DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUN - 3 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Fee-for-Service Payments for Beneficiaries Enrolled in Medicare Managed Care (A-05-02-00085)

Attached is an advance copy of our final report on Medicaid fee-for-service (FFS) payments for beneficiaries enrolled in Medicare managed care. We will issue this report to the Ohio Department of Job and Family Services within 5 business days. We suggest that you share this report with the Center for Medicaid and State Operations and other components of the Centers for Medicare & Medicaid Services (CMS) involved with Medicaid program integrity and provider issues.

Our audit objective was to determine whether Ohio made unallowable Medicaid FFS payments for beneficiaries enrolled in Medicare managed care organizations (MCO). This audit is one of a series of State reviews to determine if Medicaid is paying for services covered by Medicare managed care. Federal regulations at 42 CFR § 433.138(a) require States to take all reasonable measures to determine the legal liability of third parties to pay for services furnished under Medicaid.

The Balanced Budget Act of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare+Choice 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 FFS plans. Coordinated care plans have a network of providers under contract to deliver a health benefit package approved by CMS. Types of coordinated care organizations include health maintenance organizations, provider-sponsored organizations, and preferred provider organizations. These Medicare MCOs are able to offer additional benefits not available through Medicare FFS including coverage for dental care, eyeglasses, and prescription drugs. State Medicaid plans also provide coverage for these benefits, creating the potential for unallowable Medicaid payments for services provided to beneficiaries eligible for both Medicare and Medicaid.

We estimated that the Ohio Department of Job and Family Services paid unallowable Medicaid claims totaling $4.6 million ($2.7 million Federal share) for services covered by Medicare MCOs. The results are based on a statistical sample of 200 Medicaid FFS claims paid for dually eligible beneficiaries during the fiscal year ended June 30, 2001. We found that 29 of the

sampled Medicaid claims included services covered by Medicare. The claims included 21 pharmacy claims, 6 home health claims, and 2 long-term care claims. The State's processing system for Medicaid claims did not have controls to prevent payment of FFS claims for services covered by Medicare managed care. The Medicare enrollment information was provided to Ohio by CMS, but it was not in a format immediately usable in the Medicaid claims processing system.

We recommended that the Ohio Department of Job and Family Services take the following steps:

1. It should recover from Medicare MCOs the specific overpayments identified as part of our sample and review the balance of the claims universe to identify and recover additional overpayments. We estimate total overpayments to be $4.6 million ($2.7 million Federal share).

2. It should also review Medicare managed care enrollment data for prior and subsequent years to identify and recover additional unallowable payments.

3. Finally, it should work with CMS to obtain Medicare managed care enrollment data in a usable format and establish controls to prevent future payments for services covered by Medicare.

Officials from the Ohio Department of Job and Family Services did not concur with our recommendations because of concerns about the audit methodology and lack of adequate data from CMS about additional benefits provided to Medicare managed care enrollees. We disagreed with the comments regarding our audit methodology and believe State officials should work with CMS to obtain the necessary Medicare data. We summarized the State's comments and included our responses to those comments in our report. The full text of the State's comments is included in the report as Appendix B.

If you have any questions or comments on this report, please do not hesitate to call me or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Paul Swanson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-02-00085 JUN - 8 2004

Mr. Tom Hayes
Director
Ohio Department of Job and Family Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215

Dear Mr. Hayes:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Fee-for-Service Payments for Beneficiaries Enrolled in Medicare Managed Care" for the period July 2000 through June 2001. A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-05-02-00085 in all correspondence.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:
Ms. Cheryl Harris
Associate Regional Administrator for Medicaid
Centers for Medicare & Medicaid Services, Region V
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID FEE-FOR-SERVICE PAYMENTS FOR BENEFICIARIES ENROLLED IN MEDICARE MANAGED CARE

JUNE 2004
A-05-02-00085

EXECUTIVE SUMMARY

OBJECTIVE

Our audit objective was to determine whether Ohio made unallowable Medicaid fee-for-service (FFS) payments for beneficiaries enrolled in Medicare managed care organizations (MCO).

