DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

FEB 07 2003

CIN: A-04-02-07007

Dr. Rhonda M. Medows, Secretary
State of Florida Agency for Health Care Administration
2727 Mahan Drive
Mail Stop 1
Tallahassee, Florida 32308

Dear Dr. Medows:

Enclosed are two copies of the United States Department of Health and Human Services, Office of the Inspector General, Office of Audit Services final report, *Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees.* A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

In written comments, the State of Florida generally concurred with our recommendations and agreed to take corrective actions. The state's comments are included as an appendix to our report.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or Andrew Funtal, Audit Manager at (404) 562-7762 or e-mail at afuntal@oig.hhs.gov. To facilitate identification, please refer to report number A-04-02-07007 in all correspondence relating to this report.

Sincerely,

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

2 Enclosures

Direct Reply to HHS Action Official:

Dale Kendrick
Associate Regional Administrator
Division of Financial Management Program Initiatives
Centers for Medicare and Medicaid Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICAID FEE-FOR-SERVICE PAYMENTS FOR DUALLY ELIGIBLE MEDICARE MANAGED CARE ENROLLEES

JANET REHNQUIST
Inspector General

February 2003
A-04-02-07007

Notices

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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 HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3141
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

FEB 07 2003

CIN: A-04-02-07007

Dr. Rhonda M. Medows, Secretary
State of Florida Agency for Health Care Administration
2727 Mahan Drive
Mail Stop 1
Tallahassee, Florida 32308

Dear Dr. Medows:

This final report provides you with the results of an Office of Inspector General, Office of Audit Services' review entitled, *Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees.*

EXECUTIVE SUMMARY

OBJECTIVE

Our audit had two objectives. The first was to determine the appropriateness of Medicaid fee-for-service payments made on behalf of dually eligible beneficiaries enrolled in Medicare health maintenance organizations (HMO). The second was to ensure that services purchased from Medicare HMOs through capitation payments were not also paid by Medicaid through a capitation payment.

SUMMARY OF FINDINGS

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 Medicaid state plan. Florida's approved state plan allows the Florida Agency for Health Care Administration (FL-AHCA) to make payments for some services and subsequently determine if there is a liable third party. In addition, contracts between the State of Florida and HMOs do not allow a beneficiary to be concurrently enrolled in both a Medicare and Medicaid HMO.

The FL-AHCA made fee-for-service payments that were the responsibility of Medicare HMOs. In addition, capitation payments were made to both Medicare and Medicaid HMOs on behalf of the same beneficiary. This occurred because the Florida Medicaid Management Information System (FMMIS) was not updated to reflect the enrollment of Medicaid beneficiaries in Medicare HMOs. As a result, FL-AHCA made approximately **$4** million in improper payments during our audit period ($2,231,100 federal share).

We recommend that the FL-AHCA:

- refund to Centers for Medicare & Medicaid Services (CMS) $2,231,100 representing the federal share of the $3,947,406 in unallowable payments; and

- utilize the data available from CMS to identify services provided to beneficiaries in Medicare HMOs to ensure that unallowable payments for services are not made in the future.

In their written response to our draft report, the State of Florida generally concurred with our recommendations and agreed to take corrective actions. The state's comments, in their entirety, are included in Appendix C to our report.

Glossary of Abbreviations and Acronyms

CFR	Code of Federal Regulation
CIN	Common Identification Number
CMS	Centers for Medicare & Medicaid Services
FL-AHCA	Florida Agency for Health Care Administration
FMMIS	Florida Medicaid Management Information System
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
HMS	Health Management Systems
OAS	Office of Audit Services

INTRODUCTION

BACKGROUND

Health Maintenance Organizations

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 CMS contracts with HMOs to provide comprehensive health services on a prepayment basis to enrolled Medicare beneficiaries. The CMS 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

The Medicaid program is a joint federal and state program for providing financial assistance to individuals with low incomes to enable them to receive medical care. Under the Medicaid program, each state establishes its own eligibility standards, benefits packages, payment rates, and program administration in accordance with certain federal statutory and regulatory requirements. The provisions of each state's Medicaid program are described in the state's Medicaid "state plan" that is approved by CMS. In addition to approving the state plan and monitoring states for compliance with federal Medicaid laws, the federal role includes providing matching funds to state agencies to pay for a portion of the costs of providing health care to Medicaid recipients.

