Memorandum

Date DEC 16 1999

From June Gibbs Brown
Inspector General

Subject Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations (A-04-97-01168)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This letter alerts you to the issuance on Monday, December 20, 1999, of our final report entitled *Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations*. The objective of our audit was to determine the appropriateness of Florida Medicaid payments for services provided to dually eligible Medicare health maintenance organizations (HMO) beneficiaries. This review was conducted as part of the Office of Inspector General's (OIG) partnership efforts with States' oversight agencies to expand audit coverage of the Medicaid program. As such, the Florida Auditor General's office was a major participant in this audit.

Medicare beneficiaries, who were also eligible for Medicaid, received Medicaid medical services and drugs that should have been covered by a Medicare HMO. However, these services were submitted to and paid by the Florida Medicaid fee-for-service program rather than the HMOs. Federal regulations require that States take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State Plan. However, the State of Florida stated that its data sharing agreement with the Health Care Financing Administration (HCFA) prohibited them from seeking recovery for these payments.

We randomly selected 2 statistical samples of 100 payments each to determine if the Florida Medicaid services should have been covered by Medicare HMOs during Calendar Year (CY) 1996. One sample was from the Medicaid payments to Humana HMO, and the other was from the Medicaid payments to all other Medicare HMOs in Florida. For CY 1996, we estimate that unallowable Medicaid payments, related to dually eligible beneficiaries:

- enrolled in Humana HMO amounted to approximately $4.7 million[1] (Federal share $2.6 million). The Humana HMO was selected for a separate sample because its enrollees generated approximately half of all Medicaid payments in our universe.

- enrolled in an additional 50 Medicare HMOs in Florida amounted to approximately $11.2 million[2] (Federal share $6.2 million).

The erroneous payments occurred because the Florida Agency for Health Care Administration (FL AHCA) did not properly utilize Medicare coverage data from the HCFA Group Health Plan (GHP) database to identify beneficiaries who were enrolled in Medicare HMOs and to prevent Medicaid payments for services covered by Medicare HMOs. State agency officials have assured us that steps have been taken to add the Medicare coverage data from the HCFA GHP database to the State's Third Party Resource database.

We recommended the FL AHCA recover $4,699,776 (Federal share $2,620,595) in unallowable payments from the Humana HMO. We also recommended that FL AHCA recover the specific overpayments we identified as part of our sample and review the balance of the sampling universe to identify the liability of each of the other 50 HMOs, and recover additional overpayments. We estimate the additional overpayments to be $11,199,893 (Federal share $6,245,060).

During the performance of our audit, we noted that the condition that led to the inappropriate payments may not be limited to CY 1996. Therefore, we also recommended that the FL AHCA review HMO data for prior and subsequent years to determine if Medicare HMOs had liability for Medicaid payment.

The FL AHCA generally concurred with our report, but raised concerns regarding the recovery of the overpayments from HMOs due to its inability to produce details of claims paid because the data was not available, and that the data use agreement it signed with HCFA specifically prohibited sharing data for the purposes of recouping duplicative payments made to HMOs. Based on the data sharing agreement provided to us by FL AHCA officials, there is no specific prohibition against using the data for recovery of duplicate payments. The data sharing agreement allowed the State to use HCFA data to determine the proper payment

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[1]OIG, Office of Audit Services (OAS) policy for monetary recovery on samples is to recommend recovery at the lower limit of the 90 percent confidence level. The point estimate for unallowable payments for the Humana sample is $12,390,063. The range of the improper payments at the 90 percent confidence level is $4,699,776 to $20,080,350. (See APPENDIX B)

[2]The value of the errors in the sample for the additional 50 HMOs was $7,300. However, the range of improper payments at the 90 percent confidence level is $3,771,151 to $18,628,635, with the point estimate being $11,199,893. The point estimate is shown in the text in accordance with our OAS policy when multiple providers are identified as having overpayments as part of a sample.

levels for dually eligible individuals in the State of Florida. We believe that recoupment of duplicate payments falls within this parameter. The data sharing agreement also allowed the State to seek approval from HCFA for uses beyond coordination and proper payment levels in the delivery of medical care. If there are any doubts by the FL AHCA in using the data for recovery of duplicate payments, the agreement allows the State the latitude to work with HCFA officials to initiate an appropriate data sharing agreement to recover any overpayments identified. We would also be willing to work with the FL AHCA officials in identifying the universe of duplicate payments in order to facilitate recovery action. We have included their response in APPENDIX C of this report.

