DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUN 6 1995

From June Gibbs Brown
Inspector General

Subject Review of Medicare Payments Made to PacifiCare of Texas Incorporated (PacifiCare), a Health Maintenance Organization in San Antonio, Texas (A-06-94-00028)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on June 8, 1995 of our final report. A copy is attached.

This report, part of a series of reviews we are conducting under our "Strategic Plan for the Oversight of Managed Care," summarizes our review of the capitation payments made to PacifiCare, a health maintenance organization (HMO) in Texas, under its Medicare risk-based contract. We reviewed both the classification and payment for beneficiaries categorized as having end stage renal disease (ESRD), eligible for both Medicare and Medicaid (dual eligible), institutionalized, and out-of-area.

We previously reported two significant issues also identified in this review--the computer interface problems associated with enhanced payments for beneficiaries classified as dual eligible, and for those classified as having ESRD. These issues were reported in two early alerts, "Audit of Medicare Payments to Health Maintenance Organizations for Dually Eligible Beneficiaries" (A-04-94-01089) and "Audit of Medicare Payments Made for End Stage Renal Disease Patients to Health Maintenance Organizations" (A-04-94-01090). Because of the conditions found at PacifiCare of Texas as well as Humana of Florida, we have initiated nationwide reviews of the enhanced payments for beneficiaries classified as dual eligible and for those classified as having ESRD.

Our specific review at PacifiCare found that payments for institutionalized beneficiaries and retroactive adjustments tested were proper. However, we identified overpayments totaling $617,577 on behalf of Medicare beneficiaries who were classified as either dual eligible, ESRD, or out-of-area.

We would like to call your attention to an emerging area of concern that this review has identified--payments made for beneficiaries classified as out-of-area. The criteria for beneficiaries classified as out-of-area is that the HMO must disenroll a beneficiary who moves permanently out of its service area and does not voluntarily disenroll. According to the Health Care Financing Administration's (HCFA) HMO manual, a period of 90 days out of the service area is deemed to be a permanent move. For the month of September 1994 there were approximately 54,600 beneficiaries nationwide classified as out-of-area. The majority of these beneficiaries were enrolled in either a risk-based or cost reimbursed HMO.

Of the 50 out-of-area cases reviewed at PacifiCare, payments for 43 beneficiaries were in error. Of the 50 cases, 76 percent were reported as being outside its service area for more than 90 days. The overpayments we identified occurred because neither PacifiCare nor HCFA resolved the beneficiaries' out-of-area status. Also, PacifiCare's and HCFA's computerized enrollment systems did not properly handle zip codes servicing two counties. Further, systemic conditions within HCFA caused inaccurate out-of-area reportings. These conditions will be addressed in our nationwide review of reported out-of-area beneficiaries.

We recommended that PacifiCare refund the identified overpayments. We also recommended that PacifiCare resolve the residential location for reported out-of-area beneficiaries and take necessary disenrollment and payment adjustment actions.

We provided a draft of this report to PacifiCare for review and comment. PacifiCare concurred with our findings and recommendations.

For further information, contact:

Donald L. Dille
Regional Inspector General
for Audit Services, Region VI
(512) 767-9206

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE PAYMENTS MADE TO PACIFICARE OF TEXAS INCORPORATED

JUNE GIBBS BROWN
Inspector General

JUNE 1995
A-06-94-00028

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 4A5
Dallas, TX 75242

Common Identification Number: A-06-94-00028

Mr. Jon Wampler, President
PacifiCare of Texas, Inc.
8200 IH-10 West, Suite 1000
San Antonio, Texas 78230

Dear Mr. Wampler:

This final report provides you with the results of our audit of Medicare payments made to PacifiCare of Texas Incorporated (PacifiCare), a risk-based health maintenance organization (HMO). The objectives of our audit were to determine whether: (1) beneficiaries were correctly classified as institutionalized, Medicare and Medicaid (dual eligible), end-stage renal disease (ESRD), and out-of-area; (2) payments received for such beneficiaries were at the correct rate; and (3) retroactive payment adjustments were correctly processed by the Health Care Financing Administration (HCFA).

The HCFA made overpayments to PacifiCare totaling $617,577 on behalf of Medicare beneficiaries who were classified as dual eligible, ESRD and out-of-area. Payments for institutionalized beneficiaries and retroactive adjustments tested were proper. The overpayments on behalf of dual eligible beneficiaries were attributable to a computer programming error affecting the payment logic and interface between three of HCFA's computer systems. The ESRD overpayments occurred because HCFA's Group Health Plan (GHP) payment system did not recognize the termination of ESRD status 36 months after a kidney transplant or 12 months after dialysis was completed. These two matters are being reported to the HCFA in separate reports with recommendations for corrective action.