SUMMARY OF FINDINGS

We estimated that the Ohio Department of Job and Family Services paid unallowable Medicaid claims totaling $4.6 million ($2.7 million Federal share) for services covered by Medicare MCOs. The results are based on a statistical sample of 200 Medicaid FFS claims paid for dually eligible beneficiaries during the fiscal year (FY) ended June 30, 2001. We found that 29 of the sampled Medicaid claims included services covered by Medicare. The Medicaid overpayments resulting from the 29 unallowable claims totaled $3,603 ($2,124 Federal share).

Federal regulations at 42 CFR § 433.138(a) require States to take all reasonable measures to determine the legal liability of third parties to pay for services furnished under Medicaid. Ohio's processing system for Medicaid claims does not have controls to prevent payment of FFS claims for services covered by Medicare MCOs. The Medicare enrollment information was provided to Ohio by the Centers for Medicare & Medicaid Services (CMS), but it was not in a format immediately usable in the Medicaid claims processing system. The main difficulty with the Medicare database appeared to be the use of member identification numbers, which were usually identical to the Social Security numbers in the Medicaid database but with an additional suffix. The State could have overcome this with a minor programming change and could have worked with CMS to resolve other database issues.

RECOMMENDATIONS

We recommend that the Ohio Department of Job and Family Services take the following steps:

1. It should recover from Medicare MCOs the specific overpayments identified as part of our sample and review the balance of the claims universe to identify and recover additional overpayments. We estimate total overpayments to be $4.6 million ($2.7 million Federal share).

2. It should also review Medicare managed care enrollment data for prior and subsequent years to identify and recover additional unallowable payments.

3. Finally, it should work with CMS to obtain Medicare managed care enrollment data in a usable format and establish controls to prevent future payments for services covered by Medicare.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL (OIG) RESPONSE

Officials from the Ohio Department of Job and Family Services did not concur with our recommendations. Officials expressed concerns about the audit methodology and a lack of adequate CMS data to appropriately screen additional benefits provided to Medicare managed care enrollees. We disagreed with the State's comments regarding our audit methodology and summarized State comments and our responses at the end of this report. The full text of the State's comments is included in the report as Appendix B.

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INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act created the Medicaid program to provide medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in providing adequate medical care to eligible needy persons. The Ohio Department of Job and Family Services is the single State agency with responsibility for implementation and administration of the Medicaid program in Ohio.

The Balanced Budget Act of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare+Choice 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 insurance 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. These organizations, collectively known as MCOs, are able to offer additional benefits not available through Medicare FFS, including coverage for dental care, eyeglasses, and prescription drugs. State Medicaid plans also provide coverage for these benefits, thus creating the potential for unallowable Medicaid payments for services provided to beneficiaries eligible for both Medicare and Medicaid.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit objective was to determine whether Ohio made unallowable Medicaid FFS payments for beneficiaries enrolled in Medicare MCOs.

We examined Medicaid FFS claims paid in FY 2001 to determine if the claims included services also covered by Medicare managed care. We limited our review of internal controls to procedures intended to prevent payment of Medicaid FFS claims for services also covered by Medicare MCOs.

We compiled a computerized list of beneficiaries enrolled in Medicare MCOs in Ohio during the period July 1, 1999 through June 30, 2001. Using data from the CMS Medicaid Statistical Information System, we also created a file of Medicaid FFS claims paid in Ohio during our July 1, 2000 through June 30, 2001 audit period. We matched the two files and created a list of 459,947 FFS claims totaling $80.6 million paid by Medicaid for dually eligible beneficiaries enrolled in Medicare MCOs. Claims for less than $4 were treated as immaterial and are not included in the stated totals.

