DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242-1027

January 25, 2002

Common Identification Number: A-06-01-00039

Mr. Don A. Gilbert
Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247

Dear Mr. Gilbert:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Managed Care Payments Made Under the State of Texas Access Reform Plus Managed Care Program." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to Common Identification Number A-06-01-00039 in all correspondence relating to this report.

Sincerely,

for Gordon L. Sato
Regional Inspector General
for Audit Services

Attachment

HHS Action Official:

Dr. James R. Farris, MD
Regional Administrator
Center for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICAID PAYMENTS MADE BY THE TEXAS DEPARTMENT OF HUMAN SERVICES UNDER THE STATE OF TEXAS ACCESS REFORM PLUS MANAGED CARE PROGRAM

JANET REHNQUIST
INSPECTOR GENERAL

JANUARY 2002
A-06-01-00039

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Department of Health and Human Services

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NOTICES

THIS REPORT IS AVAILABLE TO THE PUBLIC at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Audit Services' (OAS) reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242-1027

January 25, 2002

Common Identification Number: A-06-01-00039

Don A. Gilbert
Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247

Dear Mr. Gilbert:

This report provides you with the results of our audit of Medicaid payments made by the Texas Department of Human Services (TDHS) under the State of Texas Access Reform Plus (STAR+PLUS) managed care program. The objectives of our review were to determine whether: (1) STAR+PLUS members were eligible for managed care and assigned to the appropriate risk group for payment purposes, and (2) any unallowable Medicaid payments were made in the fee-for-service sector for STAR+PLUS members for services provided under the managed care program.

The Texas Health and Human Services Commission (Commission) delegated the authority to operate the STAR+PLUS program to TDHS. Under the STAR+PLUS program, TDHS integrates acute health services with long-term care using a managed care delivery system for recipients residing in Harris County, Texas. This delivery system includes contracting with health maintenance organizations (HMOs) to provide comprehensive health care in return for a fixed monthly payment. Each HMO member is assigned to a risk group for payment purposes.

Our review disclosed that TDHS made risk group assignment errors for eligible STAR+PLUS members during fiscal year (FY) 2000. For 10 of the 30 members we reviewed, the incorrect risk group was applied for payment purposes. As a result, an overpayment of $40,070 was made to HMOs participating in the STAR+PLUS program. We did not identify the impact these payment errors had on the total population of Medicare members totaling about 49,500 for FY 2000. However, for FYs 1998 and 1999, TDHS identified an overpayment totaling $387,214 and an underpayment totaling $1,102,399. We believe that payments errors will significantly increase with the expansion of the STAR+PLUS program to other counties across Texas in the near future

Payment errors occurred during FY 2000 because:

- a programming requirement was not met to implement the 120-day delay for HMO members who upgrade to a higher payment risk group;

- the information used to determine whether the member was in the nursing facility or community-based alternatives (CBA) payment risk group was not always updated timely, and when it was updated, it overrode the prior base plan value;

- Medicare eligibility was not always recognized in determining risk group assignment; and

- the PPS made untimely payment adjustments due to TDHS' limitation of applying automated retroactive adjustments to only the prior 7 months. Adjustments necessary outside this 7-month period require manual entries and are identified through annual audits conducted by TDHS.

Our review of Medicaid fee-for-service claims for STAR+PLUS members disclosed that Medicaid made unallowable fee-for-service payments on behalf of members who were age 65 or older, and did not have both Medicare and Medicaid coverage (dual eligible). A programming error in the payment system used by the National Heritage Insurance Company (NHIC) to process claims occurred. The TDHS identified 1,580 members enrolled in STAR+PLUS during the period January 1999 through August 2001 potentially affected by this programming error.

Regarding our review of HMO payments, we are recommending that the Commission ensure that TDHS: (1) makes the appropriate adjustments for the overpayment of $387,214 and underpayment of $1,102,399 identified by TDHS in its internal audits for FYs 1998 and 1999; (2) recoups the $40,070 related to the payment errors made for 10 members; (3) makes the necessary adjustments to the related Federal Financial Participation (FFP) amount; (4) corrects the payment system problems; and (5) reports to us the impact of these problems on the 49,500 members enrolled during FY 2000.

