

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MICHIGAN MADE CAPITATION  
PAYMENTS TO MANAGED CARE  
ENTITIES AFTER BENEFICIARIES'  
DEATHS**

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**February 2020  
A-05-17-00048**

# *Office of Inspector General*

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## Report in Brief

Date: February 2020

Report No. A-05-17-00048



### Why OIG Did This Audit

Previous OIG audits found that States had improperly paid Medicaid managed care organizations capitation payments on behalf of deceased beneficiaries. We conducted a similar audit of those payments in Michigan.

Our objective was to determine whether Michigan made capitation payments on behalf of deceased beneficiaries.

### How OIG Did This Audit

Our audit covered 115,053 capitation payments, totaling \$43.9 million, with service dates from January 1, 2014, through December 31, 2016 (audit period), made on behalf of beneficiaries reported as deceased. To identify our population of beneficiaries reported as deceased, we matched the Medicaid Management Information System (MMIS) data with the Social Security Administration's Death Master File (DMF) using the beneficiaries' Social Security numbers, names, and dates of birth. We then identified all capitation payments that occurred for months following a beneficiary's month of death in the DMF.

We selected a stratified random sample of 100 capitation payments, totaling \$117,840 (\$79,410 Federal share), identified the date of death reported in the DMF, and determined whether payments were made on behalf of the deceased beneficiaries.

## Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths

### What OIG Found

We estimated that Michigan made unallowable capitation payments totaling at least \$39.9 million (\$27.5 million Federal share) to managed care entities on behalf of deceased beneficiaries during our audit period. Of the 100 capitation payments in our stratified random sample, Michigan made 99 unallowable payments totaling \$117,746 (\$79,348 Federal share).

The unallowable payments occurred because Michigan did not always identify and process Medicaid beneficiaries' death information. Although Michigan's MMIS and eligibility systems interfaced with State and Federal death files that identify dates of death, Michigan did not always identify those dates of death in its MMIS system, and the MMIS system and eligibility system did not share dates of death information with each other. Michigan also did not recover payments caused by dates of death not promptly identified in its MMIS system.

### What OIG Recommends and Michigan Comments

We recommend that Michigan (1) refund \$27.5 million to the Federal Government; (2) identify and recover unallowable payments made to managed care entities during our audit period on behalf of deceased beneficiaries, which we estimated to be at least \$39.9 million; and (3) identify capitation payments made on behalf of deceased beneficiaries before and after our audit period and repay the Federal share of amounts recovered. We also made two procedural recommendations.

Michigan did not say whether it agreed or disagreed with our recommendations. Michigan agreed that some capitation payments were made for deceased beneficiaries and not recouped. Michigan said that it would recoup payments made on behalf of beneficiaries with a verified date of death or as the DMF date of death is validated. Michigan also said it would determine whether additional recoupments are necessary outside of the audit period and, if so, return any applicable Federal funding. In addition, Michigan described actions it has taken or plans to take to address our remaining recommendations.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Michigan Department of Health and Human Services (State agency) pays managed care entities to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payment). Previous Office of Inspector General (OIG) audits<sup>1</sup> found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased beneficiaries. We conducted a similar audit of the State agency, which administers the Medicaid program.

### OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of deceased beneficiaries.

### BACKGROUND

#### The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Medicaid managed care programs are intended to increase access to and improve the quality of healthcare for Medicaid beneficiaries. States contract with a managed care entity to make services available to enrolled Medicaid beneficiaries, usually in return for capitation payments. States report capitation payments claimed for Medicaid managed care programs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as

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<sup>1</sup> See Appendix B for related OIG reports.

calculated by a defined formula (42 CFR § 433.10). During our audit period (January 1, 2014, through December 31, 2016), the FMAP in Michigan ranged from 65.15 to 66.32 percent.<sup>2</sup>

### **Social Security Administration: Date of Death Information**

The Social Security Administration (SSA) maintains death record information by obtaining death information from relatives of deceased beneficiaries, funeral directors, financial institutions, and postal authorities. SSA processes death notifications through its Death Alert, Control, and Update System, which matches the information received from external sources against the Master Beneficiary Record and the Supplemental Security Income Record.<sup>3</sup> SSA records the resulting death information in its Numerical Identification System (the Numident).<sup>4</sup> SSA then uses information from the Numident to create a national record of death information called the Death Master File (DMF).<sup>5, 6</sup>

### **Federal Requirements**

A capitation payment is “a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment” (42 CFR § 438.2).

