



Memorandum

Date . JUN 1 21997

From June Gibbs Brown
Inspector General *June Gibbs Brown*

Subject Systems and Overpayment Issues: End Stage Renal Disease Payments to Health Maintenance Organizations (A-14-96-00203)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report which provides you with the results of our continuing review of Medicare payments made to risk-based health maintenance organizations (HMO) on behalf of beneficiaries classified as having end stage renal disease (**ESRD**).

The objective of this review was to continue and update our work (see our report, "**Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries**" (A-04-94-01090)) to determine the appropriateness of payments made to HMOS on behalf of **ESRD-classified** beneficiaries. Our prior review found that the Health Care Financing Administration's (**HCFA**) systems did not recognize ESRD eligibility termination dates for beneficiaries enrolled in HMOS. This review examines eligibility and payment issues on behalf of those beneficiaries who were not included in our prior review.

We found that **HCFA's** systems have been modified to maintain a more complete history of ESRD information and, effective October 1996, HCFA - implemented systems changes to adjust payments to HMOS when a beneficiary's ESRD entitlement ends. Although several recalculations were necessary to properly identify beneficiaries' correct periods of ESRD eligibility resulting in a mistaken \$100 million in overpayments being issued in October 1996, we commend HCFA for its efforts in updating data in its systems for the ESRD beneficiary population and implementing software modifications to recognize ESRD end dates for HMO payment adjustments and enrollment decisions. These systems enhancements will prevent approximately \$15 million a year in future overpayments.

However, we also found that HCFA is unnecessarily limiting the time period for recovery of the overpayments from HMOS made on behalf of beneficiaries whose ESRD entitlement had ended. We identified \$20.5 million in

overpayments which HCFA does not plan to collect because of the time limits it is imposing on its recovery efforts. These overpayments were made to HMOS between January 1992 and February 1995 on behalf of beneficiaries who, according to HCFA's records, no longer meet the statutory definition for ESRD entitlement because they had a successful kidney transplant or are no longer dialyzing. The \$20.5 million in overpayments is **in addition** to the overpayments identified in our prior report. We noted that the law, regulations, and the HCFA HMO manual are silent regarding a statute of limitations to recover overpayments from risk **HMOs**.

We are recommending that HCFA recover **all** overpayments that have occurred at least since 1992 as a result of the system not recognizing ESRD termination dates for beneficiaries enrolled in HMOS and issue regulations to clearly specify time limits for the recovery of overpayments from **HMOs**. Also, aggressive management action should be taken to curtail payments whenever it is known or anticipated that a major overpayment may occur, such as the overpayment that occurred in October 1996.

In response to our draft report, HCFA disagreed with our recommendation to recover all overpayments that occurred since 1992, but agreed with our other recommendations. The complete text of HCFA's response is presented as the attachment to this report.

We continue to believe that HCFA should recover overpayments at least since 1992. This situation is especially disconcerting to us since 71 HMOS received this \$20.5 million in a highly enhanced payment rate to provide a special type of service which they did not provide. We are unable to determine HCFA's justification for limiting the time period for recovery of overpayments, while setting no time limitations on paying underpayments to the **HMOs**. We also still have concerns about the separate recovery schedules HCFA established for overpayment recoveries and the resulting distinction and apparent disparity in treatment between beneficiaries who lost ESRD status while enrolled in a plan and those who lost ESRD status before enrollment in a plan. Prior to HCFA's systems enhancements implemented in August 1996, the systems were not able to calculate end dates, however, the systems can now calculate end dates. We note that HCFA's systems do have information which would allow retroactive adjustments at least to 1992-- we used this information to identify the misclassified beneficiaries in our review and to calculate the overpayments.

Page 3- Bruce C. Vladeck

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 call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (41 O) 786-7104. Copies of this report are being sent to other interested Department officials.