Regarding our review of fee-for-service claims, we are recommending that the Commission ensure that TDHS: (1) instructs NHIC to identify and recoup duplicate Medicaid payments made for the 1,580 members who were incorrectly classified as dual eligible; (2) refunds the related FFP amount; (3) directs NHIC to correct the programming error in its payment system that allowed duplicate Medicaid payments to be made; and (4) reports to us the impact of the programming error, going back as far as possible.

The Commission reviewed the draft report and fully agreed with our recommendations and has stated that it has taken action to recover overpayments and correct payment system problems. The total recovery amount will be provided to us upon completion of the State's annual audits of payments to the STAR+PLUS HMOs, and NHIC's review of claim histories on the identified 1,580 clients. The complete text of the Commission's response is presented as APPENDIX A to this report. In this response, the Commission stated that it is committed to assuring the integrity of payments made to HMOs under the STAR+PLUS program.

INTRODUCTION

BACKGROUND

The Texas Senate Concurrent Resolution 55 of the 74th Legislature directed the Commission to integrate the delivery of acute and long-term care services for aged and disabled Medicaid clients using a managed care system. As a result, the STAR+PLUS managed care program was established in Harris County in 1998. The program goals are to improve Medicaid health care delivery for aged and disabled clients for both acute and long-term care at a cost that does not exceed the cost of fee-for-service delivery. The TDHS administers STAR+PLUS using two basic delivery models:

- ***HMO model*** The State contracts with an HMO to provide comprehensive quality healthcare to Medicaid members at a fixed monthly payment per member per month.

- ***Primary Care Case Management (PCCM) Model*** The State forms its own network of health care providers who receive fee-for-service reimbursement plus a monthly case management fee.

As of August 2000, there were about 49,500 HMO members and about 6,600 PCCM members enrolled in the STAR+PLUS program. During our audit period, enrollment in an HMO was mandatory for: (1) supplemental security income (SSI) clients 21 years of age and older; (2) clients in Social Security exclusions programs; (3) nursing facility residents who became Medicaid eligible after April 1, 1998 and who spent less than 12 months in the facility; and (4) clients who qualified for nursing facility level of care but elected to receive services in the community—referred to as CBA. Effective September 2000, nursing facility residents were not required to enroll in the STAR+PLUS program. For SSI clients under the age of 21, enrollment is mandatory in either an HMO or a PCCM plan. Most of the remaining Medicaid eligibles are not required to enroll, but may do so voluntarily.

Dual eligible members receive acute care from their Medicare providers and only long-term care services from the STAR+PLUS HMO. Medicaid only members receive both acute and long-term care from the HMO. The HMO payment rates reflect the differences between members with dual coverage and ones with Medicaid only coverage. Monthly payments are based on enrollment counts in each of the six STAR+PLUS eligibility risk groups: (1) nursing facility, Medicaid only; (2) nursing facility, dual eligible; (3) CBA, Medicaid only; (4) CBA, dual eligible; (5) Other Community Care (OCC), Medicaid only; and (6) OCC, dual eligible. For HMO members who upgrade to a higher risk group, the adjustment to the higher risk group will be delayed by 120 days as an incentive for the HMO to maintain members at the least restrictive setting that meets the client's health and safety needs.

To determine STAR+PLUS eligibility and calculate the payment amounts, TDHS uses its eligibility and payment systems. Medicaid and Medicare eligibility information is maintained by TDHS on its System of Application Verification Eligibility Referral and Reporting (SAVERR). The managed care Premium Payable System (PPS), also maintained by TDHS, interprets the information on the SAVERR to determine eligibility and makes risk group assignments for

payment purposes. Members are assigned to a payment risk group based on their designated Medicare eligibility, Medicaid category, type program, and base plan. The base plan identifies whether the member is in a nursing facility or CBA program.

OBJECTIVES and SCOPE

Objectives

The objectives of our review were to determine whether: (1) STAR+PLUS HMO members were eligible for managed care and assigned to the appropriate risk group for payment purposes, and (2) any unallowable Medicaid payments were made in the fee-for-service sector for STAR+PLUS HMO members for services provided under the managed care program.

