JUL 16 2002

Memorandum

Date

From Michael Mangano for Janet Rehnquist
Inspector General

Subject Review of Managed Care Payments for Dual Eligible Beneficiaries with Institutional Status (A-05-00-00015)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

As part of the Office of Inspector General's (OIG) self-initiated audit work, we are alerting you to the issuance of our final report entitled, "Review of Managed Care Payments for Dual Eligible Beneficiaries with Institutional Status." The objective of our review was to determine if enhanced Medicare payments to managed care organizations (MCO) contracting with the Centers for Medicare & Medicaid Services (CMS) are reasonable for MCO enrolled dually eligible Medicare/Medicaid beneficiaries residing in nursing facilities. Our standard for reasonableness was if the enhanced Medicare payments covered the cost of furnishing Medicare services. It is perceived that Medicare beneficiaries who are dually eligible and institutionalized generally have higher medical costs as compared to the general Medicare population. As of June 2001, there were over 61,700 Medicare beneficiaries residing in nursing facilities of which about 26,600 were Medicare/Medicaid dually eligible.

We reviewed a nationwide statistical sample of MCOs and enrolled dually eligible beneficiaries who were in nursing homes. Although the aggregate amount of Medicare payments to the MCOs appeared reasonable for the beneficiary population, we found that for individual MCOs there was a disparity between the Medicare payment and the cost for the medical care provided to enrolled beneficiaries. A number of the MCOs in our review were significantly over or underpaid for the medical services provided to the sample beneficiaries. For example, one MCO in our review had an average shortfall of almost $4,500 per sample beneficiary during 1998 and a second MCO had an overage exceeding $4,000 for each beneficiary during the same year.

We believe the disparity in payments experienced by MCOs may have hurt CMS's ability to provide managed care options to beneficiaries. Underpayments to MCOs could reduce the number of MCOs willing or able to remain in the Medicare program. If they remain in the program, these MCOs might be forced to target only healthier beneficiaries for enrollment, limiting the health care choices for those individuals who are sicker. Other MCOs will likely continue to receive overpayments or excess reimbursement. In both instances, the equitable solution is known as risk adjustment.

The implementation of risk adjustment to the MCO payment system should lessen the disparity between Medicare payments and individual beneficiaries' medical costs. The risk adjustment methodology is based on the beneficiary's health status and a phase-in is scheduled over the 8-year period 2000 through 2007. Risk adjustment factors will produce payments that more closely reflect the costs of providing care and reduce the disincentive to enroll sicker beneficiaries.

As our review showed, the existing payment structure caused significant overpayments and underpayments to MCOs. Our review also demonstrated that there is merit in implementation of a risk adjustment factor for MCO payments especially as it relates to beneficiaries who are institutionalized. Delaying full implementation of the risk-adjusted rates would perpetuate the payment problems of the existing system.

We recommended that CMS consider the results of our work as it proceeds with the implementation of the risk adjustment factors and seek legislation to quicken the phase-in of the risk adjustment factors. A more limited approach would be to seek authority to implement sooner than 2007 a full risk adjustment factor applicable to MCO institutional payments for Medicare beneficiaries residing in nursing facilities. This would be both beneficial to CMS and the MCOs since an institutional risk factor would more closely match payments to medical cost and may help retain MCOs in Medicare's managed care program.

We received written responses to our recommendations from CMS and the Acting Assistant Secretary for Budget, Technology, and Finance (ASBTF). The ASBTF generally agreed with our recommendations, stating that the managed care industry acknowledges that risk adjustments will make payments more accurate. The CMS officials generally did not concur with our recommendations and submitted numerous comments questioning our audit method and the potential effect of our recommendations. The comments are summarized, together with an OIG response, in the body of the report and they are attached as APPENDICES.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Centers of Medicare and Medicaid Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-05-00-00015 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MANAGED CARE PAYMENTS FOR DUAL ELIGIBLE BENEFICIARIES WITH INSTITUTIONAL STATUS

JANET REHNQUIST
Inspector General

JULY 2002
A-05-00-00015

Memorandum

Date JUL 16 2002

From for Janet Rehnquist
Inspector General

Subject Review of Managed Care Payments for Dual Eligible Beneficiaries with Institutional Status (A-05-00-00015)

To
Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This final report provides the results of our audit entitled, "Review of Managed Care Payments for Dual Eligible Beneficiaries with Institutional Status." The objective of our review was to determine if enhanced Medicare payments made to managed care organizations (MCO) contracting with the Centers for Medicare & Medicaid Services (CMS) are reasonable for MCO enrolled dually eligible Medicare/Medicaid beneficiaries residing in nursing facilities. Our standard for reasonableness was if the enhanced Medicare payments covered the cost of furnishing Medicare services. It is perceived that Medicare beneficiaries who are dually eligible and institutionalized generally have higher medical costs as compared to the general Medicare population. As of June 2001, there were over 61,700 Medicare beneficiaries residing in nursing facilities of which about 26,600 were Medicare/Medicaid dually eligible.