Please refer to Common Identification Number A-14-96-00203 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SYSTEMS AND OVERPAYMENT ISSUES:
END STAGE RENAL DISEASE
PAYMENTS TO
HEALTH MAINTENANCE ORGANIZATIONS**



**JUNE GIBBS BROWN
Inspector General**

**JUNE 1997
A-14-96-00203**

**Memorandum**

Date JUN 12 1997
From June Gibbs Brown
Inspector General *June G Brown*
Subject Systems and Overpayment Issues: End Stage Renal Disease Payments to Health Maintenance Organizations (A-14-96-00203)
To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our continuing review of Medicare payments made to risk-based health maintenance organizations (HMO)¹ on behalf of beneficiaries classified as having end stage renal disease (ESRD).

The objective of this review was to continue and update our prior work (see our report, *"Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries" (A-04-94-01090)*) to determine the appropriateness of payments made to HMOs on behalf of ESRD-classified beneficiaries. Our prior review found that the Health Care Financing Administration's (HCFA) systems did not recognize ESRD eligibility termination dates for beneficiaries enrolled in HMOs. The scope of the prior review included those beneficiaries who did not meet HCFA rules of HMO enrollment as an ESRD-eligible person. This review examines eligibility and payment issues on behalf of those beneficiaries who were not included in our prior review.

We found that HCFA's systems have been improved and now maintain a more complete history of ESRD information and, effective October 1996, HCFA implemented systems changes to adjust payments to HMOs when a beneficiary's ESRD entitlement ends. Although several recalculations were necessary to properly identify beneficiaries' correct periods of ESRD eligibility resulting in a mistaken \$100 million in overpayments being issued in October 1996, we commend HCFA for its efforts in updating data in its systems for the ESRD beneficiary population and implementing software modifications to recognize ESRD end dates for HMO payment adjustments and enrollment

¹ Our term "HMO" in this report includes both HMOs and competitive medical plans with Medicare risk contracts.

decisions. These systems enhancements will prevent approximately \$15 million a year in future overpayments.

However, we also found that HCFA is unnecessarily limiting the time period for recovery of the overpayments from HMOs made on behalf of beneficiaries whose ESRD entitlement had ended. We identified \$20.5 million in overpayments which HCFA does not plan to collect because of the time limits it is imposing on its recovery efforts. These overpayments were made to HMOs between January 1992 and February 1995 on behalf of beneficiaries who, according to HCFA's records, no longer meet the statutory definition for ESRD entitlement because they had a successful kidney transplant or are no longer dialyzing. The \$20.5 million in overpayments is in addition to the overpayments identified in our prior report. We noted that the law, regulations, and the HCFA HMO manual are silent regarding a statute of limitations to recover overpayments from risk-based HMOs.

We are recommending that HCFA recover *all* overpayments that have occurred at least since 1992 as a result of the system not recognizing ESRD termination dates for beneficiaries enrolled in HMOs and issue regulations to clearly specify time limits for the recovery of overpayments from HMOs. Also, aggressive management action should be taken to curtail payments whenever it is known or anticipated that a major overpayment may occur, such as the overpayment that occurred in October 1996.

In response to our draft report, HCFA disagreed with our recommendation to recover all overpayments that occurred at least since 1992, but agreed with our other recommendations. The complete text of HCFA's response is presented as the attachment to this report.

We continue to believe that HCFA should recover overpayments at least since 1992. This situation is especially disconcerting to us since 71 HMOs received this \$20.5 million in a highly enhanced payment rate to provide a special type of service which they did not provide. We are unable to determine HCFA's justification for limiting the time period for recovery of overpayments, while setting no time limitations on paying underpayments to the HMOs. We also still have concerns about the separate recovery schedules HCFA established for overpayment recoveries and the resulting distinction and apparent disparity in treatment between beneficiaries who lost ESRD status while enrolled in a plan and those who lost ESRD status before enrollment in a plan. Prior to HCFA's systems enhancements implemented in August 1996, the systems were not able to calculate end dates, however, the

systems can now calculate end dates. We note that HCFA's systems do have information which would allow retroactive adjustments at least to 1992-- we used this information to identify the misclassified beneficiaries in our review and to calculate the overpayments.