### **Michigan’s Medicaid Managed Care Programs**

In 2016, approximately 98 percent of Medicaid beneficiaries in Michigan were enrolled in managed care. During our audit period, the State agency made capitation payments totaling \$31 billion. The State agency operates seven managed care programs to provide healthcare

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<sup>2</sup> Although FMAP rates are generally determined by the formula defined in 42 CFR § 433.10, exceptions to the regular FMAP rate have been made for certain situations, populations, providers, and services. For Michigan, these exceptions include a 90-percent FMAP for family planning services and enhanced FMAP rates of up to 100 percent for certain non-elderly, non-pregnant adults as part of the Patient Protection and Affordable Care Act’s Medicaid expansion.

<sup>3</sup> SSA, *Program Operations Manual System*, GN 02602.060 (May 13, 2011). The Master Beneficiary Record is an electronic record of all Title II (of the Act) beneficiaries. The Supplemental Security Income Record is an electronic record of all Title XVI (of the Act) beneficiaries.

<sup>4</sup> The Numident contains personally identifiable information for each individual issued a Social Security number (SSN).

<sup>5</sup> SSA, *Program Operations Manual System*, GN 02602.060 (May 13, 2011).

<sup>6</sup> SSA maintains death data—including names, SSNs, dates of birth, and States of death—in the DMF for approximately 98 million deceased individuals.

services to Medicaid beneficiaries.<sup>7</sup> (Appendix C contains a detailed description of Michigan's Medicaid managed care programs.) The State agency contracts with managed care entities to make covered services available to eligible Medicaid beneficiaries in exchange for a fixed per-member, per-month capitation payment.

State Medicaid agencies use the Medicaid Management Information System (MMIS) to process payments and maintain beneficiary eligibility and enrollment information. In Michigan, the MMIS system is known as the Community Health Automated Medicaid Processing System (CHAMPS). The CHAMPS is the State agency's web-based Medicaid claims processing system and handles managed care enrollment and payments. The CHAMPS stores eligibility data received from the Bridges Integrated Automated Eligibility Determination System (Bridges), which is the State agency's system for determining Medicaid eligibility.

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 115,053 net monthly capitation payments,<sup>8</sup> totaling \$43.9 million,<sup>9</sup> with service dates during the period January 1, 2014, through December 31, 2016 (audit period),<sup>10</sup> made on behalf of beneficiaries reported as deceased. To identify beneficiaries reported as deceased, we matched the MMIS data to the DMF using the beneficiaries' SSNs, names, and dates of birth. We then identified all capitation payments that occurred for months following a beneficiary's month of death in the DMF.

We selected a stratified random sample of 100 capitation payments totaling \$117,840 (\$79,410 Federal share), identified the dates of death as reported in the DMF,<sup>11</sup> and determined whether payments were made on behalf of the deceased beneficiaries. Using the results of our sample, we estimated the total value and Federal share of unallowable capitation payments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

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<sup>7</sup> Our audit focused on five Medicaid managed care programs: the Comprehensive Health Care Program (CHCP), the Managed Specialty Supports and Services Program (MSSSP), Integrated Care/MI Health Link, MI Choice, and the Program of All-Inclusive Care for the Elderly (PACE). We excluded two programs, Healthy Kids Dental and Non-Emergency Medical Transportation (NEMT), because they lacked clear recovery requirements for capitation payments for months following a beneficiary's month of death.

<sup>8</sup> Because of payment adjustments, some beneficiaries had more than one capitation payment per month. Therefore, we netted all capitation payments that occurred for the same beneficiary in the same month into a single capitation payment.

<sup>9</sup> The actual amount was \$43,868,975.

<sup>10</sup> The audit period encompassed the most current data available at the time we initiated our audit.

<sup>11</sup> We confirmed the beneficiaries' dates of death using national investigative databases, death certificates, obituaries, and a Medicare hospice claim.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix D contains the details of our statistical sampling methodology, Appendix E contains our sample results and estimates, and Appendix F contains the Federal and State requirements.