We statistically selected 8 MCOs located throughout the country from which a sample of 30 enrolled beneficiaries was chosen from each of the MCOs. The beneficiaries were all dually eligible and residents of nursing facilities for all or part of 1998. The MCOs received payment from Medicare at the enhanced institutional rate for beneficiaries residing in qualifying nursing facilities. We compiled the medical services furnished by the MCOs to each beneficiary in our sample and compared the estimated cost of providing the services to the Medicare reimbursement received by the MCOs. The audit results for the eight MCOs were projected to the universe of all Medicare payments made for dually eligible institutionalized beneficiaries to determine the reasonableness of Medicare payments for such beneficiaries enrolled in MCOs.

Although the aggregate amount of Medicare payments to the MCOs appeared reasonable for the beneficiary population, we found that for individual MCOs there was a disparity between the Medicare payment and the cost for the medical care provided to enrolled beneficiaries. A number of the MCOs in our review appeared to have been either significantly over or underpaid for the medical services provided to the sample beneficiaries. For example, one MCO in our review had an annual average shortfall of almost $4,500 per sample beneficiary during 1998 and a second MCO had an annual overage exceeding $4,000 for each beneficiary during the same period.

We believe the disparity in payments experienced by MCOs may have hurt CMS's ability to provide managed care options to beneficiaries. Underpayments to MCOs could reduce the number of plans willing or able to remain in the Medicare program. If they remain in the program, these MCOs might be forced to target only healthier beneficiaries for enrollment, limiting the health care choices for those individuals who are sicker.

The implementation of risk adjustments to the MCO payment system should lessen the disparity between Medicare payments and individual beneficiaries' medical costs. The risk adjustment methodology, which is based on the beneficiary's health status, is planned to be phased in over the 8-year period 2000 through 2007. Risk adjustment factors will produce payments that more closely reflect the costs of providing care and reduce the disincentive to enroll sicker beneficiaries.

As our review showed, the existing payment structure caused significant overpayments and underpayments to MCOs. Our review also demonstrated that there is merit in implementation of a risk adjustment factor for MCO payments especially as it relates to beneficiaries who are institutionalized. Delaying full implementation of the risk-adjusted rates would perpetuate the payment problems of the existing system.

We recommended that CMS consider the results of our work as it proceeds with the implementation of the risk adjustment factors and seek legislation to quicken the phase-in of the risk adjustment factors. A more limited approach would be to seek authority to implement sooner than 2007 a full risk adjustment factor applicable to MCO institutional payments for Medicare beneficiaries residing in nursing facilities. This would be both beneficial to CMS and the MCOs since an institutional risk factor would more closely match payments to medical cost and may help retain MCOs in Medicare's managed care program.

We received written responses to our recommendations from CMS and the Acting Assistant Secretary for Budget, Technology, and Finance (ASBTF). The ASBTF generally agreed with our recommendations, stating that the managed care industry acknowledges that risk adjustments will make payments more accurate. The CMS officials generally did not concur with our recommendations and submitted numerous comments questioning our audit method and the potential effect of our recommendations. The comments are summarized, together with an Office of Inspector General response, in the body of this report and they are attached as APPENDICES B and C.

INTRODUCTION

BACKGROUND

The Balanced Budget Act (BBA) of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare+Choice (M+C) program. Its

primary goal was to provide a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans have a network of providers under contract to deliver a health benefit package that has been approved by CMS. Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. Beneficiaries eligible to enroll in the new M+C plans must be entitled to Part A and enrolled in Part B.

Enhanced Medicaid and Institutional Rates

The CMS makes monthly advance payments to MCOs at the per capita rate set for each enrolled beneficiary. Medicare pays a higher monthly rate to MCOs for beneficiaries who are Medicaid eligible or institutionalized. The institutional rate for most beneficiaries is higher than the Medicaid rate. The MCOs receive the enhanced institutional rate for enrollees who are residents of Medicare or Medicaid certified institutions such as: skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care hospitals, and swing-bed hospitals. Institutional status requirements specify that the beneficiary must be a resident of the qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The MCO monthly payments reflect the enhanced rate for institutional status or Medicaid eligibility. Medicare enhanced rates are based on only one of the enhanced payment categories. For example, during 1998 the monthly Medicare MCO payment for each non-Medicaid female beneficiary, ages 80 to 84, residing in a non-institutional setting in Maricopa County, Arizona is $503. The monthly payment of $503 would be adjusted to $753 if the beneficiary was Medicaid eligible, or $953 if reported to CMS as institutionalized.

