DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUL 14 1995

From June Gibbs Brown
Inspector General

Subject Review of Medicare Payments to Health Maintenance Organizations for Medicaid Special Status Beneficiaries (A-04-94-01089)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Medicare Payments to Health Maintenance Organizations for Medicaid Special Status Beneficiaries." The Health Care Financing Administration (HCFA) makes fixed monthly payments to health maintenance organizations (HMO) for Medicare beneficiaries. The payment rate is increased for certain high-cost categories of beneficiaries. The Medicare beneficiaries who are also eligible for Medicaid (Medicaid status) are one of these high-cost categories. The objective of our review was to determine the appropriateness of the enhanced Medicare payments made to risk-based HMOs for such beneficiaries.

In our early alert issued on July 26, 1994, we reported to you that our work at two HMOs indicated potential significant overpayments for Medicaid special status beneficiaries. The HCFA advised us that, since that time, it has identified overpayments to HMOs nationwide totaling almost $70.5 million related to 30,829 Medicaid special status beneficiaries.

According to HCFA officials, the inappropriate payments to HMOs occurred because HCFA computer systems did not recognize those beneficiaries initially classified as Medicaid-status but who had subsequently lost their Medicaid eligibility. We recommend that HCFA collect the overpayments it has identified. In response to our draft report, HCFA concurred with our recommendation.

However, there remains a problem regarding Medicaid status submitted by HMOs for beneficiaries for whom the State does not pay the Medicare premium. The HCFA system cannot verify the Medicaid status of those beneficiaries. We are continuing to work with HCFA to identify a cost-effective method of controlling payments for beneficiaries whose Medicaid status was established by the HMOs.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions or further comments, please call me or have your staff contact

George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-04-94-01089 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS FOR MEDICAID SPECIAL STATUS BENEFICIARIES

JUNE GIBBS BROWN
Inspector General

JULY 1995
A-04-94-01089

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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Date JUL 14 1995

From June Gibbs Brown
Inspector General

Subject Review of Medicare Payments to Health Maintenance Organizations for Medicaid Special Status Beneficiaries (A-04-94-01089)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our Review of Medicare Payments to Health Maintenance Organizations (HMO) for Medicaid special status beneficiaries. The Health Care Financing Administration (HCFA) makes fixed monthly payments to HMOs for Medicare beneficiaries. The payment rate is increased for certain high-cost categories of beneficiaries. The Medicare beneficiaries who are also eligible for Medicaid are one of these high-cost categories and are referred to as Medicaid special status beneficiaries.

Objective

The objective of our audit was to determine the appropriateness of these enhanced Medicare payments made to risk-based HMOs for Medicaid special status beneficiaries.

Summary of Findings

On July 26, 1994, we alerted HCFA that our preliminary work at two HMOs indicated potential significant overpayments for Medicaid special status beneficiaries. The HCFA advised us that since that time it has identified overpayments to HMOs nationwide totaling almost $70.5 million.

According to HCFA officials, the inappropriate payments to HMOs occurred because HCFA computer systems did not recognize those beneficiaries initially classified as Medicaid special status but who had subsequently lost their Medicaid eligibility. The HCFA staff has advised us that they have implemented systems changes that will prevent similar inappropriate payments in the future.

We recommend that HCFA collect the overpayments it has identified. In response to our draft report, HCFA concurred with our recommendation and made some suggestions for changes of a technical nature. We made these changes where appropriate. The HCFA's response has been included in its entirety as the Attachment to this report.

Background

An HMO is a legal entity that provides or arranges provision of health services for its enrollees. If a Medicare beneficiary enrolls with a contracting HMO, Medicare makes fixed monthly payments to the HMO for the services provided the beneficiary. Some Medicare beneficiaries enrolled in an HMO may also be eligible for Medicaid benefits.

The Tax Equity and Fiscal Responsibility Act of 1982 authorized prospective per capita payments to HMOs under risk contracts at a rate equal to 95 percent of the average per capita cost of Medicare fee-for-service coverage. The payments are adjusted by a set of risk factors such as age and gender. The rate is then increased for certain high-cost categories of beneficiaries. Medicare beneficiaries who are also eligible for Medicaid benefits are included in these special status categories. Nationally, HCFA reports show that there are over 87,000 beneficiaries classified as Medicaid special status.