## FINDINGS

The State agency made capitation payments on behalf of deceased beneficiaries. Of the 100 capitation payments in our sample, the State agency made 99 unallowable payments totaling \$117,746 (\$79,348 Federal share). The unallowable payments occurred because the State agency did not always identify and process Medicaid beneficiaries' death information. The State agency also did not recover payments for dates of death not promptly identified in its MMIS system (CHAMPS). On the basis of our sample results, we estimated that the State agency made payments totaling at least \$39.9 million (\$27.5 million Federal share)<sup>12</sup> to managed care entities on behalf of deceased beneficiaries during our audit period.

### THE STATE AGENCY MADE UNALLOWABLE PAYMENTS TO MEDICAID MANAGED CARE ENTITIES

Contractual agreements with the managed care entities provide for the recovery of overpayments (i.e., capitation payments made after beneficiaries' deaths).<sup>13</sup> However, the State agency did not always recover capitation payments made after beneficiaries' deaths, despite its efforts to identify and recover them.

The State agency made capitation payments, totaling \$43.9 million, on behalf of beneficiaries reported as deceased, which we identified by matching the State agency's CHAMPS data to the SSA DMF. We confirmed that the beneficiaries associated with 99 of the 100 capitation payments in our stratified random sample were deceased.

Of the 100 capitation payments in our sample:

- The State agency made 99 unallowable capitation payments totaling \$117,746 (\$79,348 Federal share). The State agency made 81 of these capitation payments to managed care entities on behalf of deceased beneficiaries who had a correct date of death in the

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<sup>12</sup> Without rounding, the estimates were \$39,873,514 and \$27,545,800, respectively.

<sup>13</sup> Our random sample results included capitation payments made on behalf of deceased beneficiaries in three managed care programs. The contracts for these programs vary in language but discuss provisions such as adjustments, recoupment of payments, retroactive disenrollments, and enrollment and payment reconciliation based on date of death. Appendix F identifies the provisions in the agreements.

CHAMPS. For the remaining 18 capitation payments, the State agency made payments on behalf of deceased beneficiaries who did not have a date of death in the CHAMPS.

- For the remaining capitation payment in our sample, we were unable to confirm the death of the beneficiary associated with the payment and thus did not treat this payment as an error.

### **THE STATE AGENCY DID NOT ALWAYS RECOVER PAYMENTS MADE AFTER IT IDENTIFIED BENEFICIARIES AS DECEASED AND DID NOT IDENTIFY OTHER BENEFICIARIES AS DECEASED**

The State agency did not always identify and process Medicaid beneficiaries' death information in the CHAMPS. When the State agency properly identified and processed death information, the CHAMPS used that information to identify a beneficiary as deceased, stop capitation payments, and initiate the recovery process for capitation payments made after the beneficiary's date of death. The State agency recorded the dates of death in CHAMPS more than 24 months after death for beneficiaries associated with 81 of the 100 sampled capitation payments. The State agency did not identify the beneficiaries' dates of death in the CHAMPS associated with 18 of the 100 sampled capitation payments.

The State agency has two separate systems that record dates of death for Medicaid beneficiaries: the CHAMPS and the Bridges. The CHAMPS and the Bridges each separately interface with the Michigan Vital Records Death file and the SSA DMF;<sup>14</sup> however, the CHAMPS and the Bridges do not share date of death information with each other. When death triggers ineligibility for Medicaid, the Bridges shares the ineligibility information with the CHAMPS. This information triggers disenrollment and stops future capitation payments. However, the CHAMPS requires a date of death in order to initiate recovery of previously paid capitation payments following a beneficiary's death. Because the Bridges does not share dates of death with the CHAMPS, the CHAMPS may not have the information it needs to initiate recovery of payments made following beneficiaries' deaths. The CHAMPS had the dates of death for the beneficiaries associated with 81 capitation payments; however, the State agency did not recover the payments. State agency staff explained that until June 2018, the CHAMPS recovered payments only for the 24 months before the date of death was entered into the CHAMPS.<sup>15</sup> The State agency entered the dates of death of the beneficiaries for whom the 81 capitation payments had been made into CHAMPS in 2018, which was more than 24 months after the dates of death, and State agency staff believed that these capitation payments were beyond the 24-month rule threshold.