Demographic Versus Health Status Adjustments

The BBA of 1997 changed the way CMS's managed care capitation rates are adjusted for each beneficiary. Before BBA and through 1999, Medicare MCO payments were based on the local Medicare fee-for-service spending. The payment rate for each area was adjusted for individual beneficiaries, using demographic factors that take into account the beneficiary's age, sex, Medicare status (aged or disabled), Medicaid eligibility, and institutional status. The demographic factors reflect the relative Medicare costs for a beneficiary to average per capita Medicare costs. These demographic factors are the same, both prior to and with the advent of the BBA of 1997.

The BBA of 1997 also required that CMS implement, by January 1, 2000, a risk adjustment methodology that accounts for variations in per capita costs based on the health of individual

enrollees. Under the new system, data collected about the health services provided to a beneficiary in a given year would be used to adjust the payment received by the MCO for that beneficiary in the following year. The payment adjustment would be based on the average total cost of health care for beneficiaries with the same diagnoses in the previous year. Officials at CMS believe the risk adjustment system will result in more appropriate payments to MCOs, and reduce the disincentive to enroll sicker beneficiaries.

In January 2000, CMS began phasing in the risk adjustment system. During the transition period, MCOs will be paid a blended rate utilizing both the old demographic adjustment factors and the new risk factors. The original implementation schedule announced by CMS called for risk factor payments of 30 percent in 2001 and 55 percent in 2002. The Benefits Improvement and Protection Act of 2000 implemented the risk factor system in which 10 percent of payments would be based on risk adjusted inpatient data and 90 percent would be adjusted solely using the demographic method through 2003. The following table outlines how the risk adjustment system will be implemented over time.

Transition From Demographic to Risk Adjustment Payment Methodology

Year:	2000-2003	2004	2005	2006	2007
Percent of Payment Based on Demographic Factors	90%	70%	50%	25%	0%
Percent of Payment Based on Risk Factors	10%	30%	50%	75%	100%

Initially, the risk adjustments will be based solely on inpatient hospital diagnoses. Beginning in 2004 medical service data from other sources, such as ambulatory settings, will be incorporated into the risk adjustment calculations. The risk adjustment system being implemented by CMS does not include an enhanced payment rate for institutionalized beneficiaries but does for those who are Medicaid eligible.

SCOPE

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if enhanced Medicare payments to MCOs contracting with CMS were reasonable for Medicaid eligible beneficiaries residing in nursing facilities.

A primary sample of 8 was selected from a universe of 74 Medicare MCOs that reported at least 30 Medicaid eligible beneficiaries as institutionalized in our August 1998 base month.

A weighted sample selection process was used to choose our eight primary units. The probability of each of the 74 MCOs being selected was proportional to the number of Medicaid eligible beneficiaries reported as institutionalized during August 1998. A simple random sample of 30 was selected for each of the 8 MCOs in the universe of Medicaid eligible beneficiaries, reported as institutionalized during the period January 1, 1998 through December 31, 1998.

We compiled the medical services furnished by the MCOs to each sample beneficiary, and compared the estimated cost of providing the services to the Medicare reimbursement received by the MCOs. Because all of the MCOs were not able to provide cost data relating to the Medicare Part B services received by the beneficiaries, we used Medicare fee-for-service amounts to estimate individual medical service costs in our calculations. The fee-for-service amounts were not less than the costs incurred by MCOs for the individual services so our methodology was conservative in that it did not understate the MCOs' actual costs. In general, the MCOs were able to provide more complete data regarding their costs of providing Medicare Part A services. In most instances, the MCOs were also able to provide cost data for plan services that the beneficiaries received, which were not covered by traditional Medicare, such as pharmaceutical drugs.

We summed the estimated costs incurred by the MCOs to provide medical services for each sample beneficiary. The costs were subtracted from the sum of the monthly Medicare payments received by the MCOs for the individual beneficiaries during corresponding time periods. The calculated differences showed the amount that medical costs either exceeded or were less than Medicare reimbursement. The sample results for the eight MCOs were projected to the universe to develop an estimate of the fit between payments and individual beneficiaries' cost for dually eligible patients living in nursing facilities. Our field work was completed at the MCOs and our field office in Columbus, Ohio.

RESULTS OF AUDIT

From the standpoint of the overall Medicare program, the aggregate amount of Medicare payments to MCOs appeared reasonable for the beneficiary population. However, we found that for individual MCOs there was a disparity between the Medicare payment and their cost for the medical care provided to the enrolled beneficiaries who were Medicaid eligible and were institutionalized.

We compiled the medical services provided to 240 beneficiaries during 1998 and compared the estimated cost of the services to the Medicare reimbursement received by the MCOs. The 240 beneficiaries were comprised of a sample of 30 from each of the 8 statistically selected MCOs. The beneficiaries were all Medicaid eligible and residents of nursing facilities for all or part of 1998. The MCOs received payment from Medicare at the enhanced institutional rate for beneficiaries residing in qualifying nursing facilities.