The overpayments for beneficiaries reported as out-of-area occurred because neither PacifiCare nor HCFA resolved the beneficiaries' out-of-area status. Also, PacifiCare's computerized enrollment system did not properly handle zip codes servicing two counties. Further, systemic conditions within HCFA caused inaccurate out-of-area reporting. These systemic conditions will be addressed in our nationwide review of reported out-of-area beneficiaries.

We recommend that PacifiCare refund the identified overpayments. We also recommend that PacifiCare resolve the residential location for reported out-of-area beneficiaries and take necessary disenrollment and payment adjustment actions.

PacifiCare agreed with our conclusions and recommendations. PacifiCare's response to our draft report is contained as an appendix to this report.

Background

The Tax Equity and Fiscal Responsibility Act of 1982 authorized prospective per capita payments to HMOs under risk contracts at a rate equal to 95 percent of the average per capita cost Medicare pays for beneficiaries under the traditional fee-for-service system, by state and county code (SCC). Payment is further adjusted by a set of risk factors such as age, sex, entitlement status, and whether the beneficiary is classified as institutionalized or dual eligible. Payment for ESRD status is a separate calculation. For the month of December 1993, PacifiCare received a payment totaling $8.4 million on behalf of 27,000 Medicare members.

In Texas, Medicaid eligibility determinations are made by either the State's Medicaid agency or the Social Security Administration (SSA). In turn, these determinations are communicated to HCFA monthly through tapes. These tapes identify beneficiaries who are currently Medicaid eligible or have had a change in status. This data is used by HCFA to establish a Medicare beneficiary's dual eligibility status.

The ESRD is a kidney impairment that requires a regular course of dialysis or kidney transplantation to maintain life. Benefits for ESRD terminate:

- 12 months after a course of dialysis ends, unless the individual receives a transplant, or begins another regular course of dialysis during that period; or

- 36 months after a transplant, unless the individual receives another transplant, or begins a regular course of dialysis during that period.

Objectives

The objectives of our audit were to determine whether: (1) beneficiaries were classified correctly as institutionalized, dual eligible, ESRD, and out-of-area; (2) payments received for such beneficiaries were at the correct rate; and (3) retroactive adjustments were correctly processed by the HCFA.

Scope

Our audit was conducted in accordance with generally accepted government auditing standards, except for limited testing of data from computer based-systems. In this regard, we tested the reliability of computer generated output by comparing data to State agency and plan records, such as beneficiary enrollment applications for our sampled claims. However, we neither assessed the completeness of the HCFA's data files nor evaluated the adequacy of the input controls.

From the "Special Status Beneficiaries Report" for December 1993, we selected random samples of beneficiaries classified by HCFA as dual eligible and out-of-area, and all ESRD beneficiaries. From the "Beneficiary Adjustment Report by Adjustment Type" for December 1993, we selected a random sample of beneficiaries classified as institutionalized. From the "Transaction Replies/Monthly Activity Reports", we selected a judgmental sample of retroactive adjustments processed during Calendar Year 1993. These reports confirm a beneficiary's status as documented on HCFA's payment system.

As part of our examination, we obtained an understanding of the internal control structure as it related to the objective. We expanded our substantive testing in areas where we found the internal control structure less than reliable. To perform our review, we:

- verified the status of institutionalized, dual eligible, and ESRD beneficiaries;
- verified the residential status of out-of-area beneficiaries; and
- reviewed supporting documentation for retroactive adjustments.

We contacted officials from the State's Medicaid agency, SSA, the ESRD Network Organization, and the HCFA regional and central offices. We accepted the Medicaid eligibility determinations made by either the State's Medicaid agency or the SSA.

Our results indicate that for the areas reviewed, PacifiCare has complied with applicable laws and regulations except for those conditions cited in the DETAILED FINDINGS section of this report. With respect to the items not tested, nothing came to our attention to suggest that the untested items would produce different results.

Our audit was performed from February 1994 through September 1994 at the HCFA in Dallas, Texas and Baltimore, Maryland, and at PacifiCare in San Antonio, Texas.

