capitations paid.

1.5 Adjust the programming of the PMHP edit to operate for more service types to prevent incorrect payment of FFS claims covered by a PMHP. An example of incorrect payment not prevented by the PMHP edit are FFS claims for psychiatric services delivered in overflow beds not using the MMIS edit programmed revenue codes.

2 We recommend Medicaid:

2.1 Provide additional documentation and authoritative source materials to the Bureau of Medicaid Operation authorizing payment of denied claims to better clarify services carved out of the MCE contracts due and payable on the FFS plan.

2.2 Reference the Carve Out Spreadsheet of services not covered by capitation to the specific provision in the MCE contracts and other documents, and ensure concurrence with the authorizing document. Include clear instruction.

2.3 Maintain the Carve Out Spreadsheet list of services not covered by an MCP and send copy to BMO and UOIG when:

a. information is updated;

b. new issues are discovered.

Appendix One	FFS inpatient claims paid incorrect for PMHP recipients by DRG and year.

The table below summarizes the FFS inpatient claims paid incorrectly by DRG and year. Medicaid incorrectly paid the FFS inpatient claims since the patients received services paid by capitation to the PMHP for the same dates of service.

		Dates of Service					
		CY 2019		CY 2020		Combined	
DRG	Description	FFS Claims	Amount	FFS Claims	Amount	FFS Claims	Amount
880	Acute adjustment reaction & psychosocial dysfunction			2	$26,226	2	$26,226
881	Depressive neuroses	7	$43,856	12	56,224	19	100,080
882	Neuroses except depressive	1	2,841			1	2,841
884	Organic disturbances & mental retardation	3	79,800			3	79,800
885	Psychoses	73	984,770[12]	40	379,705	113	1,364,474
886	Behavioral & developmental disorders			1	3,373	1	3,373
	Sum	**84**	**$1,111,267**	**55**	**$465,528**	**139**	**$1,576,795**

Medicaid also incorrectly paid the ancillary FFS claims for these recipients. Appendix two summarizes the ancillary FFS claims incorrectly paid for these recipients.

[12] TCN 19031210000002500 dates of service included 15 days in 2018 starting December 16, and ending January 15, 2019 for total incorrect payment of $80,491.72

Appendix Two — Selected FFS ancillary claims paid incorrectly for PMHP recipients.

Medicaid incorrectly paid FFS ancillary claims for the same PMHP recipients listed in appendix one. The table below summarizes the FFS ancillary claims paid incorrectly, by CPT. As a result, the below was not randomly selected but a judgement sample.

CPT	CPT Description	Amount Paid	Count
90791	Comprehensive Multidisciplinary Evaluation	$1,050	6
90792	Electroconvulsive Therapy	1,058	10
90832	Emergency Dept. Visit 3/3 H:Cm E:Cm D:Hc	1,713	29
90833	Family Psychotherapy (Conjoint)(W Patient Present)	888	14
90834	Family Psychotherapy (Without Patient Present)	1,490	14
90836	Group Psychotherapy (Other Than Multi-Fam Group)	201	2
90837	Hospital Discharge Day Management; 30 Min Or Less	6,618	51
90839	Hospital Discharge Day Management; More Than 30 Min.	359	3
90846	Initial Hospital Care Per Day 3/3 H:Cm E:Cm D:Hc	150	1
90847	Initial Hospital Care Per Day 3/3 H:Cm E:Cm D:Mc	658	4
90849	Initial Hospital Care Per Day 3/3 H:Cm E:Cm D:Sf	42	1
90853	Mental Health Assessment, By Non-Physician	1,148	33
99080	Nursing Assessment/Evaluation	480	6
99211	Observ Or Inpat Hosp Care, Same Date, Moderate Severity	152	8
99213	Ofc, Outpat Visit E/M Est May Not Require Physician	782	8
99214	Office / Outpat Visit Estab. 2/3 H:Cm E:Cm D:Hc	407	4
99215	Office / Outpat Visit Estab. 2/3 H:Dt E:Dt D:Mc	256	2
99221	Office / Outpat Visit Estab. 2/3 H:Ep E:Ep D:Lc	155	2
99222	Prolong E&M/Psyctx Serv O/P	532	5
99223	Psych Diag Eval W/Med Srvcs Per 15 Minutes	4,238	27
99231	Psych Diagnostic Evaluation Per 15 Minutes	120	4
99232	Psychosocial Rehabilitation Services, 15 Min	2,932	54
99233	Psytx Crisis Initial 60 Min	6,269	79
99235	Psytx Pt&/Fam W/E&M 30 Min	129	1
99238	Psytx Pt&/Fam W/E&M 45 Min	331	6
99239	Psytx Pt&/Family 30 Minutes	1,548	19
99285	Psytx Pt&/Family 45 Minutes	298	2
99354	Psytx Pt&/Family 60 Minutes	98	1