The sample results for the eight MCOs were projected to the universe to develop an estimate of industry differences in Medicare payments compared to their direct cost of providing services for dually eligible patients living in nursing facilities. Our audit results provided no clear pattern of either overpayment or underpayment due to risk selection for the Medicare MCOs. Viewed overall within the Medicare program, the enhanced rate process appeared to produce a reasonable average reimbursement for dually eligible patients who were institutionalized. The midpoint of our projection was close to break-even, given the estimated upper and lower limits. Results for individual MCOs in our sample, however, demonstrated that averaging was not always equitable.

Results at Individual MCOs

While our projection showed that total Medicare reimbursement was reasonable, our audit results showed a wide disparity between Medicare payment rates and the cost of furnishing medical services for MCOs on an individual basis. A number of the MCOs in our review were either significantly over or underpaid for the medical services provided to the sample beneficiaries. Examples from the 8 MCOs we reviewed included an MCO that was underpaid $137,000 for the 30 sampled beneficiaries and an MCO that was overpaid $125,000. The first MCO had an average annual shortfall of almost $4,500 per sample beneficiary during 1998, and the second MCO had an annual overage in excess of $4,000 for each beneficiary over the same period. These numbers showed that CMS's payment system for MCOs did not accurately reflect the individual plan's cost for the provided health care services.

We believe the disparity in payments experienced by MCOs may have hurt CMS's ability to provide managed care options to beneficiaries. Underpayments to MCOs could reduce the number of plans willing or able to remain in the Medicare program. If they remain in the program, these MCOs may feel forced to target their enrollment practices to healthier beneficiaries, limiting the health care choices for those individuals who are sicker.

Included in our universe were several demonstration MCOs that enrolled only institutionalized beneficiaries. Since the objective of our review was to determine if total enhanced Medicare payments were reasonable, it would not be appropriate to exclude the demonstration MCOs. However, to address CMS concerns, expressed during preliminary discussions of our findings, including this specialized population in our universe, we again examined our results at sampled demonstration MCOs and found no differences in the payment process or the causes of the overpayments**.**

New Payment System for MCOs

The CMS is currently implementing a risk adjustment payment system for MCOs that will base reimbursement on the health status of each individual beneficiary. Under the new system, data collected about the health services provided to a beneficiary in a given year would be used to adjust the payments received by the MCO for that beneficiary in the following year.

The new risk adjustment system is planned to be phased in over 8 years (2000 through 2007). Officials from CMS believe that the new risk adjustment system will produce payments that more closely reflect the costs of providing care and reduce the disincentive to enroll sicker beneficiaries. If true, the new risk adjustment system should help prevent MCOs from incurring shortfalls and leaving the program as a result. When implemented, the new system should also prevent other MCOs from targeting healthier beneficiaries to gain unreasonable profits.

Additional Analysis

We further analyzed the payments covered in our review by calculating what the payments would have been using CMS's risk adjustment methodology.[1] To make the risk adjustments, we used the MCOs' 1998 records of medical services provided to Medicare beneficiaries.

Based on our analysis, the MCOs having a high incidence of inpatient hospital stays would benefit most from risk adjustment. Since these MCOs were generally the ones we found to be under-reimbursed by the current system, an increase would appear equitable. Total payments would have increased by 35 percent for beneficiaries in the sample with an inpatient service.

Conversely, payments for beneficiaries who did not receive inpatient services would have been reduced by 27 percent after risk adjustment. The MCOs serving fewer hospitalized beneficiaries appear to be over-reimbursed under the current payment system. The payment reduction based on risk adjustment would be less severe in future years because our analysis of 1998 data did not incorporate the ambulatory setting adjustments, which is not due to be implemented by CMS until 2004.

Although this audit covered only the population of Medicaid eligible beneficiaries residing in an institution, the results clearly show that there are winners and losers in the current reimbursement system and that the number and duration of inpatient stays for MCO enrolled beneficiaries can cause a significant financial impact on an individual MCO.

In discussing these findings with CMS staff, they expressed the belief that even with full risk adjustment, there will still be underpayments or overpayments for individual MCOs' enrollees. Although risk adjustment for health status will not be error free, we believe that the over-all disparity between Medicare payments and MCO costs will be reduced.

---

[1] For our analysis, we deviated from the risk adjustment criteria. The MCOs included in the initial review supplied the 1998 inpatient data for each beneficiary. Our analysis was performed to see the impact of applying the 1998 risk factors to the 1998 Medicare payments. The 1998 risk factors were developed using 1998 inpatient data although the risk adjustment system requires the beneficiary's previous year (which for our analysis would have been 1997 inpatient data which we did not have) inpatient data be used when developing the current year's risk factor.