BACKGROUND

Under the Medicare risk program, HCFA contracts with HMOs to provide comprehensive health services on a prepayment capitated basis to enrolled beneficiaries. For each enrolled beneficiary, HCFA authorizes a fixed monthly payment which is adjusted by a set of risk factors such as the beneficiary's age and gender. An enhanced payment rate is made for certain high-cost categories of beneficiaries, such as those having ESRD. Each month, HCFA provides HMOs with a special status report which identifies beneficiaries for whom the HMO received an enhanced ESRD payment amount.

Regulations found at 42 CFR 406.13 define ESRD as the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. These regulations state that entitlement ends with:

- (1) The end of the 12th month after the month in which a course of dialysis ends, unless the individual receives a kidney transplant during that period or begins another regular course of dialysis; or
- (2) The end of the 36th month after the month in which the individual has received a kidney transplant, unless the individual receives another transplant or begins a regular course of dialysis during that period.

Once the entitlement period ends, a beneficiary is no longer classified as having ESRD. When a beneficiary is no longer classified as having ESRD, the enhanced ESRD payment to the HMO on behalf of that beneficiary is no longer payable.

In February 1996 we issued a report "*Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries*" (A-04-94-01090). In that review we found a weakness in HCFA's systems which caused the system not to recognize ESRD termination dates for beneficiaries enrolled in HMOs. As a result, the system triggered

the higher ESRD capitation rate to plans rather than the regular capitation rate even if the beneficiary was no longer diagnosed as having ESRD. We concentrated our prior review on ESRD-classified beneficiaries who, according to HCFA's records, had an ESRD start date prior to enrollment date in a Medicare HMO and were not designated as a prior commercial member of that plan. That situation is indicative of an inappropriately classified ESRD beneficiary because individuals who have been medically determined to have ESRD are not eligible to enroll in an HMO as a Medicare beneficiary unless the individual is a commercial member of the HMO just prior to Medicare eligibility. Our review found overpayments to HMOs on behalf of that group of beneficiaries which totaled approximately \$35.7 million for the period October 1990 through February 1995.

We recommended that HCFA replace the erroneous ESRD information in its files, collect the overpayments which were caused by the erroneous ESRD information, and make the necessary procedural and systems changes to prevent payment of the higher ESRD capitation rate to plans on behalf of beneficiaries who no longer meet the statutory definition of ESRD. The HCFA concurred with our recommendations.

SCOPE

The objective of this review was to continue and update our work in determining appropriateness of payments to HMOs on behalf of ESRD-classified beneficiaries who were not included in our prior review. We identified two categories of beneficiaries who were not included in our prior review: (1) beneficiaries whose ESRD status terminated while enrolled in a plan and (2) beneficiaries whose ESRD status terminated before Medicare enrollment in a plan, but who were designated as a prior commercial member of the plan. We included both transplant and dialysis beneficiaries in our review.

From HCFA's Program Management and Medical Information System (PMMIS) which captures medical and demographic information for Medicare's ESRD population, we identified all ESRD-classified beneficiaries who (1) had a transplant and who were currently or previously enrolled in a risk-based HMO or (2) had dialysis services only and were currently enrolled in an HMO.

Our review examined the appropriateness of payments through January 1996. For the ESRD beneficiaries who had a transplant, we deleted all records for

those who had a transplant after January 1993 because ESRD entitlement continues for 36 months after a successful kidney transplant. We identified 665 transplant beneficiaries in this population who were enrolled in risk-based HMOs and were not included in our prior review. For the dialyzing beneficiaries, we deleted all records for those whose last dialysis was shown after January 1995 because ESRD entitlement continues for 12 months after a person stops dialysis. There were 3,360 dialysis beneficiaries in this population.

For each of the beneficiaries in our populations who were enrolled in risk-based HMOs and who were not included in our prior review, we examined the payment histories including payment adjustments for the period of January 1992 through September 1996. We examined ESRD eligibility information from ESRD inception through September 1996.

We also obtained the beneficiaries' history from HCFA's McCoy system to determine periods of ESRD-classification, managed care plan enrollment data, as well as demographic information, such as the beneficiary's gender, date of birth, county of residence, institutional status, and Medicaid status.

