



NOV - 7 1996

**Memorandum**

Date *for* Michael Mangano  
June Gibbs Brown  
From Inspector General

Subject Nationwide Audit of Medicaid Special Status Classifications Submitted by Medicare Health Maintenance Organizations (A-04-96-01119)

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 nationwide audit of Medicaid special status classifications submitted by health maintenance organizations (HMO). The objective of our audit was to determine if overpayments have occurred due to HMOs submitting incorrect Medicaid special status classifications to the Health Care Financing Administration (HCFA). Risk-based HMOs receive fixed monthly payments for each enrolled Medicare beneficiary. The payment rate is increased for certain categories of beneficiaries designated as high cost. Medicare beneficiaries who are also eligible for Medicaid are one of these high-cost categories and are referred to as Medicaid special status beneficiaries. An HMO can receive several hundred dollars per month as an enhanced payment for each beneficiary designated as Medicaid eligible.

We found that significant overpayments were made as a result of submissions of incorrect Medicaid special status by HMOs. Our sample indicates that 90 percent of the HMO submissions were inappropriate because the beneficiaries were not eligible for Medicaid. We estimate that approximately \$15 million in overpayments occurred between October 1, 1990 and July 31, 1995 due to HMO submissions of erroneous Medicaid special status.

We are recommending that HCFA (1) identify and recover the overpayments caused by inappropriate HMO submissions of Medicaid special status; (2) implement policy and systems changes to prohibit HMOs from submitting Medicaid special status on behalf of beneficiaries who reside in States which automatically furnish Medicaid eligibility information to HCFA; (3) develop policies to require HMOs in States which do not furnish Medicaid information to verify Medicaid eligibility with applicable State agencies prior to submitting Medicaid special status; and (4) enforce current manual instructions which require HMOs to monitor the special status reports and report any changes in a beneficiary's Medicaid status.

In its response to our draft report, HCFA concurred with our recommendations. The HCFA's complete response is attached to this report.

Page 2 - 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 (410) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-04-96-01119 in all correspondence relating to this report.

Attachments

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**NATIONWIDE AUDIT OF  
MEDICAID SPECIAL STATUS CLASSIFICATIONS  
SUBMITTED BY  
MEDICARE HEALTH MAINTENANCE  
ORGANIZATIONS**



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 1996  
A-04-96-01119**

**Memorandum**

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Date

for *Michael Magan*  
June Gibbs Brown

From

Inspector General

Subject Nationwide Audit of Medicaid Special Status Classifications Submitted by Medicare Health Maintenance Organizations (A-04-96-01119)

To Bruce C. Vladeck  
Administrator  
Health Care Financing Administration

This final report provides you with the results of our nationwide audit of Medicaid special status classifications submitted by Medicare risk-based health maintenance organizations (HMO). The objective of our audit was to determine if overpayments have occurred due to HMOs submitting incorrect Medicaid special status classifications to the Health Care Financing Administration (HCFA). Risk-based HMOs receive fixed monthly payments for each enrolled Medicare beneficiary. The payment rate is increased for certain categories of beneficiaries as high-cost. Medicare beneficiaries who are also eligible for Medicaid are one of these high-cost categories and are referred to as Medicaid special status beneficiaries. The enhanced payment to the HMO due to the beneficiary being Medicaid eligible can amount to several hundred dollars, per month for each beneficiary.

Our audit was limited to payments made on behalf of Medicare beneficiaries whose incorrect Medicaid special status classification was submitted by HMOs to HCFA's Group Health Plan (GHP) system. This is our second report to HCFA relating to Medicaid special status payments to HMOs. Our first report, *Review of Medicare Payments to Health Maintenance Organizations for Medicaid Special Status Beneficiaries* (A-04-94-01089), addressed a weakness in HCFA's computer system which caused inappropriate payments to HMOs because the HMO payment system did not detect when Medicaid special status beneficiaries lost their Medicaid eligibility.