Most beneficiaries who are eligible for both Medicare and Medicaid benefits may have their Medicare premiums paid by the State. One of the options available to States under the Medicaid program is the buy-in for Medicare recipients. This gives the States the option of paying the Medicare Part B premium for any class of Medicaid-eligible recipients they chose. Payment of this Part B premium is recorded in the HCFA Third Party Master File (TPMF). Medicare Part B then pays for many physician services that the Medicaid program would have paid for.

Scope

The objective of our audit was to determine the appropriateness of the Medicare payments made to risk-based HMOs for Medicaid special status beneficiaries.

We performed a detailed review of eligibility for 140 beneficiaries listed on the Medicaid special status beneficiary reports for Humana Medical Plan, Inc. and PacifiCare of Texas, Inc. At Humana, we randomly selected 40 beneficiaries who were classified as Medicaid special status in the month of September 1992. We also reviewed records pertaining to 100 randomly selected beneficiaries classified as Medicaid special status for the month of December 1993 at PacifiCare. These beneficiaries were randomly chosen from a population of 9,119 at Humana and 958 at PacifiCare.

We alerted HCFA to our preliminary findings on July 26, 1994. In addition, we discussed their proposed corrective actions with them. Because HCFA acted promptly in response to our July 26, 1994 memorandum, there was no need for us to do additional work to fully validate the $70.5 million of overpayments that HCFA said were made to HMOs.

Field work was performed in Raleigh, North Carolina; San Antonio, Texas; and HCFA central office in Baltimore, Maryland from July to November 1994. The audit was performed in accordance with generally accepted government auditing standards.

Detailed Results of Review

At Humana, our analysis identified five beneficiaries who were inappropriately classified as being Medicaid eligible. Using Florida Medicaid data and data furnished by HCFA, we determined that Humana was overpaid enhanced capitation payments of approximately $25,500 between the months of May 1992 and December 1993 for these five beneficiaries. For example, one of our sample beneficiary's monthly payment rate when not included in one of the high-cost categories was $196.39; the payment rate for this beneficiary when included as eligible for Medicaid was $423.92.

At PacifiCare, our review disclosed that 24 beneficiaries classified as Medicaid special status were not eligible for Medicaid. These 24 ineligible beneficiaries were also ineligible for Medicaid benefits during various earlier periods. The inappropriate enhanced capitation payments for Medicaid eligibility made to PacifiCare for these 24 beneficiaries totaled $26,350 for the 2 years ending December 1993.

During the course of our review, we discussed this eligibility problem with HCFA officials. The HCFA informed us that a logic error in its computer systems caused the inappropriate Medicaid special status beneficiary payments to be made to HMOs. According to HCFA, its payment systems could not detect when Medicaid special status beneficiaries lost their Medicaid eligibility.

The HCFA's Office of Managed Care, Group Health Plan (GHP) data base is the source that generates the monthly capitation payments to HMOs. There are two ways to have a beneficiary placed on the GHP data base as having Medicaid special status:

- The first method of establishing Medicaid status occurs automatically when a State Medicaid program pays (buys-in) the Part B Medicare premium of a Medicaid recipient who is also eligible for Medicare. The TPMF records this transaction. The GHP data base is updated monthly with information from the TPMF. However, because of a logic error HCFA computer systems did not recognize those beneficiaries initially classified as Medicaid special status but who had subsequently lost their Medicaid eligibility. This error resulted in the $70.5 million overpayment.

- The second method of establishing Medicaid special status occurs when an HMO notifies HCFA that it has enrolled a Medicare beneficiary who is also eligible for Medicaid. The HCFA then adds the beneficiary to the GHP data base. This second method is necessary because some States do not buy Medicaid recipients into the Medicare program.

The Medicaid special status of beneficiaries whose eligibility is established under the second method will not change unless the HMO notifies HCFA that the beneficiary is ineligible. Because of this, the GHP data base may include beneficiaries, from any State, whose Medicaid status was erroneously determined under the second method.

The HCFA cannot verify the Medicaid special status of those beneficiaries whose Medicare eligibility was not bought in by their State.

We are continuing to work with HCFA to identify a cost-effective method of controlling payments for beneficiaries whose Medicaid special status was determined under the second method.

In October 1994, HCFA advised us that it had updated the payment systems with Medicaid special status information for Medicare beneficiaries whose Medicaid eligibility had been terminated. The HCFA has advised us that with these updates, it identified overpayments to HMOs nationwide totaling almost $70.5 million related to 30,829 Medicaid special status beneficiaries. In identifying these overpayments, HCFA staff has advised us that it has implemented system changes that should prevent future overpayments.