CPT	CPT Description	Amount Paid	Count
H0031	Special Reports (Eg Ins, Med Data) Over Usual Commun	188	1
H2000	Subseq Hospital Care, Per Day 2/3 H:Dt E:Dt D:Hc	326	1
H2017	Subseq Hospital Care, Per Day 2/3 H:Ep E:Ep D:Mc	58	6
H2019	Subseq Hospital Care, Per Day 2/3 H:Pf E:Pf D:Sf	17	1
T1001	Targeted Case Management, Each 15 Minutes	1,852	29
T1017	Therapeutic Behavioral Services, Per 15 Minutes	2,155	32
Sum		**$38,698**	**466**

Appendix Three — PMHP coverage of Utah's Counties

PMHPs provide mental health services in all counties except Wasatch.

County	Inpatient & Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
Box Elder, Cache, Rich	Bear River Mental Health 1-800-620-9949; 435-752-0750	Fee-for-Service Network (any Medicaid provider), including Bear River Health Department: 435-792-6500
Beaver, Garfield, Kane, Iron, Washington	Southwest Behavioral Health Center 1-800-574-6763; 435-634-5600 (hospital prior authorization: 435-705-1388)	Southwest Behavioral Health Center 1-800-574-6763; 435-634-5600
Carbon, Emery, Grand	Four Corners Community Behavioral Health 1-866-216-0017; 435-637-7200 (hospital prior authorization: 435-637-2358 & after hours: 435-637-0893)	Four Corners Community Behavioral Health 1-866-216-0017; 435-637-7200
Daggett, Duchesne, Uintah, San Juan	Northeastern Counseling Center 1-844-824-6776 435-789-6300 – Vernal 435-725-6300 – Roosevelt San Juan Counseling – San Juan County 1-888-833-2992; 435-678-2992	Northeastern Counseling Center 1-844-824-6776 435-789-6300 – Vernal 435-725-6300 – Roosevelt San Juan Counseling – San Juan County 1-888-833-2992; 435-678-2992
Davis	Davis Behavioral Health 1-844-305-4782; 801-773-7060	Davis Behavioral Health 1-844-305-4782; 801-773-7060
Piute, Juab, Wayne, Millard, Sanpete, Sevier	Central Utah Counseling Center 1-800-523-7412; 435-283-8400; 1-877-469-2822	Central Utah Counseling Center 1-800-523-7412; 435-283-8400; 1-877-469-2822
Salt Lake	Salt Lake County Division of Behavioral Health Services/Optum Salt Lake County: 385-468-4707; Optum: 1-877- 370-8953	Salt Lake County Division of Behavioral Health Services/Optum Salt Lake County: 385-468-4707; Optum: 1-877- 370-8953
Summit	Healthy U Behavioral 1-833-981-0212; 801-213-4104	Healthy U Behavioral 1-833-981-0212; 801-213-4104
Tooele	Optum Tooele County 1-800-640-5349	Optum Tooele County 1-800-640-5349
Utah	Wasatch Behavioral Health 1-866-366-7987; 801-373-4760 (prior approvals: 801-494-0880)	Wasatch Behavioral Health 1-844-773-7128; 385-268-5000
Wasatch	Fee-for-Service Network (any Medicaid provider), including Wasatch County Family Clinic/Wasatch Behavioral Health - 435-654-3003	Fee-for-Service Network (any Medicaid provider), including Wasatch County Family Clinic/Wasatch Behavioral Health, 435-654-3003
Weber, Morgan	Weber Human Services 1-844-625-3700; 801-625-3700; (after-hours hospital prior authorization: 801-513-9641)	Weber Human Services 1-844-625-3700; 801-625-3700

https://medicaid.utah.gov/Documents/pdfs/managedcare/02-16-2021%20Managed%20Care%20Web%20PMHP%20Chart.pdf Updated 02/16/2021