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<sup>14</sup> The State agency stopped subscribing to the SSA DMF as of July 27, 2017.

<sup>15</sup> The "date of death recoupment lookback months" was configurable in CHAMPS, and the configuration during our audit period was set to 24 months. The State agency referred to this as the "24-month rule." In June 2018, the 24-month rule was removed from CHAMPS. Thus, dates of death recorded in CHAMPS after that time would trigger recovery of all payments made after beneficiaries' dates of death.

We confirmed dates of death for the beneficiaries associated with 18 capitation payments lacking the date of death in the CHAMPS. Although the CHAMPS had a matching process during our audit period with the SSA DMF, it did not have dates of death in the CHAMPS for these beneficiaries. The Bridges had dates of death for some of the beneficiaries, but, as previously mentioned, the two systems did not share the date of death information.

As a result, the State agency did not recover 99 of the 100 sampled capitation payments even though it identified beneficiaries' dates of death in CHAMPS for 81 of the capitation payments.

### **ESTIMATE OF UNALLOWABLE CAPITATION PAYMENTS**

On the basis of our sample results, we estimated that the State agency made payments totaling at least \$39.9 million (\$27.5 million Federal share) to managed care entities on behalf of deceased beneficiaries during our audit period.

### **RECOMMENDATIONS**

We recommend that the Michigan Department of Health and Human Services:

- refund \$27,545,800 to the Federal Government;
- identify and recover unallowable payments made to managed care entities during our audit period on behalf of deceased beneficiaries, which we estimate to be at least \$39,873,514;
- identify capitation payments made on behalf of deceased beneficiaries before and after our audit period and repay the Federal share of amounts recovered;
- strengthen its policies and procedures for identifying deceased beneficiaries to ensure that dates of death are recorded accurately and in a timely manner in the CHAMPS to prevent unallowable payments; and
- ensure that capitation payments are recovered when a date of death is retroactively entered in the CHAMPS.

### **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency did not state whether it agreed or disagreed with our recommendations but agreed that, during the audit period, some capitation payments were made for deceased beneficiaries and that some payments were not recouped once the date of death was entered into its MMIS system. The State agency said that it will begin recoupment of payments made on behalf of beneficiaries with a verified date of death and will recoup any remaining capitation payments as the DMF date of death is validated. The State agency also said that it will determine whether additional recoupments are necessary

outside of the audit period and, if so, return any applicable Federal funding. In addition, the State agency said that it will develop processes to ensure that dates of death in its eligibility system and MMIS are reviewed to ensure consistency so that deceased recoupment methodologies are appropriately initiated on a timely basis. Finally, the State agency said that it removed the 24-month recoupment rule in June 2018, as noted in the audit.

The State agency's comments are included in their entirety as Appendix G.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 115,053 net monthly capitation payments, totaling \$43,868,975, made on behalf of beneficiaries whose reported dates of death preceded the service month of the capitation payment. We reviewed capitation payments with service dates during the period January 1, 2014, through December 31, 2016 (audit period). We selected a stratified random sample of 100 capitation payments totaling \$117,840 (\$79,410 Federal share) for review.

We did not review the overall internal control structure of the State agency or its Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether managed care entities in Michigan received capitation payments on behalf of beneficiaries whose dates of death preceded the capitation payment month.

We conducted our fieldwork from September 2017 through September 2019.

### METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance;
- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments after a beneficiary's death;
- reviewed the State agency contracts with the managed care entities for our audit period;
- obtained from the State agency a list of 3,499,541 beneficiaries for whom the State agency made at least 1 capitation payment for service dates from January 1, 2014, through December 31, 2016;
- matched the file of beneficiaries to the SSA's DMF and identified 109,581 beneficiaries reported as deceased;
- provided the list of 109,581 beneficiaries reported as deceased to the State agency and requested a list of all capitation payments made on behalf of the beneficiaries for service dates from January 1, 2014, through December 31, 2016;
- obtained from the State agency a file containing 4,778,317 capitation payments that were made on behalf of beneficiaries reported as deceased for service dates from

January 1, 2014, through December 31, 2016, totaling \$1,283,199,598 (the State agency file);