We then queried HCFA's Renal Entitlement and Beneficiary Utilization System (REBUS) to verify periods of ESRD-classification and determine the transplant and dialysis status of each beneficiary. We examined the REBUS data base to determine if there was any indication of a transplant failure or further dialysis.

To test the reliability of the REBUS information, we performed a review of ESRD eligibility at Group Health Cooperative of Puget Sound (Group Health), a risk-based competitive medical plan in Seattle, Washington. We reviewed Group Health's records and records at the Northwest Renal Network to verify ESRD status for 44 of the beneficiaries in our populations who were enrolled in Group Health.

Based on our analysis of the beneficiary histories and the REBUS information, and our ESRD eligibility verification for the Group Health beneficiaries, we identified beneficiaries who no longer met the statutory definition of ESRD because they had a successful kidney transplant or were no longer dialyzing. Using HCFA's national demographic cost factors for each misclassified beneficiary and the Standardized Per Capita Rates of Payment tables, we calculated the overpayments to the plans.

We also reviewed applicable laws, regulations, and Medicare manuals to determine if there are provisions in place to specify time limits or other limits for the recovery of overpayments from HMOs.

Our review was made in accordance with generally accepted government auditing standards. Our work was done at Group Health, Northwest Renal Network, and at HCFA headquarters in Baltimore, Maryland between December 1995 and November 1996.

RESULTS OF REVIEW

During the course of our review, HCFA implemented systems modifications which allow for the maintenance of a more complete

history of ESRD information. Our analysis of data in the system for the beneficiaries we tested in Group Health shows that the ESRD information shown in the system agrees with the ESRD information we obtained from Group Health and the Northwest Renal Network. Effective October 1996, HCFA's implemented systems changes to adjust payments to HMOs when a beneficiary's ESRD entitlement ends. Although several recalculations were necessary to properly identify beneficiaries' correct periods of ESRD eligibility resulting in a mistaken \$100 million in overpayments being issued in October 1996, we commend HCFA for its efforts in implementing these significant systems improvements.

However, we also found that HCFA is unnecessarily limiting recovery of the overpayments which were made on behalf of beneficiaries whose ESRD entitlement had ended. We identified \$20.5 million in overpayments which HCFA does not plan to collect because of the time limits it is imposing on its recovery efforts. This \$20.5 million is in addition to the overpayments identified in our prior report. We noted that the law, regulations, and the HCFA HMO manual are silent regarding a statute of limitations to recover overpayments from risk-based HMOs.

This situation is especially disconcerting to us since 71 HMOs received this \$20.5 million in a highly enhanced rate to provide a special type of service which they did not provide.

▶ **SYSTEMS CONTAIN MORE COMPLETE ESRD HISTORY**

As part of a systems modification project that began in 1994, HCFA has now completed its enhancements of the PMMIS to use it as a centralized source for identifying periods of ESRD entitlement and for posting the entitlement periods to the Enrollment Database (EDB). As part of this initiative, HCFA obtained updated information on the ESRD beneficiary population and instituted procedures to facilitate evaluation of continued Medicare ESRD eligibility. In addition, HCFA has recently implemented the REBUS system which contains ESRD information maintained in PMMIS. This is especially important since previous data on HMO beneficiaries with ESRD was incomplete or nonexistent.

As indicated above, we used information in the REBUS system to determine the transplant and dialysis status of the beneficiaries in our populations. We found that the REBUS system records information on kidney transplants and transplant failures, as well as information on dialysis performed while an HMO beneficiary was an inpatient even though bills are not submitted for these beneficiaries. The REBUS system also records, in most cases, a yearly status of the beneficiary's ESRD modality status, i.e., if the beneficiary has a functioning graft, is receiving hemodialysis, etc.

Our work at Group Health confirmed information found in the REBUS system. Our review of the REBUS information for 44 beneficiaries at Group Health showed that the REBUS information agreed with the records maintained by Group Health and the Northwest Renal Network for 42 of the 44 beneficiaries. For the two remaining beneficiaries, REBUS information indicated they returned to dialysis subsequent to their kidney transplant which Group Health's records did not reflect.