Reducing this disparity would have a positive impact on retaining some of the MCOs currently experiencing significant losses in Medicare's managed care program and in preventing over-reimbursement to others.

CONCLUSION AND RECOMMENDATIONS

We concluded that the current system of reimbursement for Medicaid eligible institutionalized beneficiaries, having no adjustment to payment levels for beneficiaries' health status, created inequities that should be corrected as soon as practical. Therefore, we recommend that CMS seek legislation to quicken the phase-in of the risk adjustment factors. A more limited approach would be to seek authority to implement sooner than 2007 a full risk adjustment factor applicable to MCO institutional payments for Medicare beneficiaries residing in nursing facilities. This would be both beneficial to CMS and the MCOs since an institutional risk factor would more closely match payments to medical cost and may help retain MCOs in Medicare's managed care program.

AUDITEE COMMENTS AND OIG RESPONSE

We received comments on our draft report from CMS and ASBTF.

CMS

Officials from CMS, responding to our draft audit report, submitted several comments paraphrased as follows:

CMS Comment

The sample size of 30 beneficiaries at each MCO, and 1-year review period are very limited. A few high-cost beneficiaries during a year could significantly increase costs, and MCOs underpaid 1 year could be overpaid the next year.

OIG Response

The sample size is in accordance with Office of Audit Services policy on multistage sample design and we believe the results of our review are representative. In addition, MCOs should not have to experience losses because payments are not adjusted for health status, and then hope for offsetting profit in some future year.

CMS Comment

The review does not address the impact of full risk adjustment on the sampled beneficiaries. Additionally, the percentage of institutionalized beneficiaries is relatively small, so the overall impact on MCO payment may also be small. The report also does not make it clear why implementing 100 percent risk adjustment is more important for institutionalized beneficiaries than for other groups.

OIG Response

The impact of full risk adjustment on the sampled beneficiaries was beyond the scope of this audit. However, we did find that the profits or losses experienced by the MCOs were dependent upon the number and seriousness of the inpatient hospital stays by the sampled beneficiaries. The MCOs with many hospital stays lost money, while MCOs with healthier beneficiaries profited. Since full risk adjustment reimburses MCOs based on the health services provided to the beneficiaries, we believe that its impact would be more equitable payments to the MCOs.

The percentage of institutionalized beneficiaries may be small but the dollar effect is significant. Some MCOs in our review were experiencing losses as high as $4,500 per sampled beneficiary and others profits exceeding $4,000 per sampled beneficiary.

Our recommendations were limited to institutional beneficiaries because they were the group included in the scope of our audit.

CMS Comment

Demonstration project MCOs, such as "Evercare", should not have been included in the sample because they have different payment rates. Evercare also provides different care than other MCOs, aggressively substituting skilled nursing care for hospital stays. The CMS has thus far exempted Evercare from the risk-adjusted payment under the hospital only model because of concerns that the organizations would not be paid appropriately. Therefore, any conclusions regarding the equitability of risk adjustment for MCOs should not be based on a sample that includes Evercare organizations.

OIG Response

The payment rates received by the Evercare MCOs are 98 percent (93/95) of the rates received by other MCOs and this slight rate variation had no effect on our audit results. As with the other MCOs in our review, the profits or losses experienced by Evercare MCOs were dependent upon the number and seriousness of inpatient hospital stays for the sampled beneficiaries.

CMS Comment

Although payments for managed care are prospective, the adjustment for institutionalized beneficiaries is retroactive.

OIG Response

We agree that the adjustment for institutionalized beneficiaries is retroactive. Our report does not state otherwise.

CMS Comment
The OIG does not state whether the institutionalized beneficiaries identified in the sample were limited to those who had no other medical status. Different payment rates would apply to beneficiaries with hospice, end stage renal disease, or working aged status.

OIG Response
The sample beneficiaries were not limited to those who had no other medical status. The audit compared the costs of providing medical care for each sampled beneficiary to the related reimbursement received by the MCOs.

CMS Comment
The Medicare fee-for-service amounts used to estimate Part B costs in the audit might not be comparable to the costs incurred by the MCOs.

OIG Response
The data collected during our audit indicated that the actual costs incurred by the MCOs were generally the same or slightly less than the applicable fee-for-service. As a result, we believe the fee-for-service amounts were a conservative measure of the MCOs' costs.

CMS Comment
Sooner phase-in of full risk adjustment may not lessen the MCO's danger of large underpayments.

OIG Response
As previously stated, we found that the profits or losses experienced by the MCOs were dependent upon the number and seriousness of the inpatient hospital stays for sampled beneficiaries. Since full risk adjustment reimburses MCOs based on the health services provided to the beneficiaries, we believe its implementation would greatly reduce the risk of large underpayments to MCOs.