Scope and Methodology

Our audit was performed in accordance with generally accepted government auditing standards. We limited consideration of the internal control structure to those controls concerning STAR+PLUS HMO capitation payments because the objectives of our review did not require an understanding or assessment of the complete internal control structure at TDHS. Our review was limited to the HMO model because the majority of STAR+PLUS participants are enrolled in HMOs. Our site work was conducted at TDHS in Austin, Texas during the period March 2001 through August 2001.

To achieve our objectives, we:

- obtained an understanding of the STAR+PLUS program requirements and payment process;
- reviewed the HMO contracts for eligibility and payment rate information; and
- judgmentally selected 30 STAR+PLUS HMO members enrolled in September 1999 and reviewed their STAR+PLUS eligibility, risk group assignment, payment history, and Medicaid paid claims during FY 2000 (September 1, 1999 through August 31, 2000).

FINDINGS AND RECOMMENDATIONS

Our review disclosed that TDHS made risk group assignment errors for eligible STAR+PLUS members during FY 2000. For 10 of the 30 members we reviewed, the incorrect risk group was applied for payment purposes. As a result, an overpayment of $40,070 was made to HMOs participating in the STAR+PLUS program. We did not identify the impact these payment errors had on the total population of Medicare members totaling about 49,500 for FY 2000. Based on internal audits conducted by TDHS staff, an overpayment of $387,214 and an underpayment of $1,102,399 were made for FYs 1998 and 1999. We believe that payments errors will significantly increase with the expansion of the STAR+PLUS program to other counties across Texas in the near future. Payment errors occurred during FY 2000 because:

- a programming requirement had not been met to implement the 120-day delay for HMO members who upgrade to a higher risk group;

- the information used to determine whether the member was in the nursing facility or CBA payment risk group was not always updated timely, and when it was updated, it overrode the prior base plan value;

- Medicare eligibility was not always recognized in determining risk group assignment; and

- the PPS made untimely payment adjustments due to TDHS' limitation of applying automated retroactive adjustments to only the prior 7 months. Adjustments necessary outside this 7-month period require manual entries and are identified through annual audits conducted by TDHS.

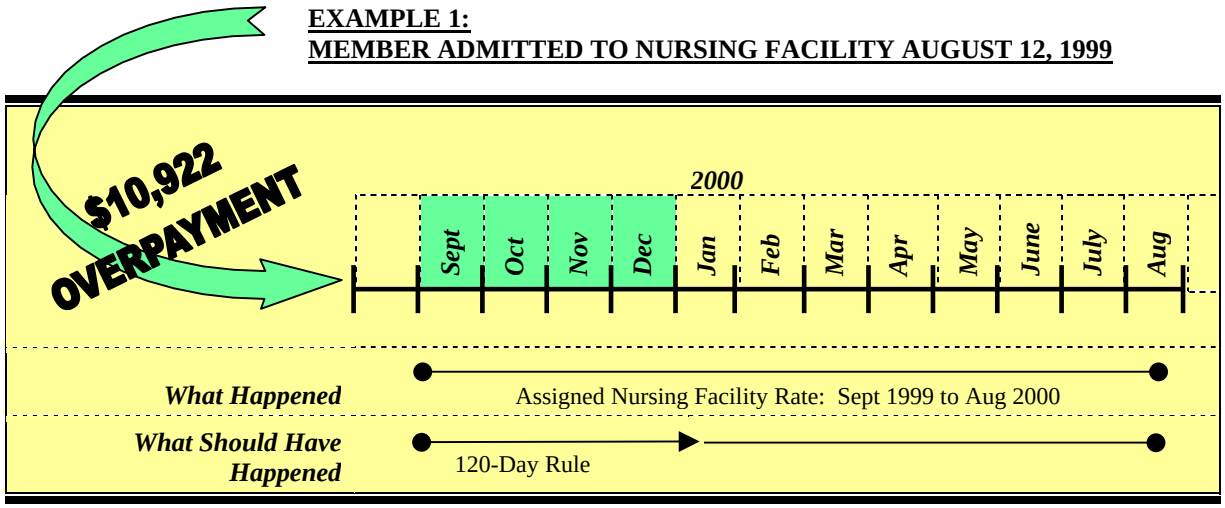
The TDHS conducts annual audits to adjust incorrect HMO payments. According to TDHS officials, these audits will become more labor intensive because STAR+PLUS will be expanding to additional counties. Therefore, we believe the payment system should be designed to make the original payments correct rather than relying on annual audits to make payment adjustments.