Recommendation

We recommend that HCFA collect the overpayments it has identified.

HCFA Comments

In response to our draft report, HCFA concurred with our recommendation and made some suggestions for changes of a technical nature. We made these changes where appropriate. The HCFA's response has been included in its entirety as the Attachment to this report.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratic

The Administrator
Washington, D.C. 20201

DATE MAY 24 1995

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Report: "Review of Medicare Payments to Health Maintenance Organizations (HMOs) for Medicaid Special Status Beneficiaries," (A-04-94-01089)

We reviewed the subject draft report concerning the appropriateness of enhanced Medicare payments made to risk-based HMOs for certain high cost categories of beneficiaries. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please advise us if you would like to discuss our position on the report's recommendation.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
"Review of Medicare Payments to Health Maintenance Organizations (HMOs) for Medicaid Special Status Beneficiaries,"
(A-04-94-01089)

OIG Recommendation
HCFA should collect the overpayments it has identified.

HCFA Response
HCFA concurs with the recommendation and we have implemented system changes that should prevent future overpayments.

Technical Comments on the Report
The report should include precise definitions and explanations of the terms "dual eligibility" and the "buy-in" program.

The report defines "Medicaid status" as those beneficiaries eligible for Medicaid benefits. The report should clarify if "Medicaid status" beneficiaries receive coverage of Medicare cost sharing amounts, additional Medicaid services not covered by Medicare, or both.

- The term "dual eligible" typically designates a Medicare beneficiary who also qualifies for assistance under the Medicaid program which includes services not covered by Medicare (i.e., prescription drugs, transportation, mental health, and substance abuse services, and long-term care services) or payments for Medicare cost sharing amounts or both.

- In the case of qualified Medicare beneficiaries and specified low-income Medicare beneficiaries, Medicaid assistance may be limited to some or all Medicare cost sharing.

The report should clarify which category of dually eligible Medicare beneficiaries receive enhanced risk payments. Medicare pays enhanced risk payments for all categories of dually eligible Medicare beneficiaries as described above.

The report should differentiate more clearly between "buy-in" as an aspect of Medicaid eligibility and coverage and "buy-in" as an administrative mechanism for States to electronically pay the Medicare Part B premium for dual eligibles.

- States must pay the Part B premiums of certain dual eligible beneficiaries--qualified Medicare beneficiaries and specified low income Medicare beneficiaries.

- States have the option of paying the Part B premium for other higher income dual eligibles.

- The "buy-in" program refers to the administrative mechanism States utilize to electronically pay the Part B premium to the Medicare program for some or all of its dual eligibles. It is our understanding that all States use the buy-in mechanism, though not necessarily for all of its dual eligibles.

- The characterization that the "buy-in" program is advantageous to the State because it shifts costs from Medicaid to Medicare is misleading. As explained above, States have the option of paying the Part B premium for certain dual eligibles. If the State did not pay the Medicare premium, the majority of these dual eligibles would pay for it out-of-pocket in order to receive physician and other medical services from the Medicare program. Thus, States' payments of the Part B premiums for these individuals reduce the costs to the beneficiaries, not the Medicaid program.

Page 2, second paragraph - We suggest starting the paragraph with "Most beneficiaries . . . ."

Page 2, second paragraph, 4th sentence - The Third Party Master File (TPMF) is a HCFA file, not an SSA file as stated.

Page 3, first bullet - The Group Health Plan (GHP) does not directly interface with the TPMF. It gets third party master data from the enrollment data base plus additional data we now prepare for the GHP.

Page 3, first bullet - We suggest adding a rewording of the last sentence from the second bullet to read "Approximately 20 percent of the records have a 6-month lag between the time that States buy Medicaid recipients into Medicare and the time their eligibility is recorded on the TPMF."

Page 3, second bullet - This bullet mixes portions of the first method with the second method. We suggest deleting the fourth sentence which was added to the first bullet above.

Page 4, first paragraph - The second line should be changed to read ". . . method will not change unless the HMO notifies . . . ."

Page 4, first two bullets - Deletion of ". . . some form of TPMF activity occurs or . . . ." in the first paragraph on page 4 will necessitate removal of the first two bullet points on page 4.