DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 10 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Payments to Medicare Managed Care Risk Plans for Deceased Beneficiaries (A-07-99-01283)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Payments to Medicare Managed Care Risk Plans for Deceased Beneficiaries." The objective of our audit was to determine if the Health Care Financing Administration (HCFA) stopped payments to risk health maintenance organizations (HMO) for deceased enrollees. Under Medicare risk-based contracts, HMOs receive a capitated payment every month for each of their Medicare enrollees. When a Medicare HMO enrollee dies, the disenrollment becomes effective on the first day of the month immediately following death. Thus, HCFA's final payment to the HMO should be for the month in which the beneficiary died.

Based on our analysis of the February 1998 Group Health Plan (GHP) data base, we found that HCFA paid $3.1 million in capitated payments to HMOs after beneficiaries died. Although HCFA recouped $1.2 million of the improper payments, $1.9 million remains outstanding due to both HCFA not being aware of all the deaths and its lack of attention in collecting some identified overpayments. We determined that the improper payments started as early as January 1993 and continued through April 1999. In addition, HCFA is continuing to pay HMOs approximately $250,000 per year on behalf of these deceased beneficiaries. We recommended that HCFA recover the $1.9 million erroneously paid and make immediate corrections to prevent overpayments of $250,000 per year being made to HMOs for deceased beneficiaries.

In response to our draft report, HCFA partially concurred with our recommendation to recover the erroneous payments. The HCFA stated they recouped $1.22 million in overpayments, however $0.68 million was not collected due to a HCFA 3-year retroactive payment adjustment policy. The HCFA concurred that there were systems problems which they corrected in mid-1998 with a system utility that updated the GHP master data base. The HCFA agreed to investigate and collect (where appropriate) any Office of Inspector General identified HMO overpayments for deceased beneficiaries and requested that we provide the necessary beneficiary-level information.

We provided HCFA staff with the beneficiary specific data to recover the outstanding overpayments as well as enable it to reexamine and refine the system utility to prevent further occurrences of overpayments. We also believe that HCFA should collect the $0.68 million because every beneficiary included in our review was recorded in HCFA's McCoy system with a change in beneficiary status (i.e., date of death change) within the 3-year policy limitation period. Furthermore, as we continued our review of potential overpayments for deceased beneficiaries in other HCFA computerized systems used in the managed care payment process, we identified an additional $1.1 million of erroneous payments related to the GHP database. All of the beneficiaries identified in this subsequent review died after February 1998, which was the cut-off date of our initial review.

Therefore, we also recommend that HCFA recover the additional $1.1 million in Medicare payments to HMOs which were not previously identified in the draft report. Beneficiary specific details have been shared with HCFA staff to facilitate recovery action. As we continue to address this issue in our review of other systems, we will work with your staff to provide the details of the potential overpayments.

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, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PAYMENTS TO MEDICARE MANAGED CARE RISK PLANS FOR DECEASED BENEFICIARIES

JUNE GIBBS BROWN
Inspector General

FEBRUARY 2000
A-07-99-01283

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 10 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Payments to Medicare Managed Care Risk Plans for Deceased Beneficiaries (A-07-99-01283)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our review of payments to Medicare managed care risk plans for deceased beneficiaries. Based on our analysis of the February 1998 Group Health Plan (GHP) data base, we found that the Health Care Financing Administration (HCFA) paid $3.1 million in capitated payments to health maintenance organizations (HMO) after beneficiaries died. Although HCFA recouped $1.2 million of the improper payments, $1.9 million remains outstanding due to both HCFA not being aware of all the deaths and its lack of attention in collecting some identified overpayments. We determined that the improper payments started as early as January 1993 and continued through April 1999. In addition, HCFA is continuing to pay HMOs approximately $250,000 per year on behalf of these deceased beneficiaries. We recommended that HCFA recover the $1.9 million erroneously paid and make immediate corrections to prevent overpayments of $250,000 per year being made to HMOs for deceased beneficiaries.

In response to our draft report, HCFA partially concurred with our recommendation to recover the erroneous payments. The HCFA stated they recouped $1.22 million in overpaid funds, however $0.68 million was not collected due to a HCFA 3-year retroactive payment adjustment policy. The HCFA concurred that there were systems problems which they corrected in mid-1998 with a system utility that updated the GHP master data base. The HCFA agreed to investigate and collect (where appropriate) any Office of Inspector General (OIG) identified HMO overpayments for deceased beneficiaries and requested that we provide the necessary beneficiary-level information.