CMS Comment
Most criticism of M+C payments has not been directed at the demographic adjustments but rather the base rates. The managed care industry has not embraced risk adjustment and the OIG's suggestion does not offer anything that has not already been attempted.

OIG Response
The criticisms may have been misdirected and change is always difficult to sell. Our review presents evidence that beneficiaries' health status may be a root cause of financial problems at some MCOs.

CMS Comment
Risk adjustment may not resolve the problem of MCOs either losing or making money on institutionalized beneficiaries who are dually eligible.

OIG Response
As previously stated, we found that the profits or losses experienced by the MCOs were dependent upon the number and seriousness of the inpatient hospital stays by the sampled beneficiaries. Since full risk adjustment reimburses MCOs based on the health services provided to the beneficiaries, we believe that its implementation would result in more equitable payments to MCOs for dually eligible beneficiaries.

CMS Comment
The CMS would be interested in the OIG's position on increasing payments for all Medicaid-eligible beneficiaries enrolled in MCOs.

OIG Response
Increasing payments for all Medicaid eligible beneficiaries would help the MCOs that are underpaid, but also increase the overpayments to the MCOs with healthier enrollments. Increasing the payment rates for all Medicaid-eligible beneficiaries would be a costly, ineffective solution to the MCO reimbursement problems identified in our review.

CMS Comment
As the OIG study shows, the payments and costs match reasonably when relatively large numbers of enrollees are studied. One does not always expect a match when small subsets of enrollees are analyzed. Risk adjustment using more clinical information will do better, but any one-time study of small groups will show discrepancies.

OIG Response
The larger the number studied the more likely that some facts will be submerged in averages. Our sample was drawn from a universe of MCOs with a significant number of dually eligible beneficiaries. It is a fact that some of these MCOs are losing and others profiting on these beneficiaries and that the determining factor was health status.

CMS Comment
The institutional beneficiary population includes two important subsets, beneficiaries in skilled nursing care following a recent hospitalization, and long-term care beneficiaries who have not had a recent hospitalization. The former are expensive because of the hospital costs. The institutional adjustment factor averages payments between the two groups. The finding of overpayment or underpayment is partially related to the mix observed in the sample, as well as the particular individuals. The same MCO observed in another period could have a different mix. Because there are relatively few institutionalized enrollees, averaging over time is important when observing such biased groupings.

OIG Response
The MCOs participating in the Medicare program should not have to sustain losses in one year in the hope that profits in successive years will offset the shortfall. The MCOs have no legitimate way to control the "mix" of institutional beneficiaries enrolled in a given year, so

there is no guarantee that the mix will improve. Given that many MCOs are for profit, it is not likely that owners/investors will continue Medicare participation if a bad mix continues from one year to the next.

CMS Comment
The imposition of floor payments and the 2 percent minimum increases over the 1997 rates could have affected the observed plan.

OIG Response
These minor rate changes do not account for our audit results.

CMS Comment
It is not clear that, given the relatively small numbers of institutionalized beneficiaries, a special effort should be focused on the factors for this particular group, outside the effort to implement an overall risk adjuster.

OIG Response
Our recommendations were limited to institutional beneficiaries because they were the group studied. Based on prior CMS testimony before the Senate, full risk adjustment is important for MCOs and for all beneficiary groups. Through our audit, we have demonstrated the failings of the current reimbursement system pertaining to MCOs and institutionalized beneficiaries.

ASBTF

ASBTF Comments
The ASBTF generally agreed with our recommendations and stated that the managed care industry acknowledges that risk adjustment will make payments more accurate. However, ASBTF pointed out that some industry resistance to a quicker phase-in of risk adjustment might occur because of the need to collect encounter data.

OIG Response
We appreciate ASBTF comments and understand that the resistance to capturing new information or changing existing record keeping is not unusual. We do not believe that the resistance would be universal but would likely come from those MCOs that have profited under the current system.

APPENDICES

APPENDIX A

VARIABLE APPRAISAL OF STATISTICAL SAMPLE (TWO STAGE)

Primary Units Sampled:	8
Primary Units Not Sampled:	66
Primary Units in Population:	74

Projection at 90 Percent Confidence Level[2]

Point Estimate of Population Total:	($953,908)
Standard Error:	$33,258,533
Lower Limit:	($55,659,206)
Upper Limit:	$53,751,390
Precision Amount:	$54,705,298

[2]The reimbursement received by the MCOs was generally much higher, or much lower, than the costs of providing the services. In our appraisal, Medicare payments in excess of costs were projected as a positive value and reimbursement shortfalls were projected as a negative (or credit) value. The upper and lower limits of our variable appraisal are positive and negative, respectively, corresponding to the over and under-reimbursement. The wide range between the upper and lower limits is reflective of our audit results where MCOs were greatly over or under-reimbursed for the services provided.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB - 4