Our review of fee-for-service claims for STAR+PLUS members identified a programming error in the payment system used by NHIC, under contract with the State to process Medicaid claims. As a result, duplicate Medicaid payments were made. This error potentially affected 1,580 members enrolled in STAR+PLUS during the period January 1999 through August 2001.

Programming Requirement Not Met

The HMO contract specifies that for HMO members who upgrade to a higher risk group, the adjustment to the higher risk group will be delayed for 120 days. This requirement is an incentive for HMOs to maintain members at the least restrictive setting that meets the client's health and safety needs.

When the STAR+PLUS program was implemented in January 1998, TDHS specified a systems requirement for the delay of the higher risk group assignment for enrolled clients until 120 days elapsed in either a nursing facility or CBA program. However, this programming requirement was not met. This programming problem can impact all members who enter a nursing facility or CBA program. The TDHS is currently working to incorporate the 120-day counter into the monthly production process. Until the programming requirement is met, TDHS is auditing previous payments and making manual corrections. For example, one member was admitted to the nursing facility on August 12, 1999 and was assigned to the nursing facility rate from September 1999 through August 2000 as shown below:



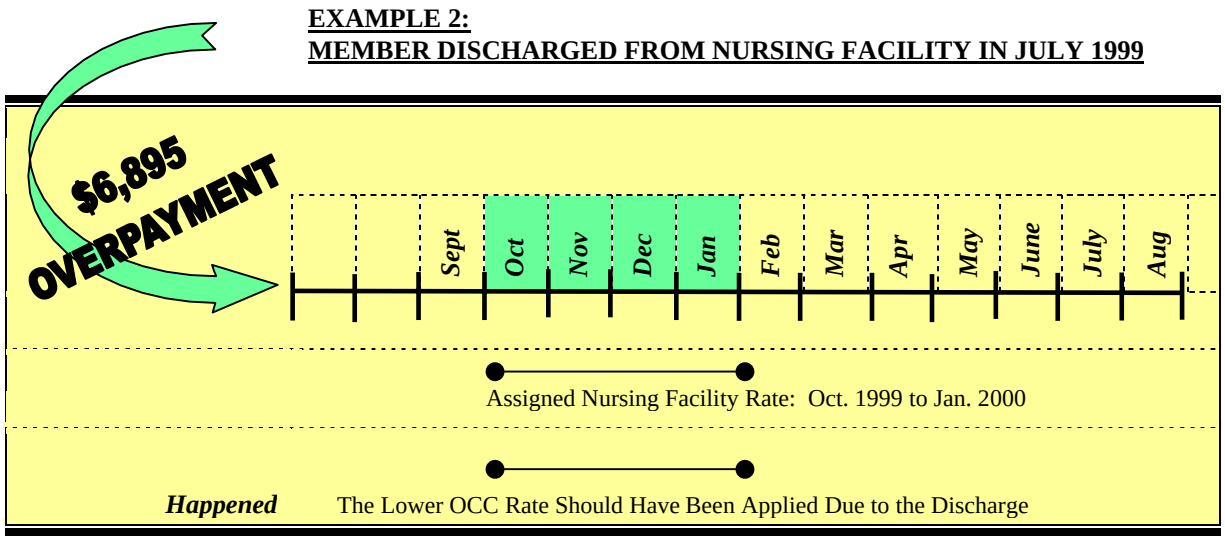
The 120-day rule should have been applied to the August 12, 1999 admission date and the upgrade to the nursing facility rate should not have occurred until January 2000. As a result of the 120-day counter not being in place, an overpayment of $10,922 was made for this member for the 4-month period, September 1999 through December 1999.

Nursing Facility and CBA Program Information

Prior to May 2000, the base plan value contained on SAVERR was used to determine whether the member was in a nursing facility or CBA program and make the appropriate risk group assignment. The base plan value was based on information submitted by TDHS caseworkers. Each month, SAVERR passed the base plan value to the PPS. The PPS calculated the monthly payment for the member using this base plan value, and also made retroactive adjustments for the preceding 7-month period. However, SAVERR did not maintain the prior base plan or the effective date of the change. As a result, changes in the base plan were interpreted by PPS as having been in effect for the month the changes were made, as well as the prior 7 months. For example, when a member changed from an eligible base plan to an ineligible base plan, the PPS made adjustments to recoup payments for the prior 7 months—even through the member was eligible for STAR+PLUS throughout that period until the base plan changed.