- limited use of the State agency file to capitation payments for 5 of the 7 Medicaid managed care programs; removed capitation payments made for each beneficiary's month of death and prior months; netted the remaining capitation payments by program, beneficiary, and month; and removed net capitation payments that were less than or equal to \$0;
- created a sampling frame containing 115,053 capitation payments, totaling \$43,868,975, that the State agency made to managed care entities on behalf of beneficiaries whose dates of death preceded the capitation payment service month;
- selected for review a stratified random sample of 100 capitation payments totaling \$117,840 (\$79,410 Federal share);
- for each sampled capitation payment, obtained current documentation from the State agency to support:
  - the beneficiaries' first and last names, SSNs, dates of birth (ensuring that the information matched the DMF), and Medicaid identification numbers;
  - whether the CHAMPS identified the beneficiaries' dates of death;
  - that a capitation payment occurred for the service month (ensuring the accuracy of the paid amount); and
  - whether any adjustments were made for the sample capitation payments;
- compared the dates of death in the CHAMPS and the DMF for the 100 sample items;
- used Accurint,<sup>16</sup> death certificates on file with the State agency, a Medicare hospice claim, and obituaries as alternative information sources to independently confirm the dates of death on file in the DMF;
- estimated the total value and Federal share of unallowable capitation payments using OIG, Office of Audit Services (OAS), statistical software; and
- discussed the results of our audit with State agency officials.

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<sup>16</sup> Accurint is a LexisNexis data depository that contains records from more than 10,000 data sources. Accurint's identity repository contains death records from multiple sources, including the DMF, State deceased records, and other proprietary sources.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<a href="#"><u>A-05-19-00007</u></a>	1/29/20
<i>The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<a href="#"><u>A-05-17-00049</u></a>	10/01/19
<i>Illinois Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<a href="#"><u>A-05-18-00026</u></a>	8/20/19
<i>Georgia Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<a href="#"><u>A-04-15-06183</u></a>	8/09/19
<i>California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<a href="#"><u>A-04-18-06220</u></a>	5/07/19
<i>Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<a href="#"><u>A-05-17-00008</u></a>	10/04/18
<i>Wisconsin Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<a href="#"><u>A-05-17-00006</u></a>	9/27/18
<i>Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<a href="#"><u>A-04-15-06190</u></a>	12/22/17
<i>Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<a href="#"><u>A-06-16-05004</u></a>	11/14/17

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<a href="#"><u>A-04-15-06182</u></a>	11/30/16

## **APPENDIX C: MICHIGAN'S MEDICAID MANAGED CARE PROGRAMS**

### **COMPREHENSIVE HEALTH CARE PROGRAM**

Michigan first introduced managed care in 1996 with the implementation of its CHCP,<sup>17</sup> an MCO program that covers acute, primary, and specialty services and prescription drugs through contracting health maintenance organizations. The CHCP is available state-wide on a mandatory basis for most beneficiary groups, including foster care children (who were added to the program in 2009). The exceptions are dual-eligible beneficiaries (who are enrolled voluntarily) and American Indians/Alaska Natives.

### **MANAGED SPECIALTY SUPPORTS AND SERVICES PROGRAM**

The Managed Specialty Supports and Services Program is a 1915(b)/(c) waiver program.<sup>18</sup> The State agency has contracted with and paid Prepaid Inpatient Health Plans on a capitated basis since 1998 to provide coverage for mental health and substance use disorder services and long-term services and supports for all Medicaid beneficiaries with mental illnesses, substance use disorders, or developmental disabilities.

### **HEALTHY KIDS DENTAL**

In 2000, Michigan introduced the Healthy Kids Dental Waiver, which covers dental care for Medicaid-eligible children under the age of 21. It covers dental services such as X-rays, cleanings, fillings, root canals, tooth extractions, and dentures provided by dentists who participate in Delta Dental's Healthy Kids Dental program. This program was not reviewed because it lacked clear recovery requirements for capitation payments for months following a beneficiary's date of death.

### **PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY**

The PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals who meet long-term-care criteria. The State introduced the PACE in 2003. For most PACE beneficiaries, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized.

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<sup>17</sup> The State agency provided a list of Michigan's Medicaid managed care programs that referred to the CHCP as Medicaid Health Plans.