Our review of a random sample of 100 HMO-submitted Medicaid special status payments from the GHP system determined that 90 were not appropriate because the beneficiary was not eligible for Medicaid. Based on this sample, we estimate that overpayments totaled approximately \$15 million of the approximately \$45 million paid for HMO-submitted Medicaid special status beneficiaries between October 1, 1990 and July 31, 1995. This estimate was determined by projecting our sample results over the population using statistical methods. Our sample projections showed the range of overpayments to be from \$13.7 million to \$16.3 million.

We recommend that HCFA (1) identify and recover the overpayments caused by inappropriate HMO submissions of Medicaid special status; (2) implement policy and

systems changes to prohibit HMOs from submitting Medicaid special status on behalf of beneficiaries who reside in States which automatically furnish Medicaid eligibility information to HCFA; (3) develop policies to require HMOs in States which do not furnish Medicaid information to verify Medicaid eligibility with applicable State agencies prior to submitting Medicaid special status; and (4) enforce current manual instructions which require HMOs to monitor the special status reports and report any changes in a beneficiary's Medicaid status.

In response to our draft report, HCFA concurred with these recommendations. The HCFA response has been included in its entirety as the Attachment to this report.

## **INTRODUCTION**

### **BACKGROUND**

An HMO is a legal entity that provides or arranges provision of health services for its enrollees. Under the Medicare program, HMOs contract with HCFA to provide health care services to beneficiaries. 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. Medicaid eligibility is determined by the State Medicaid agency in the State where the beneficiary resides.

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 categories of beneficiaries designated as high cost, including those who are also eligible for Medicaid. Nationally, HCFA reports show that there are over 87,000 beneficiaries classified as Medicaid special status in risk-based HMOs.

The GHP system maintains demographic information on each beneficiary to determine the payment rate due the HMO. If the Medicaid special status indicator is present in the GHP system for a beneficiary, the system generates the enhanced Medicaid special status payment to the HMO for that beneficiary. There are two methods to establish a beneficiary's Medicaid special status in the GHP system:

- o 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 beneficiary who is also eligible for Medicare. The Third Party Master File (TPMF) records this transaction. The GHP system then interfaces monthly with TPMF and updates its files to reflect any new information.

- o The second method of establishing Medicaid 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. This second method is necessary because some States do not buy Medicaid recipients into the Medicare program. As of the time of our audit, there were 3,099 beneficiaries in the GHP system which had their Medicaid special status submitted by HMOs.

The Medicaid status of beneficiaries whose eligibility is established under the second method will not change unless the HMO notifies HCFA that the beneficiary is ineligible for Medicaid. Each month, HCFA provides the HMOs with a special status report of all enrolled beneficiaries for whom the HMO received an enhanced payment amount. The HMOs are required to review this monthly status report and notify HCFA of any changes which have occurred.

### **SCOPE**

The objective of our audit was to determine if overpayments occurred due to HMOs submitting Medicaid special status to HCFA.

To accomplish our objective, we:

- o processed a data base of HMO-submitted Medicaid beneficiaries and payments provided to us by HCFA's Office of Managed Care to ensure that only those Medicaid special status classifications that were submitted by HMOs and generated payments to HMOs were included in our review. This resulted in a universe of 89,659 payments from October 1, 1990 to July 31, 1995 for 3,099 beneficiaries;
- o prepared a listing that showed payments to be included in our review from the data base described above;
- o randomly selected 100 payments. The sample was drawn from a universe of 89,659 payments which we developed during our survey phase;
- o requested eligibility verification from the applicable State Medicaid agency for each sample item;
- o requested eligibility verifications from the applicable HMOs regarding each sample item;

- o calculated the overpayments from our sample items; and
- o projected the results of our sample overpayments to the universe of payments.

A review of internal controls was not needed to accomplish the objective of our audit. Therefore, we did not perform a review of the internal controls.

We did not test the reliability of the computer generated output, assess the completeness of the data, or evaluate the adequacy of the internal controls in HCFA's GHP system.

We limited our review to payments made to HMOs during the period October 1990 through July 1995. Details of the methodology used in selecting and appraising the sample are contained in the appendix to this report.