These problems prompted TDHS to implement system changes in May 2000 that would make risk group assignments based on nursing facility and CBA client information submitted by

providers. However, the new procedures presented a new set of problems for the PPS. These procedures rely on providers to submit client information in a timely manner. If the information is not timely, the PPS may miscalculate payment adjustments because TDHS' system is limited to a 7-month look-back period for making automated adjustments. As a result, overpayments may occur. For example, one member was incorrectly assigned to the nursing facility rate for October 1999 through January 2000 as shown below:

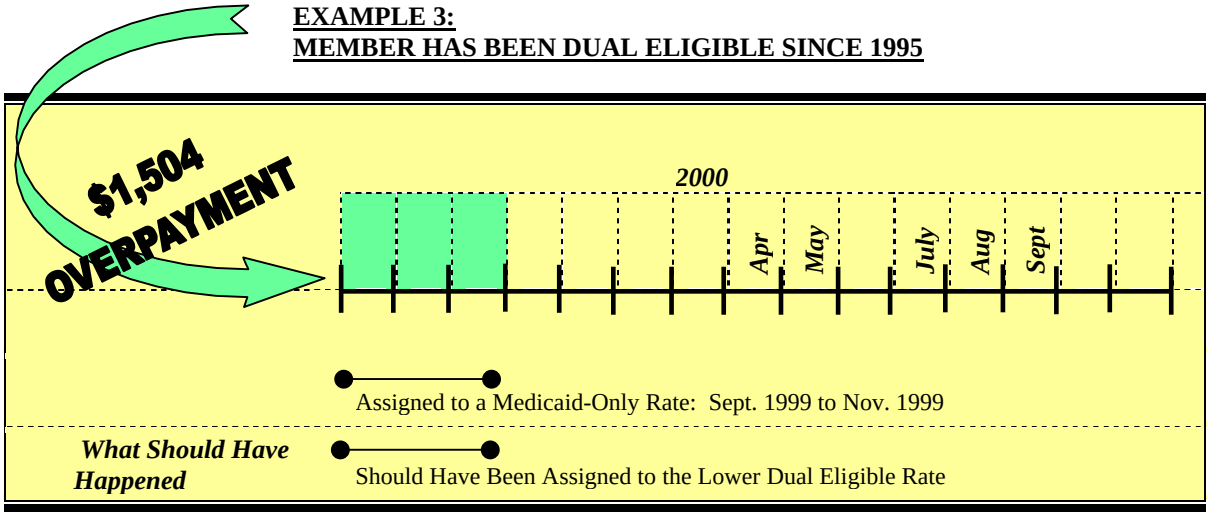


The provider form showed a nursing facility discharge effective July 1999, but it was not processed until July 2000. The PPS applied the correct adjustments for September 1999 and February 2000 through August 2000. However, no adjustments were made for October 1999 through January 2000. As a result, an overpayment of $6,895 occurred for this member for the 4-month period, October 1999 through January 2000.

Medicare Eligibility

The TDHS does not always correctly identify those members who are dual eligible. Correct classification as dual eligible is critical because rates are affected materially. The OCC rate was $597 for Medicaid only clients and $96 for dual eligible clients. The CBA rate was $3,013 for Medicaid only clients and $1,524 for dual eligible clients. The nursing facility rate was $3,328 for Medicaid only clients and $1,820 for dual eligible clients. For example, one member was

assigned to the OCC Medicaid only rate of $597 for September 1999 through November 1999 as shown below:



The SAVERR showed the member as being dual eligible since 1995. However, for the period September 1999 through November 1999 the Medicaid-only rate of $597 was paid. For this period, the dual eligible rate of $96 should have been used. As a result, an overpayment of $1,504 was made for this member for the 3-month period.