A stratified random sample of 200 claims was selected for review to determine whether the identified Medicaid claims were allowable. The sample included 99 long-term care claims,

57 pharmacy claims, and 44 other claims. We stratified the population of claims by the amount Medicaid paid, as shown below:

Stratified Sample of Medicaid FFS Claims			
Stratum	**Number of Claims**	**Medicaid Payments**	**Sampled Claims**
$4 through $100	397,382	$ 12,340,160	50
$101 through $1,000	44,817	7,980,987	50
$1,001 through $7,795	17,748	60,316,946	100
Total	459,947	$ 80,638,093	200

The Medicare MCOs were contacted to obtain plan information concerning coverage of the medical services for which the sample claims were submitted. Sample claims determined to be for services covered by Medicare were questioned and projected to the universe to estimate total Medicaid overpayments. For questioned pharmacy claims, we determined whether the drugs were brand-name, generic, or mail-order drugs and allowed for the appropriate Medicare coinsurance when calculating the Medicaid overpayment. None of the plans reviewed used restricted formularies to establish covered drugs and payment amounts.

We performed our audit in accordance with generally accepted government auditing standards. Our fieldwork was performed at the State offices in Columbus. We met with State officials to determine what internal controls were in place to prevent Medicaid payment for services covered by Medicare.

FINDINGS AND RECOMMENDATIONS

We found that 29 of the sampled Medicaid claims included services covered by Medicare MCOs. The Medicaid overpayments resulting from the 29 unallowable claims totaled $3,603 ($2,124 Federal share). Based on the statistical sample of 200 Medicaid FFS claims paid in FY 2001 for dually eligible beneficiaries, we estimated that the Ohio Department of Job and Family Services paid unallowable claims totaling $4.6 million ($2.7 million Federal share) for services also covered by Medicare. Details on the sample and projection are presented in Appendix A of this report.

Federal regulations at 42 CFR § 433.138(a) require States to take all reasonable measures to determine the legal liability of third parties to pay for services furnished under Medicaid. CMS Medicaid Manual § 3900 states that Medicaid coverage is always secondary to Medicare.

MEDICARE COVERED CLAIMS

We identified 29 claims for services paid by Medicaid that were also covered by Medicare, including 21 pharmacy claims, 6 home health claims, and 2 long-term care claims.

The 21 pharmacy claims were questioned because the beneficiaries had drug coverage through their Medicare MCOs. Other pharmacy claims in our sample were allowable for a variety of reasons, such as the beneficiary did not have drug coverage from Medicare, the claim amount was less than the Medicare coinsurance, or the beneficiary had met a spending limit set by the MCO for pharmacy claims.

Our sample included six home health claims that were paid by Medicaid. All six claims were questioned because the beneficiaries had home health care coverage through their Medicare MCOs. When we contacted the MCOs, we were told that none of the six claims had been submitted for payment.

The two identified long-term care claims were paid by Medicaid for a full month (31 days) of residency at a nursing facility. Medicare MCOs also paid a portion of the claims as skilled care.

INTERNAL CONTROLS

The Ohio Medicaid claims processing system did not have controls to match Medicare MCO enrollment data against Medicaid FFS claims and thereby prevent payment of FFS claims for services covered by Medicare managed care. Although the enrollment information was provided to the State by CMS through the Group Health Plan database, the State did not adjust its programming so that the Medicare data could be used. The main difficulty with the Medicare database appeared to be the use of member identification numbers having an additional suffix, but generally identical to the Social Security numbers in the Medicaid database. State officials are currently discussing with CMS how to best correct the problem.

RECOMMENDATIONS

We recommend that the Ohio Department of Job and Family Services take the following steps:

1. It should recover from Medicare MCOs specific overpayments identified as part of our sample and review the balance of the claims universe to identify and recover additional overpayments. We estimate total overpayments to be $4.6 million ($2.7 million Federal share).

2. It should also review Medicare MCO enrollment data for prior and subsequent years to identify and recover additional unallowable payments.

3. Finally, it should work with CMS to obtain or convert Medicare MCO enrollment data to a usable format and establish controls to prevent future payments for services covered by Medicare.

AUDITEE COMMENTS AND OIG RESPONSE

Officials from the Ohio Department of Job and Family Services provided written comments regarding our recommendations, which we summarized and responded to below. The full text of the State's comments are attached as Appendix B.