We plan to share this report with other State Medicaid agencies in an effort to encourage their participation in the OIG's partnership efforts. If you have any questions about the review, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID FEE-FOR-SERVICE PAYMENTS FOR SERVICES ON BEHALF OF BENEFICIARIES ENROLLED IN MEDICARE HEALTH MAINTENANCE ORGANIZATIONS

JUNE GIBBS BROWN
Inspector General

DECEMBER 1999
A-04-97-01168

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

CIN A-04-97-01168

Mr. Ruben J. King-Shaw, Jr.
Executive Director
Florida Agency for Health Care Administration
2727 Mahan Drive
Building 3, Room 316
Tallahassee, Florida 32308

Dear Mr. King-Shaw:

This report provides you with the results of our review of Florida Medicaid fee-for-service payments for services incurred by beneficiaries who were eligible for Medicare and Medicaid (dually eligible beneficiaries) and enrolled in Medicare health maintenance organizations (HMO).

OBJECTIVE

The objective of our audit was to determine the appropriateness of Florida Medicaid fee-for-service payments for services provided to dually eligible Medicare HMO beneficiaries.

SUMMARY OF FINDINGS

Medicare beneficiaries, who were also eligible for Medicaid, received medical services and drugs that should have been covered by a Medicare HMO. However, these services were submitted to and paid by the Florida Medicaid fee-for-service program rather than the HMOs. Federal regulations require that States take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State Plan. However, the State of Florida stated that its data sharing agreement with the Health Care Financing Administration (HCFA) prohibited them from seeking recovery for these payments.

We randomly selected 2 statistical samples of 100 payments each to determine if the Medicaid services should have been covered by a Medicare HMO during Calendar Year (CY) 1996. One sample was from the Medicaid payments to Humana HMO, and the other was from the Medicaid payments to all other Medicare HMOs in Florida. We estimate that unallowable Medicaid payments, related to dually eligible beneficiaries enrolled in Humana HMO amounted to

$4,699,776[1] (Federal share $2,620,595) for CY 1996. In this same CY, we estimate that $11,199,893[2] (Federal share $6,245,060) in unallowable Medicaid payments were made on behalf of beneficiaries enrolled in an additional 50 Medicare HMOs in Florida.

The erroneous payments occurred because the Florida Agency for Health Care Administration (FL AHCA) did not properly utilize Medicare coverage data from the HCFA Group Health Plan (GHP) database to identify beneficiaries who were enrolled in Medicare HMOs and to prevent Medicaid fee-for-service payments for services covered by Medicare HMOs. State agency officials have assured us that steps have subsequently been taken to add the Medicare coverage data from the HCFA GHP database to the State's Third Party Resource database.

We are recommending the FL AHCA recover $4,699,776 (Federal share $2,620,595) in unallowable payments from the Humana HMO. We are also recommending that FL AHCA recover the specific overpayments we identified as part of our sample and review the balance of the sampling universe to identify the liability of each of the other 50 HMOs and recover additional overpayments. We estimate the additional overpayments to be $11,199,893 (Federal share $6,245,060).

The FL AHCA generally concurred with our report, but raised several concerns regarding the recovery of the overpayments from HMOs. We have included their response in APPENDIX C of this report.

During the performance of our audit, we noted that the condition that led to the inappropriate payments may not be limited to CY 1996. Therefore, we are also recommending that the FL AHCA review HMO data for prior and subsequent years to identify if Medicare HMOs had liability for Medicaid payments. Our office will work with FL AHCA in identifying those dually eligible beneficiaries enrolled in Medicare HMOs.

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[1]The Office of Inspector General (OIG), Office of Audit Services (OAS) policy for monetary recovery on samples is to recommend recovery at the lower limit of the 90 percent confidence level. The point estimate for unallowable payments for the Humana sample is $12,390,063. The range of the improper payments at the 90 percent confidence level is $4,699,776 to $20,080,350. (See APPENDIX B)

[2]The value of the errors in the sample for the additional 50 HMOs was $7,300. However, the range of improper payments at the 90 percent confidence level is $3,771,151 to $18,628,635, with the point estimate being $11,199,893. The point estimate is shown in the text in accordance with our OAS policy when multiple providers are identified as having overpayments as part of a sample.