TDHS' Annual Audits and 7-Month Look-Back Period

The TDHS conducts annual audits to ensure that capitation payments were correct. These audits utilize a 120-day counter for nursing facility and CBA members in order to adjust payments as appropriate. For FYs 1998 and 1999, the TDHS' internal audits identified an overpayment totaling $387,214 and an underpayment totaling $1,102,399. We did not verify the accuracy of these amounts. The TDHS' FY 1998 audit was completed and disclosed that a capitation overpayment of $105,428 was made to two HMOs, and an underpayment of $234,167 was made to one HMO. The TDHS' FY 1999 audit identified an overpayment of $281,786 for one HMO and an underpayment of $868,232 for another HMO. The third HMO audit for FY 1999 is in progress.

The PPS is programmed to apply retroactive adjustments to the current month and the prior 7 months. Adjustments necessary outside this 7-month period require manual entries and are identified through annual audits conducted by TDHS. If the 7-month period was extended, the amount of time expended on annual audits would be reduced and more timely payment adjustments would be made.

Duplicate Medicaid Payments

Our review of Medicaid fee-for-service claims for STAR+PLUS members disclosed a programming error in NHIC's payment system for members who were age 65 or older, and did

not have Medicare coverage. This programming error potentially affected 1,580 members enrolled in STAR+PLUS during the period January 1999 through August 2001. For these members the: (1) HMO received a capitation payment to cover Medicaid covered services, and (2) NHIC's payment system did not preclude paying claims submitted by Medicaid providers for services covered by the HMO. As a result, duplicate Medicaid payments were made.

The TDHS considers this payment problem a high priority. The TDHS requested NHIC to review all paid claims made back to January 1998, or as far back as possible, for the 1,580 members who could potentially have had duplicate Medicaid payments made on their behalf. For these members, TDHS made a payment to the HMO, and NHIC would have also processed and paid claims made in the fee-for-service sector.

Conclusion

Our review disclosed that TDHS made risk group assignment errors for eligible STAR+PLUS members during FY 2000. For 10 of the 30 members we reviewed, the incorrect risk group was applied for payment purposes. As a result, an overpayment of $40,070 was made to HMOs participating in the STAR+PLUS program. Payment errors occurred during FY 2000 because:

- a programming requirement has not been met to implement the 120-day delay for HMO members who upgrade to a higher risk group;

- the information used to determine whether the member was in the nursing facility or CBA payment risk group was not always updated timely, and when it was updated, it overrode the prior base plan value;

- Medicare eligibility was not always recognized in determining risk group assignment; and

- the PPS made untimely payment adjustments due to TDHS' limitation of applying automated retroactive adjustments to only the prior 7 months. Adjustments necessary outside this 7-month period require manual entries and are identified through annual audits conducted by TDHS.

We did not identify the impact the above payment errors had on the total population of Medicare members totaling about 49,500 for FY 2000. However, for FYs 1998 and 1999, the impact was an overpayment of $387,214 and an underpayment totaling $1,102,399 based on internal audits conducted by TDHS staff. We believe that payment errors will significantly increase with the expansion of the STAR+PLUS program to other counties in Texas.

Our review of fee-for-service claims for STAR+PLUS members identified a programming error in the payment system used by NHIC to process Medicaid claims. As a result, duplicate Medicaid payments were made. This error potentially affected 1,580 members enrolled in STAR+PLUS during the period January 1999 through August 2001.

Recommendations

We recommend that the Commission ensure that TDHS:

- makes the appropriate adjustments for the overpayment of $387,214 and underpayment of $1,102,399 identified by TDHS in its internal audits for FYs 1998 and 1999, and the associated FFP amount;

- recoups the $40,070 related to the payment errors made for 10 members, and refunds the associated FFP amount;

- quantifies and reports to us the impact of the 120-day counter, base plan, and Medicare entitlement issues on the total population of about 49,500 STAR+PLUS HMO members enrolled during FY 2000;

- implements a programming requirement to enforce the 120-day counter for those HMO members upgrading to a higher risk group;

- improves the accuracy of the information used to determine whether the member was in the nursing facility or CBA payment risk group;

- improves the use of Medicare entitlement data in making risk group determinations;

- revises the payment programming to apply automated retroactive adjustments beyond the current limitation of 7 months;

- instructs NHIC to modify its payment system to preclude duplicate Medicaid payments for STAR+PLUS members;

- instructs NHIC to identify and recoup duplicate Medicaid payments made for the 1,580 members who were incorrectly classified by NHIC as dual eligible, going as far back as possible – refunding the related FFP amount; and

- quantifies and reports to us the impact of NHIC's programming error in its payment system that allowed duplicate Medicaid payments to be made.