1. Ohio Comment and OIG Response

Ohio officials believe the overpayment finding in the report is inappropriate and overstated and, therefore, do not agree with any recovery. The officials also believe more claims would have been concluded to be allowable if the auditors had asked Medicare MCOs whether medications were on the plan's formulary and whether the amount paid by Medicaid was equivalent to the coinsurance amounts for brand-name, generic, or mail-order drugs. State officials also believe that the postpayment contractor's identification of sampled claims, which were denied by MCOs based on ineligibility, supports their concerns about our methodology and conclusions.

We disagree that our overpayment finding is inappropriate or overstated, and we believe all necessary coverage issues related to pharmacy claims were examined during our audit. For example, for each questioned pharmacy claim, we determined whether the drug was a brand-name, generic, or mail-order drug and allowed the appropriate Medicare coinsurance when calculating the Medicaid overpayment. We addressed these concerns in our audit, as cited in clarifying language on page 2 of the report.

Although the State cited other steps needed to ensure the appropriateness of Medicaid payments, we believe that the State needs to concentrate on getting Medicare enrollment data into the Medicaid payment system to establish at least a presumptive Medicare liability. As stated earlier, none of the MCOs we reviewed had restricted formularies. In addition, we are aware that most MCOs have a set maximum amount for drug benefits. The State should work with CMS to get this information and resolve the payment issues.

In regard to its postpayment contractor reviews, the inability to collect does not mean that the Medicaid payment of the pharmacy claims was allowable. Since the State's comments do not clearly explain why several sampled claims submitted by the postpayment contractor were denied and our calculated Medicaid overpayments were based on individual Medicare MCO coverage and appropriate Medicare coinsurance amounts, we continue to recommend recovery of the calculated Medicaid overpayments. Medicaid coverage is always secondary to Medicare, and payments for Medicaid pharmacy claims for beneficiaries with drug coverage through Medicare MCOs should not occur. Postpayment collection difficulties experienced by the State agency could have been prevented if controls had been implemented to prevent the initial payment of claims for beneficiaries with Medicare coverage.

2. Ohio Comment and OIG Response

Ohio officials contend that it would be very labor-intensive and costly to review more claims to identify and recover additional overpayments and that recovery of older claims would be impossible because of Medicare claim filing requirements.

We agree that the State will incur costs to evaluate the MCO enrollment and coverage in order to consider the appropriateness of Medicaid FFS payments. However, the State did not provide an analysis showing that the costs to implement this recommendation would exceed the recoveries.

3. Ohio Comment to Implement This Recommendation and OIG Response

Ohio officials contend that, in order to effectively screen Medicaid pharmacy claims for Medicare Part C coverage of dually eligible beneficiaries, they would need information not currently available in any CMS database. For example, to avoid paying Medicare Part C pharmacy claims under Medicaid, the State would need formulary information specific to each plan. Because Medicare does not generally cover pharmacy claims, Ohio's current claims payment system has collected limited pharmacy information.

The State should work with CMS to resolve issues related to the availability of adequate Medicare enrollment and coverage data.

APPENDICES

VARIABLE APPRAISAL OF STATISTICAL SAMPLE
(STRATIFIED)

	Sample Size	Sample Value	Nonzero Items
Stratum 1:	50	$ 281	10
Stratum 2:	50	$2,673	17
Stratum 3:	100	$ 0	0
Totals	200	$2,954	27*

Projection at 90-Percent Confidence Level

Point Estimate of Population Total:	$4,629,204
Standard Error:	$1,044,406
Lower Limit:	$2,911,312
Upper Limit:	$6,347,095
Precision Amount:	$1,717,891

* We identified 29 Medicaid fee-for-service claims for services covered by Medicare MCOs. Two long-term care claims from Stratum 3 were not included because OIG policy requires a minimum of six errors in a stratum for a projection.

