

## **17. CAPITATION PAYMENTS AND REPORTING TO CMS**

### **Overview of Capitation Processing**

The State generates capitation payments based on monthly claims submitted by MCOs on a roster. Payment amounts are not generated using the roster; rather, payments are made for enrollees billed by the MCOs, who are shown to be enrolled on WMS for that period. MCOs use the roster as a primary source for generating their monthly billings, as well as for electronic communications with the LDSS. A sample of the most recent roster file layout can be found in Appendix 17.1. The fiscal agent calculates the individual rates and total payment due based on the actuarial class of the recipient as determined by using data on the statewide eligibility file (WMS) and eligibility status. If all conditions are met, the MCO is issued a remittance statement and paid. A sample remittance statement can be found in the Managed Care Provider Manual at <http://www.emedny.org/ProviderManuals/ManagedCare/index.html>.

For capitation payments, edits are in place to deny claims if:

- § The recipient is not in the MCO that submits the claim
- § Date of service is prior to enrollment from date
- § Date of service is after disenrollment from date
- § Recipient is not on the Prepaid Capitation Plan subsystem
- § The eligibility files have data that will not allow a rate to be derived

Many fee-for-service edits also apply to capitation claims including, for example:

- § Recipient must be Medicaid eligible on date of service
- § No claim will be paid twice (Duplicate and Near Duplicate edits)
- § Client identification number must match the WMS eligibility file

MCOs must submit claims to the State's fiscal agent (Computer Science Corporation), adjusted to add recipients enrolled by the LDSS after roster production and to remove recipients disenrolled by LDSS after roster production. A sample roster pull-down schedule is contained in Appendix 17.2.

### **Payment of Fee-for-Service Claims**

Fee-for-service providers are paid only if the claim is for a service not in the contracted benefit package of the MCO. Claims payment/denial is controlled by the Scope of Benefits File that is maintained by the Department of Health and used by the Fiscal Agent to adjudicate claims

### **Roster Reconciliation Process**

Since the LDSS maintains both the enrollment file and the eligibility file, enrollment and eligibility issues are reconciled by the LDSS to the extent possible, adjusting files if appropriate. (A sample error report file layout is Appendix 17.3.)

## **Maintenance of Rate Files**

Rate files are maintained by the Office of Health Insurance Programs based on transmittals sent by the Division of Managed Care after the rates have been approved by the Division of the Budget (DOB). Once rates have been approved by DOB, they are transmitted to the MMIS Provider Enrollment Unit. Provider Enrollment then loads the rates on the Rate Master file for transmittal to Computer Science Corporation.

## **Retroactive Adjustments**

Retroactive adjustments are automatically processed by the fiscal agent after the rates are posted to the file. Retroactive adjustments are noted separately on the remittance statement sent to the MCOs.

## **CMS Reporting**

Reporting requirements can be found in the Terms and Conditions for the 1115 waiver.

## **Eligibility Groups**

A list of MMIS Aid Category codes that are assigned to Medicaid recipients is Appendix 17.4 and a crosswalk of the MMIS codes that get assigned to each of these eligibility groups is Appendix 17.5. Appendix 17.6 contains a Matrix that shows to which waiver eligibility group the aid category is assigned.

## **Medicaid Managed Care Component**

TANF/Safety Net Child -- Child in either a single parent or intact family, where the case is in receipt of cash assistance. Or, a child under 21 years of age in receipt of cash assistance.

TANF Adult -- Adults in a case with children, where the case is in receipt of cash assistance. The case must consist either of a single parent or intact family. Pregnant woman in receipt of cash assistance.

Safety Net Adult -- Adults in a case, where the case is in receipt of cash assistance through the safety net program. The case must consist either of a single adult or childless couple.

SSI 0-64 -- Disabled adults or children in receipt of SSI cash assistance.

SSI 65+ -- Aged adults in receipt of SSI cash assistance.

MA-Only TANF/Safety Net Child -- Child under 21 in either a single parent or intact family, where the case does not receive cash assistance.

MA-Only TANF Related Adult -- Adults in a case with children, single parent, intact family, or pregnant women where the case does not receive cash assistance.

MA-Only Safety Net Related Adult -- Adults in a case, where the case does not receive cash assistance. The case must consist either of a single adult, a childless couple, or adults in an intact household.

MA-Only SSI Related 0-64 -- Disabled adults or children that are not in receipt of SSI cash assistance.

MA-Only SSI Related 65+ -- Aged adults that are not in receipt of SSI cash assistance.

### **Family Health Plus and FHPlus Premium Assistance**

Adults with Children – Income above the Medicaid monthly income standard but gross family income at or below 150% FPL

Single Childless adults (19 – 64) – Income above the Statewide standard of need but gross household income at or below 100% FPL

### **Family Planning Expansion Program**

Women who lose Medicaid eligibility at the conclusion of their 60-day post partum period.

Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning.

## **17. CAPITATION PAYMENTS/FINANCIAL TRACKING AND REPORTING TO CMS (FHP)**

### **Payment of Fee-for-Service Claims**

Providers cannot bill for services provided on a fee-for-service basis for FHPlus enrollees. There is no fee-for-service reimbursement outside the FHPlus benefit package, except for pharmacy. Hospitals will directly bill NYS for the GME portion of the hospital rate paid by the MCO to the hospital. Eligible FQHCs will directly bill NYS for the “wrap around” portion of their Medicaid rate not reimbursed by MCOs for visits by enrollees who have selected a FQHC provider as their primary care provider, as provided for under federal law (BIPA) and/or the 1115 Waiver Supplemental Payment Transition Payment Program.

### **CMS Reporting**

Reports are submitted pursuant to the guidelines in the Terms and Conditions for the 1115 waiver.