We provided HCFA staff with the beneficiary specific data to recover the outstanding overpayments as well as enable it to reexamine and refine the system utility to prevent further occurrences of overpayments. We also believe that HCFA should collect the $0.68 million because every beneficiary included in our review was recorded in HCFA's Managed Care Option Information (McCoy) system with a change in beneficiary status (i.e., date of death change) within the 3-year policy limitation period. Furthermore, as we continued our review of potential overpayments for deceased beneficiaries in other HCFA

computerized systems used in the managed care payment process, we identified an additional $1.1 million of erroneous payments related to the GHP database. All of the beneficiaries identified in this subsequent review died after February 1998, which was the cut-off date of our initial review.

Therefore, we also recommend that HCFA recover the additional $1.1 million in Medicare payments to HMOs which were not previously identified in the draft report. Beneficiary specific details have been shared with HCFA staff to facilitate recovery action. As we continue to address this issue in our review of other systems, we will work with your staff to provide the details of the potential overpayments.

BACKGROUND

Managed care is defined as a health delivery and payment structure in which the payer organization seeks to control costs and maintain uniform quality of care by exercising specific controls over treatment and fees charged by participating providers. Managed care concepts have helped the private sector contain health care costs and limit excess utilization. The Congress, recognizing the potential cost-control advantages, enacted legislation to incorporate managed care options into the Medicare program. Since 1985, beneficiaries have had the option of enrolling in Medicare managed care risk plans[1], commonly known as HMOs.

Enrollment into Medicare HMOs becomes effective on the first day of the month. Under Medicare risk-based contracts, HMOs receive a capitated payment every month for each of their Medicare enrollees. When a Medicare HMO enrollee dies, the disenrollment becomes effective on the first day of the month immediately following death. Thus, HCFA's final payment to the HMO should be for the month in which the beneficiary died.

To effectively process enrollment and disenrollment activity, HCFA utilizes several database systems. These systems interact with the Social Security Administration (SSA) and the Railroad Retirement Board (RRB) to maintain eligibility data for the entire Medicare population. The primary system is HCFA's Enrollment Database (EDB) which contains *"entitlement data for persons who are or have ever been enrolled in Medicare."* The EDB receives most of its information from the SSA Master Beneficiary Record (or from RRB systems) and then shares specific data with other HCFA systems, including the GHP and the Common Working File (CWF). The GHP is HCFA's system identifying every beneficiary ever enrolled in Medicare managed care and is also used to help determine the monthly HMO payments. The CWF is a HCFA system used by fiscal intermediaries and carriers to process fee-for-service claims.

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[1]Risk plans have been converted to Medicare+Choice plans under provisions of the Balanced Budget Act of 1997.

Date of death notifications can come from several sources. According to HCFA officials, notifications made to either the HMO or HCFA will be forwarded to either SSA or the RRB. After confirming that the beneficiary has died, the SSA or RRB's system should update the EDB, which should then update the GHP. The date of death on the EDB can also be updated from the CWF. Regardless of the source, the GHP should accurately reflect the date the beneficiary died. After receiving the date of death notification, the GHP should disenroll the deceased beneficiary and stop Medicare payments on the first day of the month following death.

SCOPE

We performed our review in accordance with generally accepted government auditing standards, except that we did not review internal controls for any of the payment mechanisms. Our objective was to determine if HCFA stopped payments to risk HMOs for deceased enrollees.

We accessed the GHP as of February 1998 to determine beneficiaries who had enrolled in Medicare managed care risk plans and died, but had not been disenrolled. From the Managed Care Option Information (McCoy) system, which provides access to the GHP master file about specific beneficiary records and payment rates, we calculated HCFA's capitation payments to the HMOs for the deceased beneficiaries. We examined payment rates from as early as January 1993 to April 1999.

Our review was performed at the Office of Audit Services' regional office in Kansas City, Missouri from October 1998 through September 1999.

RESULTS OF REVIEW

The Medicare program paid risk HMOs $3.1 million for deceased beneficiaries of which HCFA has identified and recouped $1.2 million. However, we found that HCFA had not recovered $1.9 million in improper payments, and unless corrections are made to HCFA's HMO payment systems, approximately $250,000 in improper payments will continue to be made annually for beneficiaries identified in this review.