▶ **HMO PAYMENT SYSTEM NOW RECOGNIZES ESRD END DATES**

In August 1996, HCFA's HMO payment system began accessing the EDB to determine beneficiaries' dialysis and transplant status. If the EDB shows that a period of ESRD has ended because the beneficiary had a successful kidney transplant or has not received dialysis treatments for a consecutive 12-month period, the system uses the end date to calculate payment adjustments to the HMOs. Actual HMO payment adjustments began effective October 1996. Updated status on ESRD beneficiaries, including those

enrolled in HMOs, will be obtained on a continuing basis through the ESRD networks.

▶ ***HMOs HAVE RECEIVED SIGNIFICANT OVERPAYMENTS***

Since HCFA's system did not recognize or react to ESRD termination dates for payment purposes until October 1996, the cumulative effects of the overpayments for periods prior to that time are sizable.

Monthly payment rates to plans on behalf of ESRD-classified beneficiaries are substantially greater than the regular non-ESRD payment rates. For example, during 1995 Group Health's rate for regular Medicare beneficiaries averaged approximately \$276 per month. For ESRD beneficiaries, Group Health's enhanced rate was approximately \$3,200 per month. Each month that a beneficiary is not eligible for ESRD status results in a significant overpayment to an HMO. Our review found that, in some cases, overpayments to HMOs on behalf of beneficiaries who lost their ESRD status spanned over 10 years.

▶ ***HCFA'S OVERPAYMENT RECOVERY ACTION***

The HCFA intends to recover only a portion of the overpayments to HMOs which were caused by its system not recognizing ESRD termination dates.

In February 1995, HCFA advised HMOs that it was in process of strengthening its ESRD payment process and would begin enforcing ESRD rules effective March 1995. In February 1996, HCFA advised HMOs that due to other priorities and resource limitations, the system enhancements had been delayed and advised plans that when the enhancements were implemented there would be no time limit for paying underpayments, but any resulting overpayments would be recovered as follows:

- ▶ for beneficiaries who had ESRD after HMO enrollment but who no longer qualify as ESRD because they had a successful transplant or who had not dialyzed for 12 consecutive months, overpayment recoveries would be made retroactively to March 1995, and
- ▶ for beneficiaries who were once ESRD but who were not ESRD at the time of HMO enrollment or for beneficiaries who never had ESRD, recoveries would be for up to 3 years (date not specified).

When implementing its systems enhancements in August 1996, HCFA identified \$132 million in overpayments based on the above recovery plan on behalf of beneficiaries whose ESRD eligibility had ended. Overpayments were calculated back to March 1995 for beneficiaries whose ESRD entitlement ended while enrolled in a plan and retroactively to October 1993 for beneficiaries who were not entitled to ESRD at the time of enrollment or who never had ESRD. The systems enhancements also identified \$2 million in underpayments due the HMOs for unlimited retroactive time periods.

Since in many cases the identified overpayment to individual HMOs was substantial, HCFA decided to give the HMOs time to review the overpayment data for accuracy and select a repayment plan. The optional repayment plans included withholding the entire overpayment from the October 1996 monthly capitation payment, or withholding 1 percent of the monthly capitation payment amount from the months of October 1996 through February 1997 and 2.5 percent per month thereafter until the entire amount is repaid. A manual adjustment in HCFA's systems was made to prevent the overpayment collection from being initiated in September 1996 which allowed the plans an opportunity to review the potential overpayment calculations. The \$2 million in identified underpayments was issued to the plans in September 1996.

Shortly after the September capitation payments to the HMOs were issued, HCFA realized that its updated ESRD information had missing data about some beneficiaries' ESRD status. After reexamining the beneficiaries' ESRD history on its system, HCFA corrected the gaps in the beneficiaries' ESRD status and recalculated the payments to the HMOs for October. As a result of this recalculation, HCFA determined that the \$132 million in previously-identified overpayments was overstated by \$102 million. However, since the decision not to collect the \$132 million in September was done by a manual adjustment rather than a systems-generated action, the monthly capitation payment calculations in October were made as if \$132 million had actually been collected in September. As a result, an extra \$102 million was issued to the HMOs in October 1996. In October 1996, HCFA also began withholding the recalculated ESRD overpayments from the HMOs according to the repayment plan selected by the HMOs. In October 1996, approximately \$18 million was withheld from the HMOs.