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 Medicare HMO covers the services.

In developing its contracts for Medicaid HMOs, FL-AHCA included provisions that specifically prohibit beneficiaries enrolled in Medicare HMOs from enrolling in a Medicaid HMO. The Medicaid HMO must notify the recipient in writing that the recipient will be disenrolled the next contract month or earlier if necessary.

Individuals in the State of Florida who are eligible for both Medicare and Medicaid may receive health care through a HMO. If an individual chooses to enroll in an HMO, Medicaid makes capitation payments to the HMO. The HMO is then responsible for all services normally covered by Medicaid. The FL-AHCA administers the Medicaid program in the State of Florida. It is FL-AHCA's responsibility to ensure that Medicaid is not paying for medical services that should be paid by HMOs. In addition, it is FL-AHCA's responsibility to ensure that capitation payments are not made to Medicaid HMOs for beneficiaries enrolled in Medicare HMOs.

During an audit entitled *Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations* (report number A-04-97-01168, issued December 20, 1999), we found that Medicare beneficiaries who were also eligible for Medicaid, received medical services and drugs that should have been covered by an HMO. In addition, capitation payments were being made on behalf of beneficiaries who were enrolled in Medicare and Medicaid HMOs concurrently. Accordingly, our audit was a follow-up audit to determine if FL-AHCA had implemented corrective actions.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our audit had two objectives. The first was to determine the appropriateness of Medicaid fee-for-service payments made on behalf of dually eligible beneficiaries enrolled in Medicare HMOs. The second was to ensure that services purchased from Medicare HMOs through capitation payments were not also paid by Medicaid through a capitation payment.

Scope

Our audit was performed in accordance with generally accepted government auditing standards. A detailed review of internal controls was not performed because the objectives of our audit were accomplished through substantive testing. We revisited the findings as outlined in the Office of Audit Services (OAS) audit report entitled *Medicaid Fee-for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations* (A-04-97-01168) to determine if corrective actions by the FL-AHCA were, in fact, implemented. In addition, we reviewed the claims of 200 randomly selected beneficiaries from a universe of 51,747 and projected the results. Our audit period was July 1, 2000 through June 30, 2001. Fieldwork was performed from December 2001 through October 2002 in the OAS Field Office in Birmingham, Alabama; CMS' offices in Atlanta, Georgia; and at FL-AHCA in Tallahassee, Florida.

Methodology

From a universe of 51,747 beneficiaries enrolled in Medicare HMOs and also eligible for Medicaid in the State of Florida, we randomly selected 200 beneficiaries for review (for details of sampling methodology see Appendix A). We requested the payment information from FL-AHCA on these beneficiaries. The FL-AHCA provided payment information on 93 of the 200 beneficiaries. We confirmed, through access to the FMMIS, that Medicaid had not made payments on behalf of the remaining 107 beneficiaries. Of the 93 beneficiaries that Medicaid made payments for, 79 beneficiaries had payments made on their behalf while they were enrolled in a Medicare HMO. For each of the 79 beneficiaries, we requested the payment information from the appropriate HMO. For each of the 200 beneficiaries, we verified the third party liability records to determine if FMMIS accurately reflected these beneficiaries HMO enrollment status.

To accomplish our objectives, we:

- reviewed criteria related to third party liability, the states responsibilities to pursue third party payers, and Florida statutes pertaining to HMO enrollment;

- compiled a listing of 51,747 Medicare beneficiaries both enrolled in a Medicare HMO and eligible for Medicaid in the State of Florida;

- utilized a simple random sample to select 200 beneficiaries for review (see Appendix A for details of our sampling methodology);

- obtained the payment history and a description of services for each beneficiary from FL-AHCA;

- obtained the payment history and a description of services for each beneficiary from the appropriate HMO;

- obtained the Adjusted Community Rate and Published Benefit Plan for each of the HMOs;

- acquired access to the FMMIS;

- used RAT-STATS Variable Appraisal Program to estimate the dollar impact of improper payments in the total universe (see Appendix B for details on the results of our projection); and

- discussed the results of our review with FL-AHCA officials.