GLOSSARY OF TERMS

Term	Description
ACO	Accountable Care Organization- Medicaid contracted health care entity organized to provide health benefits for Medicaid members in order to manage cost, utilization and quality of services. ACOs accept a set per member per month (capitation) payment for services.
BMHC	UDOH Bureau of Managed Health Care
BMO	UDOH Bureau of Medicaid Operations
CPT	Current Procedural Terminology
DOH	Utah Department of Health
DOS	Date(s) of Service
DRG	Diagnosis Resource Group
DTS	Utah Department of Technology Services
FFS	Fee for Service
ICP	Integrated Care Plans (ICP) or UMIC Plans provide recipients both physical and mental health on the same plan.
MCE	Managed Care Entity
MCO	Managed Care Organization
MCP	Managed Care Plan
Medicaid	Utah DOH: Division of Medicaid and Health Financing
MMIS	Medicaid Management Information System
NOR	Notice of Recovery
PAHP	Prepaid Ambulatory Health Plan
PIHP	Prepaid Inpatient Health Plan
PMHP	Prepaid Mental Health Plan
UMIC	Utah Medicaid Integrated Care
UOIG	Utah Office of Inspector General (UOIG)

MANAGEMENT RESPONSE

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Utah Department of Health
Division of Medicaid and Health Financing

Nathan Checketts
Interim Executive Director, Department of Health

Emma Chacon
Interim Director, Division of Medicaid and Health Financing

October 5, 2021

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

Thank you for the opportunity to respond to the audit titled *Audit of Fee-for-Service Claims Incorrectly Paid for PMHP Recipients* (Report 2021-02). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with most of the recommendations in this report. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Emma Chacon

Emma Chacon
Interim Director
Division of Medicaid and Health Financing

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Response to Recommendations

Recommendation 1.1

> *We recommend Medicaid develop, test and implement processes for the following:*
> *1.1 Review and document the benefits and costs of paying capitations retroactively. Modify the PMHP contracts to be consistent with the Division's other managed care contracts that don't allow systemic retroactive enrollment.*

Department Response:

The Department concurs with this recommendation. The Department modify the SFY 2023 PMHP contracts to discontinue retroactive capitations.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: July 1, 2022

Recommendation 1.2

> *We recommend Medicaid develop, test and implement processes for the following:*
> *1.2 Identify FFS claims paid during the same DOS covered by retroactive capitation payments.*

Department Response:

The Department concurs with this recommendation. The Department will develop, test and implement a process(es) to identify FFS claims paid during the same DOS covered by retroactive capitation payments.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: December 1, 2021

Recommendation 1.3

> *We recommend Medicaid develop, test and implement processes for the following:*
> *1.3 Recover the paid FFS claims for recipients for whom capitations retroactively issue in compliance with 42 C.F.R. § 438.60 to avoid duplicate payment of FFS for services paid by capitation.*

Department Response:

The Department concurs with this recommendation. Note that this has the same solution as 1.2. The Department will develop, test and implement a process(es) to recover FFS claims paid during the same DOS covered by retroactive capitation payments.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: December 1, 2021.

Recommendation 1.4

We recommend Medicaid develop, test and implement processes for the following:
1.4 Add a provision to the PMHP contracts requiring PMHPs to repay providers for the FFS claims recovered by Medicaid for the retroactive period covered by the capitations paid.

Department Response:

The Department partially concurs with this recommendation. The Department will review the current PMHP contract language to determine if existing language is sufficient to address this recommendation. If a contract language change is warranted, that change will be made effective July 1, 2022.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: July 1, 2022

Recommendation 1.5

We recommend Medicaid develop, test and implement processes for the following:
1.5 Adjust the programming of the PMHP edit to operate for more service types to prevent incorrect payment of FFS claims covered by a PMHP. An example of incorrect payment not prevented by the PMHP edit are FFS claims for psychiatric services delivered in overflow beds not using the MMIS edit programmed revenue codes.