<sup>18</sup> The State agency provided a list of Michigan's Medicaid managed care programs that referred to the Managed Specialty Supports and Services Program as the Prepaid Inpatient Health Plan.

## **NON-EMERGENCY MEDICAL TRANSPORTATION**

Since 2011, the State agency has provided the Medicaid NEMT program for beneficiaries who need to get to and from medical services but have no means of transportation. The Federal Government requires States to ensure that eligible, qualified Medicaid beneficiaries have NEMT to take them to and from providers. NEMT is defined as a transportation service provided to individuals who are not in an emergency situation but need more assistance than a taxi service is able to provide. Often times, these services are provided in vehicles equipped to transport riders who are in wheelchairs, on stretchers, or have other special needs. This program was not reviewed because it lacked clear recovery requirements for capitation payments for months following a beneficiary's date of death.

## **MI CHOICE**

Since 2013, MI Choice has been a state-wide program designed to give older adults and people with disabilities more choices in receiving long-term supports. It provides a variety of in-home services that are similar to those provided in a nursing home.

## **INTEGRATED CARE/MI HEALTH LINK**

Implemented in 2015, MI Health Link is a healthcare option with built-in care coordination for Medicare and Medicaid services. MI Health Link offers medical services, medications, dental services, vision services, in-home services, equipment to help with activities of daily living, community-based long-term-care services, community mental health services, and nursing-home care.

## APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

The target population consists of net positive capitation payments that the State agency made (a) for five of its Medicaid managed care programs, (b) for calendar years (CYs) 2014 through 2016, and (c) for months following a beneficiary's month of death in the SSA DMF.

### SAMPLING FRAME

The State agency provided a file of 3,499,541 beneficiaries for whom it made at least 1 capitation payment for CYs 2014 through 2016. We matched that file to the SSA's DMF to identify 109,581 beneficiaries with dates of death. The State agency then provided a file with 4,778,317 capitation payments made on behalf of these 109,581 beneficiaries for CYs 2014 through 2016. The capitation payments were for all seven Michigan Medicaid managed care programs, so we removed capitation payments for the two excluded programs.<sup>19</sup> We then removed any capitation payments for each beneficiary's month of death and prior months. Finally, we netted capitation payments by program, beneficiary, and month and then removed net capitation payments that were less than or equal to \$0.

The resulting sampling frame consisted of 115,053 net capitation payments totaling \$43,868,975.<sup>20</sup>

### SAMPLE UNIT

The sample unit was a net capitation payment.

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<sup>19</sup> Each program in which a beneficiary participated received a separate capitation payment on the beneficiary's behalf.

<sup>20</sup> There are no capitation payments for the PACE in the resulting sampling frame.

## SAMPLE DESIGN AND SAMPLE SIZE

We used the following stratified random sample:

**Table 1: Sample Design Summary**

<b>Payment Range</b>	<b>Number of Payments in Frame</b>	<b>Amount of Payments in Frame</b>	<b>Sample Size</b>
Less than \$494.50	87,399	\$15,593,009	40
\$494.50 through \$1,500	26,813	24,399,634	46
More than \$1,500	841	3,876,333	14
<b>Total</b>	<b>115,053</b>	<b>\$43,868,975<sup>21</sup></b>	<b>100</b>

## SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

## METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the capitation payments within strata 1 through 3. After generating the random numbers for each stratum, we selected the corresponding capitation payments from the sampling frame.

## ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total value and Federal share of unallowable payments made on behalf of deceased beneficiaries during our audit period. To be conservative, we recommend recovery of unallowable payments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual total of unallowable payments in the sampling frame 95 percent of the time.

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<sup>21</sup> The stratum amounts do not sum to the total net capitation payments amount due to rounding.