BACKGROUND

The Tax Equity and Fiscal Responsibility Act of 1982 authorized prospective per capita payments to health maintenance organizations/competitive medical plans (hereafter referred to as HMOs) under a risk based contract. The HCFA contracts with HMOs to provide comprehensive health services on a prepayment basis to enrolled Medicare beneficiaries. The HCFA authorizes fixed monthly payments to risk-based plans for each enrolled Medicare beneficiary.

In exchange for these monthly payments, the HMOs agree to provide the same package of services as is covered under the traditional Medicare fee-for-service system. If the average Medicare payment amount is greater than the amount the plan estimates it needs to cover the cost of the Medicare package, a savings is noted. The HMO is required to use these savings to either improve their benefit package to the Medicare enrollees, reduce the Medicare enrollee's premium, contribute to a benefit stabilization fund, or accept a reduced capitation payment. Most HMOs elect to offer additional expanded benefits that are not available under Medicare fee-for-service; these services serve as a marketing tool for the HMOs. These expanded benefits include: dental, eyeglasses, prescription drugs, deductibles, and coinsurance amounts.

Medicaid is always the payer of last resort. This means that payments are not to be made from the Medicaid program unless no other third party is liable. With respect to Medicare covered services, Medicaid is always secondary. This secondary responsibility extends to the expanded benefits pledged by the Medicare HMO. Because of this, Medicaid expenditures on behalf of dually eligible beneficiaries are unallowable if the services are covered by the Medicare HMO.

SCOPE

Our audit was conducted in accordance with generally accepted government auditing standards. The objective of our audit was to determine the appropriateness of Florida Medicaid fee-for-service payments for services provided to dually eligible Medicare HMO beneficiaries.

The objective of this audit did not require a full understanding or assessment of the internal control of the HMOs reviewed. Our review of the internal control was limited to obtaining an understanding of the Medicaid payments made on behalf of dually eligible beneficiaries enrolled in Medicare HMOs.

To accomplish our objective, we:

- compiled a listing of approximately 46,000 dually eligible beneficiaries who were enrolled in Medicare HMOs and were residing in Florida during CY 1996;

- coordinated with the Florida Auditor General in obtaining a matching of the above mentioned listing with the Florida Adjudicated Medicaid Claims database;

- reviewed the Florida Auditor General's data match and sampling procedures to ensure they complied with OIG, OAS guidelines;

- sorted and analyzed the results of the data match. Based on our results, we separated our universe of payments made on behalf of beneficiaries enrolled in 51 HMOs. The Humana HMO was selected for a separate sample because its enrollees generated approximately half of all Medicaid payments in our universe made on behalf of Medicare HMO enrollees. The second sample was selected from Medicaid payments made on behalf of the other 50 HMOs with Medicare enrollees. (The match showed that 137,229 payments totaling $14,698,223 were made on behalf of 5,674 Humana HMO beneficiaries while 146,726 payments totaling $13,262,425 were made on behalf of 8,550 beneficiaries enrolled in 50 other HMOs.);

- examined 2 statistical samples of 100 payments each to determine if the Medicaid services should have been covered by Medicare HMOs during CY 1996. One sample was from the Medicaid fee-for-service payments to Humana HMO, and the other was from the Medicaid fee-for-service payments to the other 50 HMOs. (For details on the sampling methodology, see APPENDIX A.);

- interviewed numerous officials and obtained a detailed listing of transactions from the FL AHCA and at each of the selected HMOs; and

- interviewed staff at HCFA's Office of Managed Care in Baltimore, Maryland.

To determine if the HMO was responsible for each of the services covered under the sampled Medicaid fee-for-service payments, we:

- obtained the HMO's Adjusted Community Rate proposal and published benefits for 1996;

- obtained the description of the revenue code accounting classifications;

- obtained the detail of services provided for each payment from the Florida Medicaid Fiscal Agent;

- obtained the medical definitions of the services covered by the payments from the FL AHCA;

- compared the services and goods provided with the contractual liabilities of the Medicare HMO; and

- informed each HMO of its potential liability for overpayments and provided them the opportunity to respond.