Field work was performed in Raleigh, North Carolina; Atlanta, Georgia; and HCFA headquarters in Baltimore, Maryland from January to May 1996. The audit was performed in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

### **RESULTS OF REVIEW**

We found that significant overpayments were made as a result of submissions of Medicaid special status by HMOs. Our sample indicates that 90 percent of the HMO submissions were inappropriate because the beneficiaries were not eligible for Medicaid. We estimate that approximately \$15 million in overpayments occurred between October 1, 1990 and July 31, 1995 due to HMO submissions of erroneous Medicaid special status.

#### **Overpayments Caused by HMO-Submissions**

Our verification of Medicaid eligibility from the State Medicaid agencies showed that 90 of the 100 sample beneficiaries were not eligible for Medicaid in the month for which the payments were made. In those instances where the beneficiary had been eligible for Medicaid, the State Medicaid agency provided us with the period(s) for which the beneficiary had been eligible.

We calculated the overpayments for the 90 beneficiaries in our sample found not to be eligible for Medicaid at the time of the payment. We determined the HMOs were overpaid \$16,743 for these beneficiaries. We projected the results of our sample over the population using statistical methods. We estimate that overpayments range from \$13.7 million to \$16.3 million and have resulted due to the submissions of unverified erroneous Medicaid special status by HMOs. The point estimate of these overpayments is approximately \$15 million.

### **HMOs' Basis for Submitting Medicaid Special Status**

We asked the HMOs to indicate their basis for submitting the Medicaid special status to HCFA. The HMOs responded to 84 of the 100 sample items. Their responses indicated the following:

- o 54 responses indicated that the HMO had no documentation to support why the Medicaid indicator was submitted by the HMO,
- o 29 responses indicated that the HMO had relied on statements made by the beneficiary to determine their eligibility, and
- o one response indicated that the HMO had appropriately verified the Medicaid status with the applicable Medicaid State agency at the time of enrollment. However, the HMO had not monitored the eligibility after this point.

None of the information provided by the responding HMOs contradicted the information provided by the State Medicaid agencies concerning the beneficiaries' Medicaid eligibility.

### **Most Erroneous Submissions Were From Buy-In States**

Ninety-six of our 100 sample items were from buy-in States. Medicaid eligibility for Medicare beneficiaries in buy-in States is automatically furnished to HCFA via a monthly computer tape exchange. Due to the high error rate we found from buy-in States, and since the Medicaid eligibility information will be automatically updated to HCFA's records, we do not believe there is a need for HMOs in buy-in States to submit Medicaid special status to HCFA. The HMOs will receive the enhanced Medicaid special status payment as a result of the data exchange if warranted. Even if there is a lag between the time a State establishes Medicaid eligibility and the time the eligibility information is furnished to HCFA, the payment rates are adjusted to the HMOs to reflect the higher payment due for the entire retroactive period.

### **Monitoring of Medicaid Special Status Submissions**

Section 6008 of HCFA's HMO Manual permits HMOs to change the status of a beneficiary such as Medicaid eligibility. Section 6008.2 states that once the beneficiary is enrolled in the Medicaid special status, he or she will remain in that status until the HMO notifies HCFA of a change in status. Therefore, the HMO is ultimately responsible for verifying the Medicaid eligibility with the applicable Medicaid State agency for any beneficiary it submits as Medicaid special status. The vehicle for notifying HCFA of status changes is the monthly status report.

### **Concerns Over High Error Rate**

We are concerned about the high error rate we found in HMO submissions of Medicaid special status. As indicated by the responses from the HMOs, the basis for their submissions and their monitoring efforts were not adequate. Yet the plans financially benefitted from their inappropriate submissions. Each month the HMOs received an enhanced rate for each beneficiary who had a Medicaid special status indicator. For example, the payment rate for one of our sampled beneficiaries when classified as eligible for Medicaid was \$907; the basic payment rate for this beneficiary without the Medicaid special status indicator was \$513.