**APPENDIX E: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Total Value of Sample</b>	<b>Incorrectly Billed Sample Items</b>	<b>Value of Over-payments in Sample</b>
1	87,399	\$15,593,009	40	\$7,702	39	\$7,608
2	26,813	24,399,634	46	38,404	46	38,404
3	841	3,876,333	14	71,734	14	71,734
<b>Total</b>	<b>115,053</b>	<b>\$43,868,975<sup>22</sup></b>	<b>100</b>	<b>\$117,840</b>	<b>99</b>	<b>\$117,746</b>

**Table 3: Estimates of Unallowable Payments for the Audit Period  
(Limits Calculated for a 90-Percent Confidence Interval)**

	<b>Total Amount</b>	<b>Federal Share</b>
Point estimate	\$43,318,429	\$29,769,959
Lower limit <sup>23</sup>	39,873,514	27,545,800
Upper limit <sup>24</sup>	43,868,975	31,994,118

<sup>22</sup> The stratum values of frame amounts do not sum to the total amount due to rounding.

<sup>23</sup> To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

<sup>24</sup> The upper limit calculated using the OIG/OAS statistical software (\$46,763,344) was adjusted downward to equal the total paid amount in the sampling frame (\$43,868,975).

## APPENDIX F: FEDERAL AND STATE REQUIREMENTS

### FEDERAL REQUIREMENTS

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

In connection with the Medicaid managed care program, providers are defined as "any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which it delivers the services" (42 CFR § 400.203).

A capitation payment is "a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

### STATE REQUIREMENTS

The State agency and managed care entities entered into contractual agreements that provide for recovery of an overpayment (e.g., a capitation payment made after a beneficiary's death). These contracts differed among the Medicaid managed care programs that the State offered.

#### Relevant Contract Provisions for the Comprehensive Health Care Program

For the CHCP, the State agency contracted with managed care entities known as MCOs. The contract provides for recoupment of capitation payments for retroactive disenrollments and enrollment errors by the State agency. The contract states that the State agency "may initiate a process to recoup capitation payments made to the Contractor for Enrollees who were retroactively disenrolled" (Exhibit A, § 4.1 Payment Terms, II.G).<sup>25</sup> The contract further states: "If a non-eligible individual . . . is enrolled with the Contractor and [the State agency] is notified within 15 days of enrollment effective date, [the State agency] must retroactively disenroll the individual and recoup the capitation payment from the Contractor" (Exhibit A, § 1.1 Contractor Requirements, IV.H.1). When the State agency is notified after 15 days of the enrollment effective date, the contract states that the State agency "will disenroll the Enrollee prospectively the first day of the next available month" (Exhibit A, § 1.1 Contractor Requirements, IV.H.2).<sup>26</sup>

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<sup>25</sup> The cited language is found in a different section in the 2014 and 2015 contracts. Refer to Article 1, section 1.060, part 1.062 Price Terms, A. Payment Provisions.

<sup>26</sup> Cited language from the 2016 contract differs from recoupment language presented in 2014 and 2015 contracts. They state: "If [the State agency] enrolls a non-eligible person with a Contractor, [the State agency] will retroactively disenroll the person as soon as the error is discovered and will recoup the capitation paid to the

## **Relevant Contract Provisions for the Managed Specialty Supports and Services Program**

The Managed Specialty Supports and Services Program contract specifically provides for recoupment of capitation payments on behalf of deceased beneficiaries under the provisions governing Medicaid payments (part II(A) § 8.4.1).<sup>27</sup> Specifically, regarding the Medicaid State Plan and (b)(3) Payments, the contract states: “The capitation payment will be adjusted for recovery of payments for Medicaid eligibles for whom [the State agency] has subsequently been notified of their date of death” (part II(A) § 8.4.1.3).<sup>28</sup> In addition, regarding 1915(c) Habilitation Supports Waiver Payments, the contract states that these payments may be adjusted for “recovery of payments previously made to beneficiaries prior to [the State agency] notification of death” (part II(A) § 8.4.1.4).<sup>29</sup>

## **Relevant Contract Provisions for the Program of All-Inclusive Care for the Elderly**

Paragraph III (Reimbursement Methodology) under Section B (Method of Payment and Financial Reports) of the Work Statements for each contract for the PACE specifically states that “if a capitation payment was made for a month subsequent to the month of death of a covered person, the capitation for that month and any following month will be recovered.”