We issued a memorandum to HCFA in October 1996 expressing our concern over this situation and met with your staff to discuss this \$102 million in overpayments and the loss of interest to the trust funds as a result of this unsupported disbursement.

We were pleased to note that when calculating the November 1996 monthly capitation payments, HCFA withheld the outstanding portion of the \$102 million that was erroneously issued to the HMOs in October 1996. A payment adjustment was also made to withhold a portion of the outstanding ESRD overpayment per the ongoing repayment plan. Approximately \$94 million was withheld from the HMOs in November 1996 which, when coupled with the \$18 million withheld in October 1996, effectively recaptured the \$102 million in overpayments and a portion of the correctly identified overpayments of about \$30 million. The HMOs were advised on November 1, 1996 that the previously agreed upon repayment plan would remain in effect, but interest would be charged on the outstanding balance beginning December 1, 1996.

We are pleased that HCFA moved quickly to correct the gross error of \$102 million made in the October 1996 payments. We recommend that aggressive management action be taken to curtail incorrect payments whenever it is known or anticipated that a major overpayment amount may occur, such as the overpayment that occurred in October 1996.

► **MILLIONS OF DOLLARS ARE NOT SUBJECT TO RECOVERY**

After all recalculations were completed, HCFA identified approximately \$30 million in overpayments retroactive to either March 1995 or October 1993. According to officials in HCFA's Office of Managed Care, no attempts were made to identify or quantify the overpayments which occurred prior to March 1995 or October 1993 for the respective categories of beneficiaries.

Based on HCFA's recovery plans, we determined that since January 1992, **\$20.5 million in overpayments** made to 71 HMOs on behalf of the misclassified beneficiaries in our review **will not be recovered**. The details of the HMO-specific overpayment amounts we identified which HCFA does not intend to recover are provided in the appendix to this report.

By unnecessarily limiting recovery of the overpayments, HCFA will not recover \$20.5 million in overpayments from HMOs.

As explained above, HCFA's proposed recovery schedule defined two categories of beneficiaries: (1) those who lost their ESRD status **before**

enrollment in an HMO and (2) those who lost their ESRD status **while enrolled** in an HMO. Overpayments for the first category will be recovered retroactively to October 1993 and overpayments for the second category of beneficiaries will be recovered retroactively to March 1995. We determined that the \$20.5 million in overpayments that HCFA does not intend to collect falls into the following categories:

	<i>Overpayments Not Subject to Recovery</i>
ESRD Status Ended Before Enrollment	
Transplant Beneficiaries	\$ 7.2 million
Dialysis Beneficiaries	<u>\$ 1.2 million</u>
TOTAL	\$ 8.4 million
ESRD Status Ended While Enrolled	
Transplant Beneficiaries	\$ 4.9 million
Dialysis Beneficiaries	<u>\$ 7.2 million</u>
TOTAL	\$12.1 million

► **CONCERNS OVER TIME LIMITS IMPOSED ON OVERPAYMENT RECOVERIES**

We are concerned with the above time limits that HCFA plans to impose on the recovery of the overpayments. We believe that additional recoveries should be made at least back to 1992 for several reasons.

First and foremost, the plans were advised each month via the monthly special status report of each beneficiary for whom they were receiving the enhanced ESRD payment. The plans knew, or should have known, that the misclassified beneficiaries were not receiving ESRD services. The plans received a highly enhanced payment rate to provide a special type of service which they did not provide. Overpayments for some of the misclassified beneficiaries continued for years, with the plan receiving each month thousands of dollars which they knew were not due. Any business entity would expect to have to refund any monies it inappropriately received. We

referred this information to our Office of Investigation for evaluation of possible improprieties on the part of the HMOs.