The sample results were used to project the unallowable Medicaid fee-for-service payments attributable to the Humana HMO and all other HMOs in Florida during CY 1996. (See APPENDIX B for details on the results of our samples.)

Our work was performed at the offices of the Florida Auditor General and FL AHCA offices in Tallahassee, Florida and the offices of the HMOs. Based on comments received from the FL AHCA, additional work was performed at the HCFA central office in Baltimore, Maryland.

DETAILED RESULTS OF REVIEW

We randomly selected 2 statistical samples of 100 payments each to determine if the Medicaid services should have been covered by Medicare HMOs during CY 1996. One sample was from the Florida Medicaid payments to Humana HMO, and the other was from the Florida Medicaid payments to all other HMOs in Florida. We estimate that unallowable Medicaid payments, related to dually eligible beneficiaries enrolled in Humana HMO, amounted to $4,699,776 (Federal share $2,620,595) for CY 1996. In this same CY, we estimate that $11,199,893 (Federal share $6,245,060) in unallowable Medicaid payments were made on behalf of beneficiaries enrolled in an additional 50 Medicare HMOs in Florida.

The erroneous payments occurred because the FL AHCA did not properly utilize Medicare coverage data from the HCFA GHP database to identify beneficiaries who were enrolled in Medicare HMOs, and to prevent Medicaid fee-for-service payments for services covered by Medicare HMOs.

Criteria

Section 1902(a)(25) of the Social Security Act and 42 CFR 433.135 through 433.140 require that States take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan.

The Federal regulations at 42 CFR 433.138 (a) require Medicaid State agencies to determine the legal liability of the third parties that are liable to pay for services furnished under the State Plan.

Section (b)(1) of this citation further requires the collection, from the applicant or recipient during the initial applications and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in section 433.139(b) through (f).

The 42 CFR 433.138 (g)(1)(i) requires the State agency to include follow-up procedures for identifying legally liable third party resources. In meeting this criteria, the State of Florida promulgated 1996 supplement to Florida State Statutes 1995. Chapter 641.31, paragraph 14 of these statutes states:

> "Whenever a subscriber of a (Medicare or Medicaid) health maintenance organization is also a Medicaid recipient, the health maintenance organization's coverage shall be primary to the recipient's Medicaid benefits and the organization shall be a third party subject to the provisions of section 409.910(4)."

Condition

Medicare beneficiaries, who were also eligible for Medicaid, received medical services and drugs that should have been covered by a Medicare HMO. However, these services were submitted to and paid by the Medicaid fee-for-service program rather than the HMOs.

Our sample of 100 Medicaid fee-for-service payments made on behalf of dually eligible enrollees of the Humana HMO determined that 76 payments were unallowable. The unallowable payments included 61 for drugs, 2 for mental health, and 4 for institutional care. The remaining nine included vision, home health, and all other items.

Our sample of 100 Medicaid fee-for-service payments made on behalf of dually eligible enrollees of the 50 other contracted Medicare HMOs, determined that 82 payments were unallowable. The unallowable payments included 70 for drugs, 4 for mental health, and 3 for institutional care. The remaining five included vision, home health, and all other items.

Cause

Medicaid fee-for-service payments were made for medical services and supplies that should have been covered by a Medicare HMO. This occurred because the FL AHCA did not routinely identify Medicaid beneficiaries enrolled in Medicare HMOs.

The FL AHCA did not identify beneficiaries who had Medicare HMO coverage for the purpose of establishing a source of third party reimbursement. The FL AHCA requested and the HCFA transmitted, on a monthly basis, a data file which reported all Florida Medicare beneficiaries enrolled in Medicare HMOs. However, this data file was not used to identify which Medicaid beneficiaries had Medicare HMO coverage.

The FL AHCA did not enter the Medicare HMO data file onto its Third Party Resource database. The FL AHCA contracted with the Unisys Corporation to maintain its Third Party Resource database. This database included all recipients with third party liability sources. The FL AHCA did not instruct Unisys to add the information on the monthly HCFA transmissions to their Third Party Resource database.