DETAILED FINDINGS

The HCFA made overpayments totaling $617,577 to PacifiCare on behalf of beneficiaries who were incorrectly classified as dual eligible or ESRD, and for those who were reported as being outside its service area. These overpayments were caused by a HCFA computer programming error and a payment system that did not recognize certain terminations of ESRD benefits. Further, PacifiCare and HCFA failed to determine whether retroactive disenrollment and payment adjustments were necessary for beneficiaries reported as out of area. We recommend that PacifiCare: refund $615,064 in overpayments, which is net of an adjustment of $2,513 made during our field work, and resolve the residential location and corresponding payments for reported out-of-area beneficiaries.

Problem: Beneficiaries Were Incorrectly Classified

PacifiCare received inappropriate payments on behalf of beneficiaries who were incorrectly classified as dual eligible or ESRD. A random sample of 100 beneficiaries, out of 835 who were classified as dual eligible for December 1993, disclosed that 24 were not Medicaid eligible. Of the 12 beneficiaries classified as ESRD for December 1993, 4 were not eligible. In August 1993, PacifiCare notified the HCFA regional office that these four beneficiaries were not receiving dialysis. While PacifiCare questioned the receipt of higher ESRD payments, HCFA continued to make these higher payments.

The Effect: PacifiCare Received Overpayments Totaling $614,720

Dual Eligible Misclassifications

PacifiCare received overpayments totaling $26,386 on behalf of 24 beneficiaries who were misclassified as dual eligible during the period January 1992 through December 1993. Based on our sample results, HCFA identified the cause for this dual eligible overpayment problem, and is planning to recover overpayments totaling $70.4 million nationwide. For PacifiCare, HCFA calculated overpayments totaling $457,338 for beneficiaries misclassified as dual eligible for the period October 1990 through September 1994. The HCFA is determining if there are additional liabilities for beneficiaries classified as dual eligible.

ESRD Misclassifications

PacifiCare received overpayments totaling $157,382 on behalf of four beneficiaries who were not eligible for ESRD benefits during the period January 1992 through December 1993.

The Causes:

Computer System Errors

A HCFA computer programming error which altered the logic between three of HCFA's computer systems caused higher payments to be made for dual eligible beneficiaries who did not qualify for these payments. This error caused a nationwide payment problem. The HCFA has: (1) initiated action to correct the computer programming error; and (2) notified HMOs of the payment problem and of its plans to recoup dual eligible overpayments beginning in January 1995. As of the close of our field work, these overpayments had not been recovered.

HCFA ESRD Payment System

A systemic problem affecting ESRD designated beneficiaries nationwide caused the overpayments. The HCFA's GHP payment system does not recognize termination of ESRD status. The HCFA is planning to modify this system to discontinue ESRD eligibility and higher payments for ineligible beneficiaries. As of the close of our field work, these ESRD overpayments had not been recovered.

Problem: Inappropriate Payments Were Made for Beneficiaries Reported by HCFA as Out-of-Area

A random sample of 50 beneficiaries, out of 512 reported as out-of-area in December 1993, disclosed that payments for 43 beneficiaries were not appropriate. A HMO must disenroll a beneficiary who moves permanently out of its service area and does not voluntarily disenroll. According to HCFA's HMO manual, 90 days is deemed to be a permanent move. Of the 50 cases, 76 percent of the beneficiaries were reported as being outside its service area for more than 90 days.

The Effect: PacifiCare Received a Net Overpayment of $2,857

PacifiCare received a net overpayment of $2,857 on behalf of 43 beneficiaries who were classified as out-of-area for December 1993:

- payments were based on SCC rates outside the service area for 41 beneficiaries who resided within PacifiCare's service area. For these beneficiaries, PacifiCare received an overpayment of $941 for 14 beneficiaries, and an underpayment of $2,128 for 27 beneficiaries, or a net underpayment of $1,187;

- payments totaling $1,531 were received for one beneficiary who resided out of area for 5 months; and

- payments totaling $2,513 were received for one beneficiary who was both enrolled in error and reported out of area for 5 months. PacifiCare adjusted this overpayment during our field work.

Because PacifiCare adjusted the $2,513, the net overpayment totals $344.

The Causes:

Lack of Definitive Instructions and Address Data

The HCFA has not issued definitive instructions to HMOs specifying the actions and time frames that it expects them to take to resolve the out-of-area status shown on monthly exception reports. The instructions HCFA has provided are essentially limited to a request that HMOs have beneficiaries update their address with SSA. Further, these exception reports do not provide the HMOs with the current address that caused the out-of-area reporting. This information would be helpful for initiating proper resolution.