Commission's Response

The Commission reviewed the draft report and fully agreed with our recommendations and has stated that it has taken action to recover overpayments and correct payment system problems. The total recovery amount will be provided to us upon completion of the State's annual audits of payments to the STAR+PLUS HMOs, and NHIC's review of claim histories on the identified 1,580 clients. The Commission acknowledged the risk group assignment errors, and has indicated that it has taken the following steps at TDHS to preclude these types of errors:

- An interim process to delay payment for 120 days when a client is moved to a higher risk group has been implemented. A program is being designed to automatically track the 120 days.

- The procedure for identifying nursing home and CBA status for risk group payment has been improved, and a client eligibility history is now maintained by month.

- The payment system has been enhanced to determine Medicare eligibility.

- A request was sent to the automation staff to provide for automatic retroactive adjustments to go back 24 months.

The Commission also acknowledged the error in the payment system used by NHIC to process paid claims. A formal request has been sent to NHIC to correct this system so it will accurately reflect Medicare and managed care status prior to paying claims. Another request has been submitted to NHIC to run the claims history on the identified 1,580 clients and to provide the total amount of duplicate claims and initiate recoupments. Upon completion by NHIC, the results will be provided to us.

The complete text of the Commission's response is presented as APPENDIX A to this report. In this response, the Commission stated that it is committed to assuring the integrity of payments made to HMOs under the STAR+PLUS program.

Sincerely,

for Gordon L. Sato
Regional Inspector General
for Audit Services

APPENDIX

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Don A.Gilbert, M.B.A.
COMMISSIONER

October 30, 2001

Gordon L. Sato
Regional Inspector General
For Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

Re: STAR+PLUS Audit
Common Identification Number A-06-01-00039

Dear Mr. Sato:

Thank you for the opportunity to respond to the audit of Medicaid payments made by the Texas Department of Human Services (TDHS) under the STAR+PLUS program. We have reviewed your findings and are taking action on your recommendations. The state is committed to assuring the integrity of payments made to HMOs for members of STAR+PLUS.

At the onset of the audit with the U.S Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services (OAS) staff, TDHS acknowledged that there were problems with the automated payment system for STAR+PLUS. Several payment features in the design of STAR+PLUS were never fully implemented in the automated system. Also of concern is the limitation in the automated system to make retroactive payment adjustments. Risk group errors older than 7 months must be handled manually.

Aware that there are errors in risk group assignment, the state performs an annual audit of payments to the STAR+PLUS HMOs. This audit involves checking payments against the risk group logic for accuracy. As noted by the OIG-OAS auditors, payment errors were made for the following reasons:

- the automated payment system does not recognize the 120-day delay in risk group adjustment when a member moves to a higher risk group;
- information concerning a member's status as a Community Based Alternative (CBA) client or a Nursing Facility client is not always updated timely in the automated system;
- Medicare eligibility is not always recognized accurately; and
- retroactive automated payment adjustments can only correct the prior 7 months.

Our annual audit reviews for each of these potential payment errors and identifies overpayments and underpayments and adjusts payments accordingly.

Page Two
October 30, 2001
Mr. Gordon Sato

Your review of Medicaid fee-for-service claims disclosed an error in the payment system used by the National Heritage Insurance Company (NHIC). It appears that the NHIC system assumes all Medicaid recipients over 65 have Medicare. As a result of this assumption, payments may have been made for potentially 1580 STAR+PLUS members over 65 without Medicare. We acknowledge this error and have taken steps to correct the system and recoup any erroneous payments.

Response to OIG-OAS Recommendations

Recommendation - TDHS recoup the net overpayment of $494,576 for SFY 98 and SFY 99 and refund the associated FFP amount. ***(*See Auditor's Note Below.)***

Response - Below is the table summarizing the data from our SFY98/99 audits.

HMO	SFY 98	SFY 99	TOTAL
ACCESS	$ (93,112.57)	**	$ (93,112.57)
Amerigroup	$ (12,315.25)	$(281,786.08)*	$ (294,101.33)
HMO Blue	$234,167.33	$ 868,231.41	$1,102,398.74
TOTAL	$128,739.51	$ 586,445.33	$ 715,184.84

* Reduced from $502,388.41
** Audit in progress

The payment adjustments for SFY98 have been completed. We adjusted the monthly payment voucher to each plan by the amount of net overpayment or added an amount equal to the net underpayment.