State agency officials have assured us that steps have subsequently been taken to add the Medicare coverage data from the HCFA GHP database to the State's Third Party Resource database.

Effect

Through an analysis of two samples, we estimate that unallowable Medicaid fee-for-service payments were made for dually eligible beneficiaries in CY 1996. One sample involved only beneficiaries enrolled in Humana HMO and the unallowable amount was $4,699,776 (Federal share $2,620,595). In this same CY, based on our second sample, we identified $7,300 in unallowable Medicaid fee-for-service payments made on behalf of beneficiaries enrolled in an additional 50 Medicare HMOs. Based on our projections, we estimate the additional overpayments to be $11,199,893 (Federal share $6,245,060).

We chose a separate sample from the Medicaid fee-for-service payments made on behalf of Medicare beneficiaries enrolled in the Humana HMO because they represented approximately 50 percent of the Medicaid fee-for-service payments in our universe.

OTHER MATTERS

During the course of our audit, we noted that 177 of our 200 sampled fee-for-service payments were on behalf of beneficiaries who were enrolled in HMOs prior to 1996. Since the scope of our audit encompassed only CY 1996, we did not determine if Medicaid payments had been made for these beneficiaries during those earlier years. However, based on the materiality of our findings in CY 1996, we recommend that the FL AHCA determine if this condition existed not only in prior years but also subsequent to CY 1996.

RECOMMENDATIONS

We recommend that the FL AHCA:

- recover $4,699,776 (Federal share $2,620,595) from the Humana HMO for services that were the responsibility of Humana under its Medicare HMO contract;

- recover the specific overpayments we identified as part of our sample and review the balance of our sampling universe related to 50 Medicare HMOs to identify and recover additional overpayments. We estimate the total overpayments to be $11,199,893 (Federal share $6,245,060); and

- review the HCFA HMO data for prior and subsequent years to identify if Medicare HMOs had liability for Medicaid fee-for-service payments. We will work with the FL AHCA in identifying those dually eligible beneficiaries enrolled in Medicare HMOs.

STATE AGENCY'S RESPONSE

The FL AHCA (State Agency) concurred with our recommendation to pursue any and all liable third parties. However, it:

- questioned the appropriateness of establishing a program overpayment based on a statistical analysis, since it must provide insurers with details of claims paid;

- stated its inability to produce details of claims paid because the data was either not available, or it could not be used to recover overpayments based on current HCFA policy;

- stated that even if details of claims paid were available, contractual issues would prevent the agency from making substantial recoveries from the HMOs; and

- stated it did not receive the HMO enrollment data until October 1996, thus preventing it from avoiding unallowable claims during CY 1996.

OIG RESPONSE

With respect to the specific issues raised in the State's response:

- It is the routine policy of the OIG to use statistical analysis to identify and recover overpayments in the Department's programs. The use of the OIG statistical sampling methodology has provided reliable evidence of the amount of unallowable costs claimed by a provider and has also withstood the judicial appeal process. Under separate cover, we will provide the FL AHCA with the methodology we used to identify the universe of potential payment errors. We believe the methodology will enable FL AHCA to identify and adjudicate the claims as well as recover the overpayments.

- Based on the data sharing agreement provided to us by FL AHCA officials, there is no specific prohibition against using the data for recovery of duplicate payments. The data sharing agreement allowed the State to use HCFA data to determine the proper payment levels for dually eligible individuals in the State of Florida. We believe that recoupment of duplicate payments falls within this parameter. The data sharing agreement also allowed the State to seek approval from HCFA for uses beyond coordination and proper payment levels in the delivery of medical care. If there are any doubts by the FL AHCA in using the data for recovery of duplicate payments, the agreement allows the State the latitude to work with HCFA officials to initiate an appropriate data sharing agreement to recover any overpayments identified. We would also be willing to work with the FL AHCA officials in identifying the universe of duplicate payments in order to facilitate recovery action. We have included their response in APPENDIX C of this report.

- The regulations cited in this report are the basis for questioning these payments. All HMOs that operate in Florida are subject to these regulations, regardless of contracts with providers.

- Our records show that the FL AHCA began receiving the Medicare coverage data from HCFA as of August 1995.