To determine if the HMO was responsible for any of the services provided to our sample beneficiaries we:

- compared the payment history and description of services from the FL-AHCA with the payment history and description of services from the HMO for each beneficiary;

- reviewed the Adjusted Community Rate and Published Benefit Plan to determine what services should have been the responsibility of the HMO; and

- accessed FMMIS to verify the Medicaid and Medicare HMO data.

To determine if a beneficiary was dually capitated we:

- reviewed the payment history for each beneficiary; and

- accessed FMMIS to verify the Medicaid and Medicare HMO data.

The FL-AHCA's relevant comments are summarized after our recommendations and their written comments are included, in their entirety, in Appendix C of this report.

FINDINGS AND RECOMMENDATIONS

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 Medicaid state plan. Florida's approved state plan allows FL-AHCA to make payments for service and subsequently determine if there is a liable third party. In addition, contracts between the State of Florida and HMOs do not allow a beneficiary to be concurrently enrolled in both a Medicare and Medicaid HMO.

The FL-AHCA made fee-for-service payments that were the responsibility of Medicare HMOs. In addition, capitation payments were made to both Medicare and Medicaid HMOs on behalf of the same beneficiary. This occurred because the FMMIS was not updated to reflect the enrollment of Medicaid beneficiaries in Medicare HMOs. As a result, FL-AHCA made approximately $4 million in improper payments during our audit period.

CRITERIA

Section 1902 (a)(25) of the Social Security Act and 42 Code of Federal Regulations (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 42 CFR 433.139 (b)(1) requires the state agency to establish probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability.

An exception to this provision, incorporated into the state plan and approved by CMS, allows FL-AHCA to make payments and then determine if there is a liable third party. That portion of the Florida state plan states:

> All claim types pass through the TPL cost avoidance subsystem. However, in the following circumstances, post payment recovery is instituted rather than cost avoidance: …pharmacy services provided to recipients who are covered by any health insurance policy except a health maintenance organizations (HMO) coverage or a separate pharmacy card. Pharmacy services provided to these recipients are cost avoided.

The State of Florida 1996 supplement to Florida State Statues 1995, chapter 641.31, paragraph 14 of these statutes further states:

> Whenever a subscriber of a 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).

The contract between the State of Florida and the HMOs providing services to Medicaid beneficiaries has provisions that will not allow a beneficiary to be concurrently enrolled in both a Medicare and Medicaid HMO. Sections 10.3 of the State of Florida HMO contract states:

> Medicaid eligible recipients who are also members of a Medicare-funded health maintenance organization (HMO) are not eligible for enrollment in the Medicaid HMO.

Further, Section 30.13 states:

> The agency shall arrange for the plan to receive a monthly list of eligible members and a list of those members ineligible or disenrolled from the HMO. The plan shall be responsible for notifying, in writing, enrollees involuntarily disenrolled by the plan of the disenrollment effective date and the reason for disenrollment.

MEDICARE HMO SERVICES ARE BEING PAID BY MEDICAID

The FL-AHCA made Medicaid fee-for-service payments that should have been the responsibility of Medicare HMOs. In addition, capitations payments were made to Medicaid HMOs for individuals also enrolled in Medicare HMOs. The FL-AHCA made payments on behalf of 79 individuals in our sample of 200. Thirty-three of the 79 individuals had unallowable Medicaid fee-for-service payments made on their behalf and 8 had unallowable capitation payments made on their behalf to Medicaid HMOs while the individual was enrolled in a Medicare HMO. There were 3,024 payments made on behalf of the 79 beneficiaries. Of these payments, 415 were unallowable. Thirty-two of these payments were capitation payments made to Medicaid HMOs on behalf of individuals enrolled in a Medicare HMO. The remaining 383 payments were fee-for-service payments for pharmacy, dental, vision, and institutional care.