Medicare Capitation Payments for Deceased Beneficiaries

Using the GHP, we found 102 deceased beneficiaries who were enrolled in a risk HMO and had not been disenrolled effective the first day of the month immediately following death. We confirmed the date of death through the CWF and SSA's Master Beneficiary Record database.

All 102 beneficiaries died prior to February 1994. We determined that through April 1999, HCFA paid $3.1 million in capitations after the beneficiaries died. (A detailed listing of the number of HMOs by State is included as Attachment A.) Although HCFA identified and

recouped $1.2 million of the improper payments, $1.9 million remains outstanding and consists of the following:

- Overpayments of $1.2 million relate to 35 deceased beneficiaries where the HMOs continued to receive payments through at least April 1999. If corrections are not made, improper payments of approximately $250,000 per year will continue. Through discussions with HCFA, we believe these payments continue because HCFA is not aware of the specific beneficiaries who are enrolled after the date of death. To stop the overpayments, the OIG sent a list of the deceased beneficiaries to HCFA for corrective action.

- The remaining $700,000 relates to 67 beneficiaries where payments to the HMOs have stopped. However, HCFA only collected approximately 3 years of overpayments. HCFA stated its policy was to recoup 36 months of improper payments from the month the problem was identified. In 1997, we issued a report (A-14-96-00203) which stated *"Our review of statutory, regulatory, and manual provisions found no provisions that specify any time limits for the recovery of overpayments from risk-based HMOs (or for the correction of underpayments to such HMOs). Per 42 CFR 417.598 and section 5005 of the HMO Manual, HCFA is authorized to conduct enrollment reconciliations, as necessary, to ensure that payments do not exceed or fall short of the appropriate per capita rate of payment, but these sections do not address time frames for the reconciliations. We believe that there needs to be clearly specified time limits for the recovery of overpayments from risk-based HMOs."*

The HCFA stated they were aware payments were being made to HMOs for deceased beneficiaries and took actions to identify the problem. Specifically, there were instances where interactions between HCFA's systems came to an abnormal stop and were not properly restarted. As a result, HCFA continued to pay HMOs on behalf of deceased beneficiaries.

We concur with HCFA that HMO payment problems exist for deceased beneficiaries. The findings identified in this report relate to HCFA's GHP database. We have also identified potential overpayments for deceased beneficiaries in other HCFA computerized systems used in the managed care payment process. We will address these issues when we have completed our review of these systems.

RECOMMENDATIONS

We recommend that HCFA:

1. Recover the $1.9 million in improper capitation payments.

2. Make immediate system corrections to the GHP system to prevent overpayments of $250,000 per year being made for the identified deceased beneficiaries.

HCFA's COMMENTS

The HCFA partially concurred with our recommendations to recoup improper capitation payments and make corrections to prevent future overpayments. The HCFA stated they recouped $1.22 million in overpayments, however $0.68 million was not collected due to a HCFA 3-year retroactive payment adjustment policy. The HCFA also concurred there was a systems problem, but believed the problem was corrected. Through modifications to its systems, HCFA searches for beneficiaries whose date of death may not have been properly updated. The HCFA agreed to investigate and collect (where appropriate) any OIG identified HMO overpayments for deceased beneficiaries and requested that we provide the necessary beneficiary-level information.

OIG RESPONSE

We believe HCFA should recoup all payments made in the months after the beneficiaries died. In its comments to the draft report, HCFA stated it initiated a policy to make retroactive payment adjustments to a 3-year period preceeding the month in which it received **ANY** data (emphasis added) that would indicate a change in beneficiary status. For every beneficiary included in our review, HCFA received and recorded in its McCoy system the date of death (a change in beneficiary status) within the 3-year policy limitation period. Therefore, recoupment of all the overpayments identified in our report does not violate HCFA's policy.

We look forward to HCFA's enhancements to its systems to identify beneficiaries whose date of death may not have been properly updated.

BENEFICIARIES WHO DIED AFTER OUR DRAFT RESULTS WERE COMPILED

Since the issuance of the draft report, we accessed the GHP and found an additional 157 deceased beneficiaries who were enrolled in a risk HMO and who had not been

disenrolled effective the first day of the month immediately following death. All of the beneficiaries identified in this subsequent review died after February 1998, which was the cut-off date of our initial review. Matching payment information, we determined that through September 1999, HCFA paid an additional $1.1 million in capitation payments after the beneficiaries died. (A detailed listing of the number of HMOs by State is included as Attachment B.) Virtually none of the overpayments have been recovered. If corrections are not made, improper payments of approximately $1.1 million per year will continue.