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In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to the exemption in the Act which the Department chooses to exercise.

We request that you respond within 30 days from the date of this letter to the Department of Health and Human Services (HHS) action official shown below. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

To facilitate identification, please refer to the above Common Identification Number A-04-97-01168 in any correspondence related to this report.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

HHS Action Official

Mr. Eugene Grasser
Associate Regional Administrator
Division of Medicaid & State Operations
Region IV

AUDIT OF MEDICAID PAYMENTS FOR SERVICES PROVIDED TO BENEFICIARIES ENROLLED IN MEDICARE HMOS SAMPLING METHODOLOGY

OBJECTIVE:

Our objective was to determine the overall dollar effect of fee-for-service payments made to Medicaid providers while beneficiaries were also enrolled in Medicare HMOs.

POPULATION:

Our universe consisted of 283,955 Medicaid fee-for-service payments totaling $27,960,648 made on behalf of 14,224 beneficiaries while they were enrolled in 51 Medicare HMOs. From this population, we decided to draw two samples. We decided to take one sample from Humana HMO beneficiaries since they comprised about 50 percent of the Medicaid fee-for-service payments in our universe. We then sampled all other Medicare HMO beneficiaries in a separate sample.

The Humana HMO population contained 137,229 Medicaid fee-for-service payments totaling $14,698,223 paid on behalf of 5,674 beneficiaries.

The remaining 50 HMOs contained 146,726 payments totaling $13,262,425 in Medicaid fee-for-service payments made on behalf of 8,550 beneficiaries. For sampling purposes, we divided this population into two strata. The first strata was composed of payments made on behalf of Medicare beneficiaries that were enrolled in United Health Care, Foundation Healthcare, Health Options, and Physicians Corporation of America Health Plans of Miami. This strata contained 92,854 payments totaling $7,591,321. The second strata was composed of payments made on behalf of Medicare beneficiaries enrolled in the remaining 46 contracted HMOs in Florida. This strata contained 53,872 payments totaling $5,671,104.

SAMPLING FRAME:

To develop the universe for both samples, a computer file containing dually eligible Medicare/Medicaid beneficiaries that were enrolled in Florida Medicare HMOs during CY 1996 was developed by the OIG's Health Care Financing Audits Division from HCFA's Medicaid Statistical Information System and Group Health Plan records. This listing identified approximately 46,000 beneficiaries that had been enrolled in Medicare HMOs and were dually eligible.

This listing was used by the Florida Auditor General to develop a listing of Florida dually eligible beneficiaries that were enrolled in Medicare HMOs in CY 1996 and received services which were covered by Medicaid during their periods of enrollment.

SAMPLING UNIT:

The sampling unit was a payment. We reviewed each sampled payment to determine if the services should have been fully or partially covered by the Medicare program during the audit period.

SURVEY AND BACKGROUND INFORMATION:

The objective of this audit was to identify the unallowable Medicaid fee-for-service payments made on behalf of recipients while they were enrolled in the Medicare managed care program.

Medicare HMOs must offer core services that meet the coverage offered under Medicare fee-for-service. Additionally, the Medicare HMO may offer certain optional services to Medicare HMO beneficiaries. Because of this, responsibility for a particular service is dependent on the annual contract formed by each Medicare HMO and HCFA.

SAMPLE DESIGN:

Two simple random samples were used in this review. At the Humana HMO, a simple random sample of payments was reviewed. At the remaining 50 HMOs, a stratified random sample of payments were reviewed.

SAMPLE SIZE:

Each sample consisted of 100 sampling units. The stratified sample consisted of 2 strata of 50 sampling units each.

SOURCE OF RANDOM NUMBERS:

Random numbers were generated using the Florida Auditor General's statistical software.

METHOD OF SELECTING SAMPLE ITEMS:

The Florida Auditor General's computer specialists randomly drew the samples from each universe. The claims information for all of the selections was printed out for the auditors.

CHARACTERISTICS TO BE MEASURED:

The characteristic measured was the amount of Medicaid overpayments that resulted from the payment of services under Medicaid which should have been covered by the Medicare HMOs.

TREATMENT OF MISSING SAMPLE ITEMS:

If support for any of the sampling items was not located, they were treated as errors.