The state recognizes that for tracking purposes, these audit findings should be handled separately from the monthly payment vouchers. For future audit findings, STAR+PLUS will request a check for the amount of overpayment so that the receipts can be properly posted to the year of service. A check will be cut for the amount of underpayment.

The SFY 99 adjustments to HMO Blue have been completed and a payment made in August 2001 for $868,231.41. A preliminary finding of $502,288.41 owed by Amerigroup is under review. Amerigroup has provided information/documentation to support the risk group payments made for CBA members. Documentation provided to date has reduced that liability to $281,768.08. They have until November 1, 2001 to submit additional documentation to further reduce the liability. We will provide you with the final numbers when all reconciliation has been completed.

The audit of Access+Plus for SFY99 is almost complete. A formal letter will be sent with notification of these findings. The FFP for any overpayments will be refunded.

Recommendation - Recoup the $40,070 in overpayments for the 10 clients in the sample of 30 that were reviewed and refund the associated FFP.

Response - We will recoup the overpayments for these members. The 30 clients in the sample will be removed from our year-end audit. The state will refund the associated FFP.

Recommendation - Quantify and report the impact of payment errors for SFY 2000.

Response - The state will conduct a year-end audit on SFY 2000, just as it did for SFY 98 and SFY 99. This audit will be completed by March 2002. The results will be sent to OIG-OAS after completion.

Recommendation - Implement programming for the 120-day delay for members moving from OCC to a higher risk group.

Response - We have implemented an interim process to delay payment for 120 days when a client is moved to a higher risk group. Automation staff are currently working on a program that will automatically track the four months.

Recommendation – Improve the accuracy of information used to identify a client's nursing home or CBA status.

Response - In April 2000, we changed the procedure for identifying nursing home and CBA status for risk group payment. We use the Service Authorization System (SAS), which provides a more accurate assignment of risk group. Also, unlike the previous method, SAS retains a client eligibility history by month providing the ability to adjust for the prior 7-month period.

Recommendation - Improve the use of Medicare entitlement data for making risk group determinations.

Response - In May 2000, we made several enhancements to the automated system to provide proper determination of Medicare eligibility. A remaining problem concerns members with only Medicare Part A coverage who are not identified as dual eligible in the state's eligibility system. For these cases, the state seeks the most current information regarding Medicare status directly from the Social Security Administration system.

Recommendation – Revise the payment programming to apply automated retroactive adjustments beyond the 7-month look back and adjustment period

Response - The state agrees with this recommendation. We have requested automation staff to enhance the system to provide for retroactive adjustment to go back 24-months. Until that process is implemented, the state will have to continue to rely on the year-end audit process to make adjustment beyond the 7-month period.

Recommendation – Instruct NHIC to modify its payment system to preclude duplicate Medicaid payments for STAR+PLUS members.

Response - NHIC's programming assumes that all clients over the age of 65 are Medicare eligible. A formal request has been sent to NHIC to correct this system so it will accurately reflect Medicare and managed care status prior to paying FFS claims.

Recommendation - Instruct NHIC to identify and recoup duplicate Medicaid payments made for the 1,580 members who were incorrectly classified as dual eligible

Response - A formal request has been completed and submitted to NHIC to run the claims history on the identified 1,580 clients and to provide the total amount of duplicate claims and initiate recoupments where appropriate.

Recommendation - Quantify and report the impact of NHIC's programming error in its payment system that allowed duplicate Medicaid payments to be made.

Response - The formal request to NHIC asked that the claims review go back to January 1, 1998, the implementation of STAR+PLUS. Upon completion by NHIC, the results will besent to OIG-OAS.

We would like to thank the OIG-OAS audit staff, Amy Voight and Lynda Baker for their diligence, patience and good humor during this audit process. We are confident that the system enhancements in progress will significantly reduce future payment errors. Thank you again for the opportunity to review and respond to this draft report.

If you have any questions please contact Pamela Coleman at 512/438-5067.

Sincerely,

Don A. Gilbert

DAG:LKW:lal