ADDITIONAL RECOMMENDATIONS

We recommend that HCFA:

3. Identify and recoup all Medicare payments to HMOs made on behalf of all deceased beneficiaries, and

4. Recover the additional $1.1 million in improper capitation payments made on behalf of beneficiaries who died after February 1998, who were not included in our initial draft report.

We look forward to working with HCFA as we continue to review the computerized systems used in the managed care payment process. The complete text of HCFA's response is presented as Attachment C to this report.

Attachment A

Medicare Payments to Risk HMOs by State
For Deceased Beneficiaries

State	HMO	Number of Beneficiaries	Medicare Payments Since Death	Amount Recovered	Amount Outstanding
Arizona	1	1	$23,476	$0	$23,476
Arizona	2	2	46,402	11,883	34,519
Arizona	3	1	26,065	19,632	6,433
California	1	3	97,652	22,586	75,066
California	2	13	412,193	70,272	341,921
California	3	32	1,003,652	603,074	400,578
California	4	3	87,389	54,996	32,393
California	5	1	29,311	21,444	7,867
California	6	1	19,957	14,262	5,695
California	7	1	28,700	20,317	8,383
Florida	1	1	31,621	22,662	8,959
Florida	2	1	29,607	22,096	7,511
Florida	3	19	619,988	129,158	490,830
Florida	4	3	110,097	22,412	87,685
Illinois	1	4	102,513	51,906	50,607
Illinois	2	1	5,853	0	5,853
Indiana	1	1	36,093	0	36,093
Kentucky	1	1	20,462	14,754	5,708
Minnesota	1	1	29,532	0	29,532
Nevada	1	3	69,877	33,012	36,865
Nevada	2	2	55,821	16,028	39,793
New York	1	1	37,969	0	37,969
Oregon	1	1	21,356	0	21,356
Pennsylvania	1	1	40,203	28,579	11,624
Pennsylvania	2	2	71,859	48,470	23,389
Texas	1	1	19,439	13,867	5,572
Washington	1	1	19,947	0	19,947
Totals		102	$3,097,034	$1,241,410	$1,855,624

Notes: Beneficiaries Died Prior to February 1994
Payments After Death through April 1999

Medicare Payments to Risk HMOs by State
For Deceased Beneficiaries

State	HMO	Number of Beneficiaries	Medicare Payments Since Death	Amount Recovered	Amount Outstanding
Alabama	1	1	$8,326	$0	$8,326
Arizona	1	1	4,347	0	4,347
Arizona	2	1	4,271	0	4,271
Arizona	3	1	6,317	0	6,317
Arizona	4	2	11,564	0	11,564
Arizona	5	1	7,111	0	7,111
California	1	5	28,754	0	28,754
California	2	15	123,848	0	123,848
California	3	1	8,114	616	7,499
California	4	5	12,312	0	12,312
California	5	1	8,966	0	8,966
California	6	8	62,207	0	62,207
California	7	1	4,476	340	4,136
California	8	1	8,093	0	8,093
California	9	1	6,977	0	6,977
Colorado	1	1	3,955	0	3,955
Florida	1	3	25,296	0	25,296
Florida	2	3	22,693	0	22,693
Florida	3	1	6,782	0	6,782
Florida	4	1	11,058	0	11,058
Florida	5	16	120,472	0	120,472
Florida	6	1	6,317	0	6,317
Florida	7	1	4,635	0	4,635
Florida	8	2	14,857	0	14,857
Florida	9	1	7,670	0	7,670
Florida	10	2	12,947	0	12,947
Florida	11	2	14,799	0	14,799
Florida	12	1	7,205	0	7,205
Florida	13	1	8,276	0	8,276