ESTIMATION METHODOLOGY:

We projected overpayments using the HHS, OIG, OAS RAT-STATS Appraisal Program which uses the difference estimator. See APPENDIX B for details of our projections.

APPENDIX B

REPORTING OF SAMPLE RESULTS

We used 2 random samples of 100 claims each out of a population of 283,955 Medicaid adjudicated paid claims totaling $27,960,648 to project the amount of claims paid in error. We selected 2 samples of 100 claims, one for Humana and the other for the remaining 50 HMOs. Following are the details of results of these samples and the projections:

SAMPLE RESULTS FOR HUMANA HMO

Sample Size	Value of Sample	Numbers of Errors	Value of Errors
100	$11,361	76	$9,029

Variable Projections

Point estimate:	$ 12,390,063
At the 90% Confidence Level:	
Lower Limit:	$ 4,699,776
Upper Limit:	$20,080,350

SAMPLE RESULTS FOR THE REMAINING 50 HMOs

Strata	Sample Size	Value of Sample	Numbers of Errors	Value of Errors
1	50	$4,763	40	$4,276
2	50	$3,641	42	$3,024
Total	100	$8,404	82	$7,300

Variable Projections

Point Estimate:	$11,199,893
At the 90% Confidence Level:	
Lower Limit:	$3,771,151
Upper Limit:	$18,628,635

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., DIRECTOR

June 23, 1999

Mr. Charles J. Curtis, CPA
Regional Inspector General
for Audit Services, Region IV
61 Forsyth Street, S.W., Room 3T41
Atlanta, GA 30303-8909

Mr. Charles L. Lester, CPA
Florida Auditor General
Post Office Box 1735
Tallahassee, FL 32302

Dear Sirs:

Thank you for the opportunity to review the draft report entitled ***Medicaid Fee-For-Service Payments for Services Provided to Beneficiaries Enrolled in Medicare Health Maintenance Organizations*** (CIN: A-04-97-01168). The Agency for Health Care Administration (Agency) takes seriously its responsibility to pursue and recover funds owed to the Medicaid program from liable third parties. Therefore, we concur with your emphasis on the importance of pursing any and all liable third parties. However, we offer the following comments in an effort to highlight several potential issues related to recovery from Medicare HMOs.

First of all, it is our understanding that the amounts provided in the report are estimates based on a statistical analysis and, therefore, cannot be interpreted as program overpayments.

We are unable to bill an insurer based on a statistical analysis; we must provide detail of claims paid. The Florida Medicaid Management Information System maintains two years of claims paid data, preventing us from producing the necessary claims detail for 1996 though our carrier billing system. Therefore, we had considered providing the file we received from the Florida Office of the Auditor General to our contractor. However, the data use agreement we signed specifically prohibits sharing of this data for the purposes of recouping duplicative payments made to HMOs. We have confirmed with HCFA representatives that this is, in fact, current policy.

Even if the 1996 claims detail were available to our carrier billing system, there are contractual issues that would prevent the Agency from making any substantial recovery. HMOs typically require the use of certain providers. Further, many services would require a prior authorization or a referral in order to be paid. Because the HMO was not billed initially, we do not anticipate that these requirements will have been met. In addition, we are concerned that our recovery would be further limited due to short filing deadlines imposed by Medicare HMOs.

It is our understanding that at the time of this review, Florida was only one of nine states receiving the data. The Agency, in a letter dated April 20, 1995, requested the monthly Group Health Plan tape. Our records indicate that we received our first tape in March 1996. Agency records indicate that due to various problems in data format and systems requirements, the HMO enrollment data was not available until October 1996. With this timeline, the Agency could not have cost avoided claims during the calendar year 1996. The Medicare HMO information has been added to our resource file. By doing this, providers are put on notice of the third party resource and thereby required to use this coverage before Medicaid will pay.

As I state earlier, the agency takes seriously its responsibility to pursue and recover funds owed to the Medicaid program. We believe that we have acted aggressively concerning the use of Medicare HMO data.

If you require additional information, please contact Rufus Noble at (850) 921-4897.

Sincerely,

Ruben L. King-Shaw, Jr.
Executive Director

RJKS/jeh