Department Response:

The Department concurs with this recommendation. The Department will submit a DOT to expand the PMHP edit in the legacy system. In addition, the department will submit a CR to PRISM. However, if the CR will delay the PRISM implementation date, the CR will be delayed until post go live.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: February 1, 2022

Recommendation 2.1

We recommend Medicaid:

2.1 Provide additional documentation and authoritative source materials to the Bureau of Medicaid Operation authorizing payment of denied claims to better clarify services carved out of the MCE contracts due and payable on the FFS plan.

Department Response:

The Department concurs with this recommendation. The Department will work internally to improve understanding with BMO of MCO carved out services and revise BMOs internal Error Resolution Guides as applicable.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: January 1, 2022

Recommendation 2.2

We recommend Medicaid:
2.2 Reference the Carve Out Spreadsheet of services not covered by capitation to the specific provision in the MCE contracts and other documents, and ensure concurrence with the authorizing document. Include clear instruction.

Department Response:

The Department partially concurs with this recommendation. The carve out spreadsheet was a document constructed for PRISM design and not intended as an official document for use by BMO to force a claim. The Department will develop an SOP and update BMOs Internal Error Resolution Guides to provide appropriate guidance to BMO on this issue.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: January 1, 2022

Recommendation 2.3

We recommend Medicaid:
2.3 Maintain the Carve Out Spreadsheet list of services not covered by an MCP and send copy to BMO and UOIG when:
a. information is updated;
b. new issues are discovered.

Department Response:

The Department partially concurs with this recommendation. Please see our response to 2.2.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801 538-6088
Implementation Date: January 1, 2022

EVALUATION OF MANAGEMENT RESPONSE

Utah Medicaid management concurs with five and partially concurs with three of the eight recommendations.

Management must correctly design and then consistently execute the corrective actions to adequately correct the issues described.

Mangement partially concurs with the following recommendations.

Recommendation 1.4:
Add a provision to the PMHP contracts requiring PMHPs to repay providers for the FFS claims recovered by Medicaid for the retroactive period covered by the capitations paid.

Management Response:
The Department partially concurs with this recommendation. The Department will review the current PMHP contract language to determine if existing language is sufficient to address this recommendation. If a contract language change is warranted, that change will be made effective July 1, 2022.

Issue:
The current PMHP contract language does not take a position on this matter. The UOIG recommendation 1.4 is for the contract to add language requiring the PMHP cooperate on payment of invoices due and payable but submitted incorrectly directly to Medicaid for payment and then recovered by the UOIG.

Recommendation 2.2:
Reference the Carve Out Spreadsheet of services not covered by capitation to the specific provision in the MCE contracts and other documents, and ensure concurrence with the authorizing document. Include clear instruction

Management Response:
The Department partially concurs with this recommendation. The carve out spreadsheet was a document constructed for PRISM design and not intended as an official document for use by BMO to force a claim. The Department will develop an SOP and update BMOs Internal Error Resolution Guides to provide appropriate guidance to BMO on this issue.

Issue:
UOIG agrees an SOP and update to BMO's Error Resolution Guides are good tools to develop and update. All tools useful for payment of a carve out must reference to authoritative documents, i.e. contracts, the Utah State Plan, et cetera. Otherwise, incorrect payments may occur based on misunderstanding. *This protects not only Utah Medicaid and the taxpayer, but also the person deciding payment of the invoice.*

Recommendation 2.3

Maintain the Carve Out Spreadsheet list of services not covered by an MCP and send copy to BMO and UOIG when:

a. information is updated;

b. new issues are discovered.

Management Response:

The Department partially concurs with this recommendation. Please see our response to 2.2.

Issue:

We acknowledge the need for an SOP and update to the BMO Internal Error Resolution Guides. The SOP and update to the BMO Internal Error Resolution Guides will ultimately need a quick reference sheet for decision makers to use, perhaps similar to a carve-out sheet list of all carve outs. Again, the action that decides payment of claims must reference an authoritative document. Otherwise, incorrect payments may occur based on misunderstanding.

The management response is ambiguous as to the UOIG recommendation for Utah Medicaid Bureau of Managed Health Care to keep Medicaid Bureau of Operations and the UOIG updated when:

a. carve out information is updated and
b. new issues are discovered.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACTS

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UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste, and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

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