Medicare Payments to Risk HMOs by State
For Deceased Beneficiaries

State	HMO	Number of Beneficiaries	Medicare Payments Since Death	Amount Recovered	Amount Outstanding
Florida	14	1	11,856	0	11,856
Georgia	1	1	4,272	0	4,272
Georgia	2	1	7,033	0	7,033
Illinois	1	2	16,763	0	16,763
Illinois	2	5	33,869	0	33,869
Indiana	1	5	35,988	0	35,988
Louisiana	1	1	8,723	0	8,723
Louisiana	2	1	7,489	0	7,489
Mass.	1	7	55,542	0	55,542
Mass.	2	4	28,349	0	28,349
Maryland	1	1	5,189	0	5,189
Michigan	1	1	9,674	0	9,674
N. Carolina	1	1	5,407	0	5,407
New Jersey	1	2	11,406	0	11,406
New Jersey	2	1	5,267	408	4,859
New Jersey	3	1	8,195	0	8,195
New Mexico	1	2	10,474	0	10,474
Nevada	1	2	12,737	0	12,737
New York	1	3	25,118	0	25,118
New York	2	1	11,300	0	11,300
New York	3	1	2,869	0	2,869
New York	4	1	4,919	0	4,919
New York	5	2	18,423	0	18,423
Ohio	1	1	5,080	0	5,080
Oregon	1	1	3,973	0	3,973
Oregon	2	1	4,362	0	4,362
Oregon	3	3	17,136	0	17,136
Pennsylvania	1	3	19,746	0	19,746
Pennsylvania	2	1	7,147	0	7,147

Medicare Payments to Risk HMOs by State
For Deceased Beneficiaries

State	HMO	Number of Beneficiaries	Medicare Payments Since Death	Amount Recovered	Amount Outstanding
Pennsylvania	3	8	73,842	801	73,041
Pennsylvania	4	3	18,759	0	18,759
Rhode Island	1	3	15,066	0	15,066
Rhode Island	2	3	17,801	0	17,801
Texas	1	3	17,953	0	17,953
Texas	2	3	24,645	0	24,645
Wash.	1	1	3,865	0	3,865
Totals		157	$1,142,882	$2,165	$1,140,717

Notes: Beneficiaries Died After February 1998
Payments After Death through September 1999

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 7 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Review of Payments to Medicare Managed Risk Plans for Deceased Beneficiaries," (A-07-99-01283)

Thank you for the opportunity to review and comment on the above subject report. The report focused on payments made to risk Health Maintenance Organizations (HMOs) for deceased beneficiaries, and whether the Health Care Financing Administration (HCFA) stopped payments to risk HMOs for deceased enrollees. The report found that HCFA paid $3.1 million in capitated payments to HMOs after beneficiaries died.

We concur with the recommendations in the report. Our detailed comments follow:

OIG Recommendation 1
HCFA should recover the $1.9 million in improper capitation payments.

HCFA Response
We partially concur and have recouped $1.22 million in overpaid funds. In 1994, HCFA implemented a retroactive payment adjustment policy (Operational Policy Letters 12 and 13) that limits payment adjustments to "a 3-year period preceding the month in which we receive any data that would indicate a change in beneficiary status." Under this policy, retroactive payment adjustments (both up and down) would be limited to a 3-year period preceding the month in which we receive any data that would indicate a change in beneficiary status. The 3-year retroactive policy would apply to both risk and cost contractors as well as health care prepayment plans. As this policy precludes us from recouping overpayments that exceed the 36-month window, we can not recover the outstanding $.68 million.

We note that this policy was developed to bring managed care time frames for payment adjustments more in line with the fee-for-service recoupment procedures.

OIG Recommendation 2
HCFA should make immediate system corrections to the Group Health Plan (GHP)

system to prevent overpayments of $250,000 per year being made to HMOs for the identified deceased beneficiaries.

HCFA Response

We concur that there was a systems problem; however, we believe we have corrected this problem with the establishment of a utility in mid-1998. This utility searches for notifications of death that may have been dropped during nightly updates of the Enrollment Database to the GHP Master Database. This system utility is run once a month and is included in the monthly enrollment and payment processes that creates the capitation payments and enrollment reports for the managed care plans. If the OIG has identified additional deceased beneficiaries, we would ask that beneficiary-level information be provided to allow us to investigate and recoup additional funds, if appropriate. This information will also allow us to reexamine and refine our utility to prevent further occurrences, if necessary.

Additionally, HCFA has other initiatives underway to enhance our ability to collect and maintain accurate and timely information on the death of Medicare beneficiaries. One of these initiatives is the Beneficiary Database Project which is in the prototype developmental phase. Reports of Medicare beneficiary deaths will be solicited from a wide range of viable sources. This database will be the foundation for a formal data resource of beneficiary information that will serve all Medicare software applications.