TO: Janet Rehnquist
Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of Managed Care Payments for Dual Eligible Beneficiaries with Institutional Status* (A-05-00-00015)

Thank you for the opportunity to review and comment on the above-referenced draft report. The OIG makes one recommendation in this study: that the Centers for Medicare & Medicaid Services (CMS) seek legislation to quicken the phase-in of the risk-adjustment factors. In lieu of a quicker phase-in of the risk-adjustment factors, OIG recommends that CMS seek the authority to implement sooner than 2007 a full risk-adjustment factor applicable to managed care organizations' (MCO) institutional payments for Medicare beneficiaries residing in nursing facilities. In general, we find that the information in this report does not support the recommendation made. Our basis for that conclusion follows:

- The OIG offers very sweeping conclusions for such a small study. The study finds that although the payment to MCOs for institutionalized enrollees appears reasonable, for individual MCOs, there are differences between Medicare payment and the cost of care for the institutionalized. The sample size at the MCO level (30 beneficiaries) and the study timeframe (1 year) are very limited. A few high-cost institutionalized beneficiaries in a MCO during a particular year could significantly increase costs. Additionally, MCOs that appear to be underpaid for 1 year could appear to be overpaid the next year. The report contains no caveats regarding these limitations.

- The report suggests that payment disparities at the MCO level may be addressed by implementing full risk-adjusted payment just for the institutionalized sooner than 2007. The report indicates that even if there are still payment disparities under risk adjustment, the overall disparity between Medicare payments and MCO costs would be reduced. However, the impact of full risk adjustment on the payment for the sampled enrollees is not addressed by the study. Additionally, the percentage of institutionalized enrollees for most MCOs is relatively small, which implies that the overall impact on a MCOs payment may be small.

- Full risk adjustment would not only improve payment for the institutionalized but would also improve payment for non institutionalized enrollees. For instance, implementing 100 percent risk adjustment for any particular group of enrollees would likely lessen the disparity between Medicare payments and the costs for the individuals in that group. The report does not make it clear why implementing 100 percent risk adjustment is more important for institutionalized enrollees than it is for other groups.

- Several demonstrations were included in the universe of MCOs from which the eight MCOs were selected. The report states on page 6 that "since the objective of our review was to determine if total enhanced Medicare payments were reasonable, it would not be appropriate to exclude demonstration MCOs." Managed care demonstrations often have very different payment rates and rules. As an example of what this can mean, demonstrations such as Evercare provide care in a very specialized manner. First of all, Evercare aggressively substitutes skilled nursing facility stays and intensive nursing home based case management for hospital stays. As a result, Evercare's utilization and cost patterns are not necessarily representative of MCOs. Second, Evercare's payments are negotiated (ninety-three ninety-fifth [93/95] of the county ratebook amount). Thus, a comparison of the costs of Evercare to this negotiated rate cannot serve as an appropriate benchmark for evaluating the adequacy of Medicare payments for the institutionalized. In addition, CMS has thus far exempted Evercare from risk-adjusted payment under the hospital-only model because of concerns that this particular risk-adjustment model would not necessarily pay these organizations appropriately. Therefore, any conclusions regarding the equitability of risk adjustment for MCOs should not be based on a sample that includes Evercare organizations. Because "several" demonstrations are included in the universe, we are concerned that the sample is not representative of the MCO population and that the conclusions, therefore, cannot be extrapolated to all Medicare + Choice (M+C) payments. It is not clear what is meant by the note that there were "no differences in the payment processes." There are differences in the payment levels for Health Maintenance Organizations enrolling only the institutionalized.

- Page 3, Paragraph 1 of the report states, "CMS makes monthly advance payments to MCOs at the per capita rate set for each enrolled beneficiary. Medicare pays a higher monthly rate to MCOs for beneficiaries who are Medicaid eligible or institutionalized. The institutional rate for most beneficiaries is higher than the Medicaid rate." Although the payments for managed care are prospective, the adjustment for institutionalized beneficiaries is retroactive. After the MCO has provided CMS the information that a beneficiary was in an institution for 30 consecutive days, the payment is adjusted *retroactively* for the previous period.

- The OIG does not state that the beneficiaries identified in the sample were limited to those who had no other medical status. The payments to MCOs are determined in a hierarchical order. If a beneficiary is on Medicaid and institutionalized, the payment

will be made at the institutional rate, regardless of which amount is higher. However, if the beneficiary has another health status such as hospice, end stage renal disease, or working aged, the MCO will receive the monthly payment for that beneficiary at one of these rates because they are higher in the payment hierarchy.