MEDICAID ENROLLMENT WAS NOT ADEQUATELY UPDATED

During the 12-month period of our audit the FL-AHCA did not process the CMS HMO update on four occasions and the contractor failed to process the CMS update in a timely fashion during two of the eight months when the information was processed. This caused FMMIS records to inaccurately reflect the third party liability. Consequently, capitation payments were made unnecessarily, and because FMMIS records did not show a liable third party, collections were not made.

The FMMIS was not adequately updated to reflect the enrollment of Medicaid beneficiaries in Medicare HMOs. In order to preclude the problem of dually capitated beneficiaries and to ensure that third party liability records are current, FL-AHCA receives, on a monthly basis, an update of beneficiaries enrolled in Medicare HMOs from CMS. When the Medicaid contractor (Consultec) processes this information, the FMMIS third party liability portion of a beneficiary record is updated to reflect the existence of a liable third party. Also, if the beneficiary is enrolled in a Medicaid HMO, the state provides each Medicaid HMO with a monthly report of beneficiaries enrolled in Medicare HMOs to facilitate disenrollment from the Medicaid HMO.

The FL-AHCA utilizes a cost avoidance decision matrix to determine if a claim is paid or returned to the provider. This matrix has two codes to differentiate between Medicare HMO beneficiaries with pharmacy benefits and those without. However, all Medicare HMO beneficiaries are coded “19” which represents Medicare HMO beneficiaries with unlimited pharmacy benefits. Even though FL-AHCA has the capability to differentiate between beneficiaries with pharmacy benefits and those without, they have chosen to treat all Medicare HMO beneficiaries the same and pay pharmacy claims and then seek post payment recovery. To further complicate this issue, Medicaid is not provided the specific plan identification by CMS that would allow it to determine the extent to which an HMO covers pharmacy claims.

The FL-AHAC has instituted a policy to pay all pharmacy claims including those of beneficiaries enrolled in an HMO and then to seek post payment recovery. This policy is in direct conflict with the State of Florida’s approved state plan.

As of November 2001, the FL-AHCA has contracted out its third party liability collections to Health Management Systems, Inc. (HMS). During our audit period, HMS was also under contract with the State of Florida to provide collection services to supplement the state's activities. The HMS's supplemental responsibilities were limited to processing collections missed by state employees.

FL-AHCA OVERPAID BY MORE THAN $3.9 MILLION

We estimate that FL-AHCA paid $3,947,406 ($2,231,100 federal share) in either capitation payments or fee-for-service benefits that it should not have paid. The FL-AHCA made 32 capitation payments to Medicaid HMOs on behalf of eight beneficiaries who were concurrently enrolled in a Medicare HMO. These 32 payments totaled $24,322. With the exception of two cases, these payments were for several months following the beneficiary's enrollment in a Medicare HMO. Three of the payments were made after the death of the beneficiary.

The FL-AHCA had also made 383 fee-for-service payments for services that were the responsibility of a Medicare HMO. These services include pharmacy, dental, and vision services and totaled $13,429. Of the 79 beneficiaries who were enrolled in a Medicare HMO and had fee-for-service payments made on their behalf, Medicaid made payments for 33 beneficiaries that should have been the responsibility of one of the Medicare HMOs.

When projected to the universe of 51,747 beneficiaries, we estimate that FL-AHCA would have paid $3,947,406 ($2,231,100 federal share) in capitation payments and fee-for-service benefits that it should not have paid. The FL-AHCA and its contractor, HMS, did not properly seek reimbursement from these HMOs.

RECOMMENDATIONS

We recommend that the FL-AHCA:

- refund to CMS $2,231,100 representing the federal share of the $3,947,406 in unallowable payments; and

- utilize the data available from CMS to identify services provided to beneficiaries in Medicare HMOs to ensure that unallowable payments for services are not made in the future.

AUDITEE COMMENTS

In written comments, the State of Florida generally concurred with our recommendations and agreed to take corrective actions. The state's comments, in their entirety, are included in Appendix C of this report.

* * * * * *

Final determination as to actions taken on all matters reported would be made by the Department of Health and Human (HHS) action official named on the second page of the letter preceding this report. We request that you response to the HHS action official within 60 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.