## **Relevant Contract Provisions for MI Choice**

Section (1)(e) of Attachment Q to the MI Choice program contract states:

The [State agency] will review program data monthly to assure proper capitation payments are made for each enrolled participant over the previous six-month period. The purpose of the review process is for the [State agency] to make recovery and recoupment payments to the [contractor] as necessary.<sup>30</sup> The [contractor] must notify the [State agency] of all incorrect capitation payments

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Contractor. The Contractor must notify [the State agency] within 15 days of enrollment effective date. If the Contractor does not notify [the State agency] within this time frame, the disenrollment will be prospective” (Article 1, § 1.020, part 1.022 Work and Deliverables, A. Medicaid Eligibility and CHCP Enrollment, (9) Enrollment Errors by [the State agency]).

<sup>27</sup> The reference is in part II section 7.4.1 in the January 1 through September 30, 2014, contract (9-month contract).

<sup>28</sup> The reference is in part II section 7.4.1.3 in the 9-month contract.

<sup>29</sup> The reference is in part II section 7.4.1.4 in the 9-month contract.

<sup>30</sup> The reference is in part II, section IV, part B.1.d (Reimbursements) in the October 1, 2013, through September 30, 2014 (FY 2014), contract.

made to the [contractor] within 30 days of receipt of the incorrect capitation payment.<sup>31</sup>

State agency staff clarified that the review process described includes recouping payments made after a beneficiary's death.

### **Relevant Contract Provisions for Integrated Care/MI Health Link**

Section 2.3.7 of the Integrated Care/MI Health Link contract states that termination of coverage will be effective on the last day of the month in which the beneficiary dies, and termination may be retroactive to that date. Further, section 4.6.1 states that CMS and the State will implement a process to reconcile enrollment and capitation payments for the contract that takes into account changes because of beneficiary death. Section 4.6.2 also explains retroactive adjustments to enrollment and payment and that the State will correct payments to the contractor for any retroactive enrollment adjustments.

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<sup>31</sup> The reference is in the FY 2014 Amendment No. 1, 3. Amendment Purpose (9).

APPENDIX G: STATE AGENCY COMMENTS



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LANSING

GRETCHEN WHITMER  
GOVERNOR

ROBERT GORDON  
DIRECTOR

December 19, 2019

Ms. Sheri L. Fulcher  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region V  
233 North Michigan Avenue, Suite 1360  
Chicago, Illinois 60601

Re: Report Number A-05-17-00048

Dear Ms. Fulcher:

Enclosed is the Michigan Department of Health and Human Services' response to the draft report entitled "Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths."

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Pam Myers at Myersp3@michigan.gov or (517) 241-4237.

Sincerely,

/Robert Gordon/

Robert Gordon

RG:kk

Enclosure

c: Elizabeth Hertel  
Farah Hanley  
Kate Massey  
Pam Myers

## **MDHHS Audit Response**

### **Management Response:**

MDHHS agrees that during the audit period some capitation payments were made for deceased beneficiaries and that some payments were not recouped once the date of death was entered into its MMIS system. However, MDHHS believes that the audit methodology overstates the scope of the problem. The auditor verified that 99 out of 100 beneficiaries paid by MDHHS were deceased. However, the audit began with the intention to sample deceased beneficiaries exclusively, and so it is unsurprising that 99% of those sampled were deceased beneficiaries. More to the point, the audit found capitation payments made for 14,752 potentially deceased individuals out of 3,499,541 unique beneficiaries who make up the entire universe of beneficiaries that received capitation payments for the programs reviewed during the audit period. This results in an error rate that is less than one half of one percent (0.422%). However, Michigan acknowledges that it is never appropriate to reimburse for a deceased beneficiary.

### **Planned Corrective Action:**

MDHHS will begin recoupment of payments made on behalf of beneficiaries with a verified date of death in January 2020 and expects to have recoupment completed within twelve months. Additional recoupment will occur for any remaining capitation payments as the death master file date of death is validated.

As noted in the audit, MDHHS initially had a 24-month recoupment rule in its MMIS system as it believed this would capture all necessary recoupments. MDHHS removed the 24-month recoupment rule in June 2018. In addition, MDHHS will develop processes to ensure that dates of death in its eligibility system and MMIS are reviewed to ensure consistency so that deceased recoupment methodologies are appropriately initiated on a timely basis. Finally, MDHHS will determine if additional recoupments are necessary outside of the audit period and, if so, return any applicable federal funding.