- On page 5 of the report, OIG states that estimated fee-for-service (FFS) costs were used for individual medical service costs. This may not be an appropriate measure of the costs of MCOs. MCOs usually arrange for Part B services through contractual arrangements. Payments for these services may be through capitation, discount FFS, or a payment schedule and may not be comparable to Medicare FFS payments.

- The OIG states that the overall payment amount is appropriate, but each organization is exposed to the great risk of large underpayments. The OIG's solution, sooner phase-in of full risk adjustment, may not lessen this danger. Risk adjustment was conceived as a way to more accurately measure costs–not increase payments to MCOs.

- All MCOs can potentially lose money on any given beneficiary, not just dually eligible institutionalized members. Most of the criticism for CMS payments under M+C have not been directed at problems caused by demographic adjustment of base payment rates but rather the base rates themselves. It is possible to take these arguments far enough to condemn risk-based payments in general. Since full M+C risk adjustment and competitive pricing have not been embraced by the managed care industry, OIG's suggestion does not offer anything that has not already been attempted.

- At the same time, OIG notes that some MCOs are overpaid and aggregate payments are adequate. This makes risk-based payment appear excessive. Thus, the report suggests that changes must be made so that some organizations do not lose money in a risk-based payment environment. Full risk adjustment may not resolve that problem. Some organizations will continue to make money on dually eligible institutionalized members; some will continue to lose money.

- A problem with the current system may be that Medicaid-eligible beneficiaries have health problems that are not appropriately compensated under institutionalized rates. Perhaps these beneficiaries are a much higher risk to MCOs than those members who are non Medicaid institutionalized. The CMS would be interested in OIG's position on increasing payments for all Medicaid-eligible M+C enrollees.

We also have the following comments:

- This study points out a characteristic of capitated payments being made using a limited set of risk factors to adjust the payments. As the OIG study shows, the

payments and the costs (imputed in this study) match reasonably when relatively large numbers of enrollees are studied. One does not always expect a match when small subsets of enrollees are analyzed. Risk adjustment using more clinical information will do better, as suggested, but any one-time study of small groups will show discrepancies.

- The particular set of enrollees studied here is the population institutionalized for at least part of 1998. Our own studies indicate that there are two important subsets of people in this group, and the particular mix of these in the sample can have a large effect on whether the payments exceed or fall short of costs. Some of the institutionalized are in skilled nursing status following a hospitalization. Some are long-term residents who have not had a recent hospitalization. The latter are typically costly to Medicaid and not to Medicare. The former are particularly expensive to Medicare especially since the hospital costs are usually included in the calculation. The institutional factor for adjustment of payments averages over these two groups. The finding of overpayment or underpayment is partially related to the mix observed in the sample as well as the particular individuals. The same MCO observed in another period could have a different mix. Because there are relatively few institutionalized enrollees, averaging over time is important when observing such biased groupings.

- A point only subtly mentioned in the report is that the payment levels depend greatly on the county rates. The year studied was the first year in which the Balanced Budget Act affected the county rates. The imposition of floor payments and the 2 percent minimum increase over the 1997 rates could have affected the observed plan through plan findings since the plans presumably were in different counties.

- Although it may seem reasonable to study the institutionalized as a special group, the report does not put the payment issues into the context of payment for any biased subgroup of enrollees, e.g., those hospitalized, those with particular diseases, and those who have no significant disease. One would likely find payments do not match costs for any of these. One should look at the payments to a plan as a whole, and over time, to determine whether it is disadvantaged. It is not clear that, given the relatively small numbers of institutionalized, a special effort should be focused on factors for this particular subgroup outside of the overall effort to implement a more effective overall risk adjuster covering a broader range of subgroups.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises.

APPENDIX C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN 28 2002

MEMORANDUM TO: Janet Rehnquist
Inspector General

FROM: Dennis P. Williams
Acting Assistant Secretary for Budget, Technology, and Finance

SUBJECT: Comments on Draft Report: "Review of Managed Care Payments for Dual Eligible Beneficiaries with Institutional Status"

We appreciate the need to determine if enhanced Medicare payments made to managed care organizations (MCOs) contracting with the Centers for Medicare and Medicaid Services (CMS) are reasonable for this class of beneficiaries. Thank you for the opportunity to review the OIG draft report (A-05-00-00015) on this subject.

Our comments are as follows:

- ASBTF agrees that implementation of comprehensive risk adjustment will mitigate, if not resolve, the payment problems identified by the IG. However, while the managed care industry acknowledges that risk adjustment will make payments more accurate, it has also found the encounter data collection required for risk adjustment to be extremely burdensome. Consequently, the industry would be unlikely to support legislation to phase in risk adjustment more quickly.

Thank you for the opportunity to review this report. We look forward to assisting you in the future regarding Medicare issues. If your staff have questions regarding these comments, please refer them to Joanna Hastings, Office of Budget, 202-690-6553.