Sincerely,

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

APPENDICES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVES

Our audit had two objectives. The first was to determine the appropriateness of Medicaid fee-for-service payments made on behalf of dually eligible beneficiaries enrolled in Medicare HMOs. The second was to ensure that services purchased from Medicare HMOs through capitation payments were not also paid by Medicaid through a capitation payment.

POPULATION

The population is the listing of 51,474 Medicare beneficiaries both enrolled in a Medicare HMO and eligible for Medicaid in the State of Florida.

SAMPLE UNIT

The sampling unit will be each beneficiary who was enrolled in a Medicare HMO and was also eligible for Medicaid in the State of Florida from July 2000 through June 2001.

SAMPLE DESIGN

The sample will be a simple random sample.

SAMPLE SIZE

The sample size will be 200 beneficiaries.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of the Inspector General, OAS RAT-STATS Variable Appraisal Program for random samples, we projected the amount of improper Medicaid payments.

APPENDIX B

VARIABLE PROJECTION

SAMPLE RESULTS

The results of our review are as follows:

Sample Size	Value of Sample	Number of Errors	Value Errors
200	$268,959	40*	$37751

VARIABLE PROJECTION

Point Estimate $9,767,629

90 Percent Confidence Interval

Lower Limit	$ 3,947,406
Upper Limit	$15,587,853

*There were 35 beneficiaries with erroneous fee-for-service payments and 8 beneficiaries with erroneous capitation payments. However, one of these beneficiaries had both types of error. The fee-for-service errors and the capitation errors were combined which is why the sample results shows 40 errors while the language in the report reflects 41 errors.

AHCA/ INTERNAL

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAPP, SECRETARY

January 16, 2003

Mr. Charles J. Curtis
Office of the Inspector General
Office of Audit Services – Region IV
61 Forsyth Street, S.W., Suite 3T4
Atlanta, Georgia 30303

RE: CIN A-04-02-07007

Dear Mr. Curtis:

Thank you for the opportunity to respond to the *U.S. Department* of Health and Human Services Office of the Inspector General, draft report *Medicaid Fee-For-Service Payments for Dually Eligible Medicare Managed Care Enrollees,* dated December 2002. Each of the report recommendations and the Agency's response follows:

We recommend that the Florida AHCA:

- Refund to the Centers for Medicare & Medicaid Services (CMS) $2,293,531 representing the federal share of the $4,057,863 in unallowable payments.

  Agency Response:

  The Third Party Liability (TPL) contractor, Health Management Systems, Inc. (HMS) is responsible for billing Medicare HMOs for payments in which the Medicare HMO is liable. Payments that are recouped through this billing process are reported on the next CMS-64 report. Of the $38,724 identified in the audit sample, $20,347 has been billed and $7,787 of this amount has been recouped to date. For the remaining $10,140, we have requested the Medicare HMO information from the auditors. When this information is received, HMS will add the Medicare HMO to the Florida Medicaid Management Information System (FMMIS). HMS will then bill the Medicare HMOs through its carrier billing process.

  As you know, the unallowable payments amount provided in the report is an estimate based on a statistical analysis. The HMOs will not pay in response to a bill based on a statistical analysis; they require the claim detail. Without claim detail, HMS will be unable to bill the estimated overpayments amount.

- Utilize the data available from CMS to identify services provided to beneficiaries in Medicare HMOs to ensure that unallowable payments for services are not made in the future.

Agency Response:

We have taken steps to ensure that the Medicare HMO information provided by CMS is entered into the FMMIS in a timely manner. The TPL unit now maintains a log of each Medicare HMO tape to track receipt and processing.

If you have any questions regarding this response, please contact Rufus Noble at (850) 921-4897 or Kathy Donald at (850) 922-8448.

Sincerely,

Rhonda M. Medows, M.D.
Secretary

RMM/kd

ACKNOWLEDGMENTS

This report was prepared under the direction of (RIGAS). Other principal Office of Audit Services staff who contributed include:

Andrew Funtal, *Audit Manager*
Emmitt Barnett, *Senior Auditor*
Maureen Bates, *Auditor-in-Charge*
Kozette Todd, *Auditor*
Anna Dubois, *Referencer*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.