Some of the erroneous Medicaid special status classifications submitted by HMOs caused overpayments which started in October 1990 and continue today. Due to the erroneous submissions and failure to monitor the submissions, the resulting overpayments allowed the HMOs to use the Medicare trust funds without cost. We are discussing our findings with our Office of Litigation Coordination to determine if any further action is warranted.

### **RECOMMENDATIONS**

We recommend that HCFA:

- (1) identify and collect the overpayments to date caused by inappropriate HMO submissions of Medicaid special status, which we believe to be approximately \$15 million;
- (2) establish policy and systems changes to prohibit HMOs from submitting Medicaid special status on behalf of beneficiaries who reside in buy-in States;
- (3) develop policies to require HMOs from non buy-in States to verify Medicaid eligibility with applicable State agencies prior to submitting Medicaid special status; and
- (4) enforce current manual instructions which require HMOs in non buy-in States to monitor the special status reports and report any accretions and deletions; i.e, changes in the beneficiary's Medicaid status.

In response to our draft report, HCFA concurred with these recommendations. The HCFA response has been included in its entirety as the Attachment to this report.

## SAMPLE METHODOLOGY

Our objective was to determine whether significant overpayments have resulted from Medicaid special status submissions by HMOs to HCFA. To determine this, we requested a data base download of all of the Medicaid special status beneficiaries that had been submitted by HMOs. The Office of Managed Care extracted this data from the GHP system in accordance with our specifications.

The data was then electronically transferred to our HCFA Division, which then downloaded the data to DBASE IV files. The DBASE IV files were then processed to ensure that only those beneficiaries whose Medicaid special status classifications were submitted by HMOs and generated payments to HMOs at the Medicaid special status rate were included for review. The resulting list of beneficiaries and payments was then exported to Quattro, printed and included in our working papers.

The resulting listing included 3,099 beneficiaries that generated 89,659 Medicaid special status payments during the period October 1, 1990 to July 31, 1995.

From the listing described above, we randomly selected 100 payments. The sample was a simple random sample to project the amount of Medicaid special status payments and overpayments.

Using the Sets of Two Random Number Generator Program we generated a pair of numbers with the first representing the beneficiary (1-3,099) and the second representing a payment month. The payment month was between 1 and 58 based on each month of the audit period (October 1990 through July 1995) being assigned a sequential number. If a pair of numbers did not result in a payment, the number was discarded and the next number was used.

For the sample items, we requested and reviewed verifications of eligibility from the applicable State Medicaid agencies for the months chosen. We also requested and reviewed supporting documentation from the applicable HMOs.

The total value of the 100 sample payments was \$51,036. Our analysis of the sample showed that 90 of the 100 payments resulted in errors totaling \$16,743. We used the Department of Health and Human Services, Office of Inspector General, Office of Audit Services Variables Appraisal Program, which uses the difference estimator, to project the results of our sample. We projected both the universe and the overpayment amounts. The point estimate for the universe projection was \$45,758,367 with a precision of plus or minus \$2,256,523 at the 90 percent confidence level. The point estimate for the overpayment projection was \$15,011,606 with a precision of plus or minus \$1,272,698 at the 90 percent confidence level.



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administr

The Administrator  
Washington, D.C. 20201

DATE: OCT 17 1996

TO: June Gibbs Brown  
Inspector GeneralFROM: Bruce C. Vladeck  
Administrator

A handwritten signature in cursive script, appearing to read "Bruce C. Vladeck", written over the printed name.

SUBJECT: Office of Inspector General (OIG) Draft Report: "Nationwide Audit of the  
Medicaid Special Status Classifications Submitted by Medicare Health  
Maintenance Organizations (HMOs)," (A-04-96-01119)

We reviewed the above-referenced report that determines if overpayments have occurred due to HMOs submitting incorrect Medicaid special status classifications to the Health Care Financing Administration. We are in agreement with the report recommendations to recover overpayments, develop and implement policy and systems changes, and enforce current manual instructions.

Thank you for the opportunity to review and comment on this report