Overpayments which are not subject to recovery result in giving away Medicare trust funds to the plans. This seems particularly inappropriate considering the negative financial status of the trust funds and the financial status of many of the plans. For example, according to financial data reported to HCFA, the three HMOs which we identified as having the largest amount of overpayments not subject to recovery all had very substantial net income and net worth in 1995:

	<i>Overpayment Not Subject to Recovery</i>	<i>Net Worth (1995)</i>	<i>Net Income (1995)</i>
Plan A	\$3.4 million	\$313,842,000	\$52,736,000
Plan B	\$3.2 million	\$381,728,241	\$17,494,497
Plan C	\$2 million	\$ 86,426,498	\$82,397,550

We also have concerns about the distinction and apparent disparity in treatment between beneficiaries who lost ESRD status while enrolled and those who lost ESRD status before enrollment. We were unable to determine the basis or justification for treating these categories of beneficiaries differently and establishing separate recovery schedules. We also note there was a difference in treatment between overpayments and underpayments, with a maximum 3-year recovery limitation on overpayments and no limitations on paying underpayments.

Although there are no statutory, regulatory, or manual provisions which specify time limits for the recovery of overpayments from HMOs (discussed below) we believe it would be logical to collect overpayments at least on the same basis as overpayments are collected from providers in the Medicare fee-for-service program, that is for up to 3 years. We believe that the notice that HCFA sent to the plans in February 1995 served as due notice to the plans and that recoveries should be made retroactively at least 3 years from that date for all categories of beneficiaries.

► **PROVISIONS LACKING FOR RECOUPMENT OF OVERPAYMENTS FROM HMOs**

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.

RECOMMENDATIONS

We recommend that HCFA:

- ► recover all overpayments that have occurred at least since 1992 as a result of the system not recognizing ESRD termination dates for beneficiaries enrolled in HMOs;
- ► issue regulations to clearly specify time limits for the recovery of overpayments to risk-based HMOs. Similarly, regulations specifying time frames for the correction of underpayments to risk-based HMOs should be issued; and
- ► take aggressive management action to curtail incorrect payments whenever it is known or anticipated that a major overpayment amount may occur, such as the overpayment that occurred in October 1996.

HCFA RESPONSE AND OIG COMMENTS

In response to our draft report, HCFA did not agree with our recommendation to recover all overpayments that occurred at least since 1992. The response stated "the decision not to go back to 1992 to recover overpayments was made in order to limit HCFA's liability to pay any disputed claims from managed care plans that may have numbered back several years... This decision was made because HCFA's systems were in error (following the belief "once ESRD, always ESRD") and not able to calculate end dates". The HCFA agreed with our other recommendations.

We continue to believe that HCFA should recover overpayments at least since 1992, especially since the \$20.5 million in overpayments represented a highly enhanced payment rate to provide a special type of service which was not provided. Although HCFA's decision to limit overpayment recoveries was made to "limit HCFA's liability to pay disputed claims...that may have numbered back several years", this decision was not applied to underpayments as there was no time limit on underpayments which were paid to the plans. In addition, we still have concerns about the separate recovery schedules HCFA established and the resulting distinction and apparent disparity in treatment between beneficiaries who lost ESRD status while enrolled in a plan and those who lost ESRD status before enrollment. The HCFA response does not address why HCFA established separate liability limits for underpayments and overpayments, as well as for the two categories of beneficiaries.

Even though these ESRD overpayments occurred because HCFA's systems were in error, the plans were advised each month that they were receiving the enhanced ESRD rate on behalf of beneficiaries who they knew, or should have known, were not receiving ESRD services. Therefore, we believe the plans should be liable to repay the overpayments. Prior to HCFA's systems enhancements implemented in August 1996, the systems were not able to calculate end dates, however, the systems can now calculate end dates. We note that HCFA's systems do have information which would allow retroactive adjustments at least to 1992--we used this information to identify the misclassified beneficiaries in our review and to calculate the overpayments.