Bob Taft
Governor

Tom Hayes
Director

30 East Broad Street • Columbus, Ohio 43215
www.state.oh.us/odjfs

October 16, 2003

Mr. Paul Swanson
Office of the Inspector General
Office of Audit Services 233 North Michigan Avenue
Chicago, Illinois 60601

RE: A-05-02-00085

Dear Mr. Swanson:

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 Beneficiaries Enrolled in Medicare Managed Care Organizations*, dated July 2003. We have provided the report recommendations and our responses as follows:

Recommendation:

- Recover from Medicare MCOs specific overpayments identified as part of our sample and review the balance of the claims universe to identify and recover additional overpayments. We estimate the total overpayments to be $4.6 million (Federal share $2.7 million).

Agency response:

We believe this finding is inappropriate and overstated and, therefore, do not agree with any recovery. Overall, we find that the draft report fails to address all of the coverage information necessary to determine if claims identified in the report had been appropriately cost avoided. For example, of the 57 pharmacy claims originally identified, the auditor eliminated 63% by contacting the Medicare MCO to make limited inquiries for information concerning potential drug coverage. ODJFS believes that even more claims would be eliminated if additional questions were asked such as whether the medication was on the plan's formulary, and, whether the amount paid by Medicaid was equivalent to the coinsurance amounts for generic, brand, or mail order drugs.

In fact, a review of the pharmacy claims included in the sample by our post payment recovery contractor, Health Management Systems, Inc. (HMS), tells us that HMS submitted pharmacy claims to Medicare Part C plans, and several of the claims were denied by the plans due to ineligibility. This further supports our concerns about the OIG's methodology and conclusions.

In order to effectively cost avoid all Medicare Part C claims submitted for dually eligible beneficiaries the state Medicaid agency would have to have information not currently provided in any CMS database available to states. For example, for pharmacy claims submitted to the state Medicaid agency for dually eligible beneficiaries enrolled in Medicare MCOs, the MCOs involved would have to be individually contacted by the state agency in order to determine; 1) whether the beneficiary paid a premium to enroll in the MCO; 2) whether the beneficiary was enrolled in a pharmacy benefit plan, and whether they were required to pay a premium upon enrollment; 3) whether the plan imposed a drug copayment or coinsurance amount (i.e., 25% of the cost of the drug); 4) whether the beneficiary had met the plan's benefit maximum, or if a deductible was applicable; and finally, 5) if the medication was on the plan formulary. It would not be cost effective for a state Medicaid agency or its fiscal agent to engage in this very labor intensive process in light of the nominal recoveries generated from this work as evidenced by the experience in the state of Florida.

Recommendation:

- Review Medicare MCO enrollment data for prior and subsequent years to identify and recover additional unallowable payments.

Agency Response:

As stated above, we do not believe this would be cost effective. Furthermore, our recovery contractor's experience indicates that recovery would be impossible from Medicare MCOs due to claim filing time limits.

Recommendation:

- Work with CMS to obtain or convert Medicare MCO enrollment data to a usable format and establish controls to prevent future payments for services covered by Medicare.

Agency Response:

The department's claims payment system contains very broad edits that identify Medicare beneficiaries and appropriately cost-avoids Medicare covered services. However, because pharmacy is not generally covered by Medicare, there are limited edits that are applied by ODJFS. To accurately cost avoid Medicare Part C pharmacy claims, the department would need detailed formulary information specific to each plan that is currently not available from CMS.

The current data base options provided to states by CMS to be used for cost avoidance of Medicare Part C claims are inadequate. These databases as designed by CMS are for identifying enrollment in Medicare Part C plans and they contain no information on benefit coverage, nor do they provide paid claims information. In addition, the process established by CMS to help state Medicaid agencies identify dually eligible beneficiaries enrolled in Medicare Part C plans is cumbersome, requiring repeated submissions of 'finder' files from the state Medicaid agency.

It is our recommendation that the federal government develop data systems that adequately interpret all relevant information addressing coordination of benefits for Medicare Parts A, B, or C. State Medicaid agencies need timely, usable COB data in order to cost avoid up front because post payment recovery is neither timely nor cost effective.

If you have any questions regarding our response, please contact Robyn Colby or Peggy Smith at (614) 466-6420.

Sincerely,

Barbara Coulter Edwards

Barbara Coulter Edwards, Deputy Director
Office of Ohio Health Plans
Ohio Department of Job and Family Services