APPENDIX

**HMO OVERPAYMENTS NOT SUBJECT TO RECOVERY
ON BEHALF OF BENEFICIARIES WHOSE
ESRD STATUS TERMINATED
(JANUARY 1992 - FEBRUARY 1995)**

<i>PLAN</i>	<i>TOTAL</i>	<i>PLAN</i>	<i>TOTAL</i>
1	\$3,381,736	37	\$75,503
2	3,165,322	38	70,079
3	2,000,895	39	68,651
4	1,337,974	40	62,285
5	1,108,548	41	61,521
6	1,016,490	42	61,260
7	886,196	43	54,328
8	561,323	44	51,293
9	413,544	45	51,037
10	398,267	46	46,492
11	393,392	47	46,381
12	355,563	48	40,538
13	334,473	49	39,147
14	272,071	50	37,829
15	260,924	51	37,139
16	259,684	52	34,912
17	240,281	53	34,488
18	234,821	54	31,148
19	206,862	55	30,775
20	204,863	56	29,395
21	201,541	57	26,377
22	199,276	58	22,702
23	197,728	59	21,489
24	193,196	60	20,192
25	192,539	61	17,434
26	190,344	62	17,038
27	189,459	63	14,474
28	155,669	64	14,234
29	151,033	65	11,069
30	125,380	66	10,965
31	111,823	67	8,626
32	109,935	68	8,000
33	109,144	69	7,329
34	90,485	70	5,928
35	83,212	71	2,816
36	79,463		
		TOTAL	\$20,586,330



The Administrator
Washington, D.C. 20201

DATE: APR 19 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Systems and Overpayment Issues: End-Stage Renal Disease Payments to Health Maintenance Organizations," (A-14-96-00203)

We reviewed the above-referenced report that examines Medicare payments made to risk-based health maintenance organizations on behalf of beneficiaries classified as having end stage renal disease.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA) on
Office of Inspector General (OIG) Draft Report
“Systems and Overpayment Issues: End-Stage Renal Disease (ESRD) Payments to
Health Maintenance Organizations (HMOs),” (A-14-96-00203)

OIG Recommendation

HCFA should recover all overpayments that have occurred at least since 1992 as a result of the system not recognizing ESRD termination dates for beneficiaries enrolled in HMOs.

HCFA Response

We do not concur with the recommendation to recover overpayments back to 1992. However, we recovered overpayments back to October 1993 for: (1) beneficiaries who were once ESRD, but not ESRD at the time of HMO enrollment (i.e., had chronic renal disease, but had a successful transplant prior to enrollment or were no longer being dialyzed at the time of enrollment); and (2) beneficiaries who have never had chronic renal disease and were established on the ESRD master file in error.

The decision not to go back to 1992 to recover overpayments was made in order to limit HCFA's liability to pay any disputed claims from managed care plans that may have numbered back several years.

We recovered ESRD overpayments back to March 1, 1995, for enrolled beneficiaries who had chronic renal disease after HMO enrollment but who no longer qualified because they had a successful transplant, or had not been dialyzed for 12 consecutive months (and no longer qualify as ESRD).

This decision was made because HCFA's systems were in error (following the belief “once ESRD, always ESRD”) and not able to calculate end dates.

OIG Recommendation

HCFA should issue regulations to clearly specify time limits for the recovery of overpayments to risk-based HMOs. Similarly, regulations specifying time frames for the correction of underpayments to risk-based HMOs should be issued.

HCFA Response

We concur with the need to clarify our existing time limits on payment recovery and underpayment. HCFA is reviewing its policies regarding time limits for the recovery of overpayments and for the payment of any amounts due our managed care organizations. However, we do not believe a regulation is necessary to achieve this.

Page 2

OIG Recommendation

HCFA should take aggressive management action to curtail incorrect payments whenever it is known or anticipated a major overpayment amount may occur, such as the overpayment that occurred in October 1996.

HCFA Response

We concur, and have taken action to improve our payment review process. As pointed out in the OIG report, HCFA management was very aggressive in recouping the \$102 million overpayment made in October 1996, by November 1996. HCFA updated data in its systems for the ESRD beneficiary population, and implemented software modifications to recognize ESRD end dates for HMO payment adjustments and enrollment decisions.

A management review was conducted of the monthly payment process and found that internal management controls are in place and all documentation exists to properly account for the offsets to the regular monthly payments. However, the review disclosed a need for improvement in overall internal management controls and debt collection procedures. A corrective action plan was established and will be implemented immediately.