In addition, Section 2004 of HCFA's HMO Manual states that HMOs must initiate a disenrollment "as soon as they become aware" that the beneficiary has moved permanently outside of the service area. It does not specify whether the effective date should be retroactive to the time frame of the permanent move, or to the date of notification. A regional HCFA official told us that there is no requirement for HMOs to request retroactive disenrollments when HMOs do not timely identify a move out of area. This official said that the retroactive disenrollment requests from HMOs are usually initiated by beneficiaries after Medicare claims for out of plan services are denied. Because of this ambiguity, PacifiCare disenrolled a beneficiary effective 2 months after notification of a move out of area, rather than retroactively for the 10 months this beneficiary reported he resided out-of-area.

Lack of Effective Resolution

PacifiCare did not determine whether retroactive disenrollment and payment adjustments were necessary. It also did not identify those cases involving incorrect out-of-area reportings for beneficiaries who were residing in its service area. These payments needed to be adjusted because of incorrect SCC payment rates.

PacifiCare officials acknowledged that in the past, efforts to resolve the status of out-of-area beneficiaries were not sufficient, but that it will now have dedicated staff tracking reported out-of-area beneficiaries.

Other Systemic Problems

Certain beneficiaries were inappropriately reported as out of area because:

— HCFA's system continued to make payments on the basis of out-of-date SCCs for beneficiaries who updated their address with SSA during a time when HCFA did not use such changes to update its SCCs;

— some in-area zip codes were incorrectly matched to out-of-area SCCs;

— HCFA's payment system did not properly handle cases where the beneficiary resides in the service area, but has an out-of-area address and zip code for mailing purposes; and

— neither PacifiCare's nor HCFA's computerized enrollment systems are designed to handle zip codes which service two counties.

RECOMMENDATIONS

We recommend that PacifiCare refund:

- $457,338 for beneficiaries who were misclassified as dual eligible for the period October 1990 through September 1994;

- $157,382 for four beneficiaries who were misclassified as ESRD for the period January 1992 through December 1993; and

- $344 net adjustment for 42 beneficiaries who were reported as out of area but were either in area, or had moved out of area and should have been disenrolled in a timely manner.

We also recommend that PacifiCare:

- notify HCFA of instances when it becomes aware that it is receiving higher payments for beneficiaries who are not dual eligible;

- continue to ensure that higher payments are terminated when ESRD ends 36 months after transplant or 12 months after dialysis stops; and

- ensure timely resolution of beneficiaries reported as being out of area.

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PACIFICARE RESPONSE AND OIG COMMENTS

PacifiCare concurred in our findings and recommendations. The auditee's response stated that HCFA withheld the dual eligible overpayment from its April 1995 payment, and that the ESRD overpayment is expected to be withheld from a future payment. PacifiCare's written response did not address our recommended net financial adjustment for beneficiaries reported as out of area, nor our procedural recommendations. However, a PacifiCare official, via a telephone exit conference, stated that PacifiCare concurred in all of our findings and recommendations. The complete text of PacifiCare's response to our draft report is contained as an appendix to this report.

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

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS OIG Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See 45 CFR, Part 5.) To facilitate identification, please refer to the above common identification number in all correspondence relating to this report.

Donald L. Dille

DONALD L. DILLE
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Ms. Julia N. Kennedy
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration
1200 Main Tower Building, Room 2010
Dallas, Texas 75202

PacifiCare®

April 21, 1995

Donald L. Dille
Regional Inspector General for Audit Services
Department of Health & Human Services
1100 Commerce, Room 4A5
Dallas, Texas 75242

RE: Common Identification Number A-06-94-00028

Dear Mr. Dille:

Our parent corporation PacifiCare Health Systems has been working with HCFA for repayment of the referenced Medi-Medi, ie, dual eligible Medicare beneficiary overpayment. Additionally, we agree with your specific listing of ESRD overpayments. Attached is correspondence notifying HCFA of those four members plus an additional two members.

The approximately $455k Medi-Medi overpayment was withheld from the HCFA April 1995 payment to Texas. The $157k ESRD overpayment is expected to be withheld from a future payment.

Please do not hesitate to contact me in San Antonio at (210) 524-2178 if you have any questions.

Sincerely,

Susan N. Andrade

Susan N. Andrade
Accounting Manager

CC: Sharon Brumley
Madeline Harlan
Peter Van Valkinburgh
Nancy S. Gonzales
Jon F. Koch, Senior Auditor in Austin
Linda Dannels
file

[OIGESRD]

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March 17, 1995

Dorothy Williams
Health Care Financing Administration
Region VI
1200 Main Street, Room 2000
Dallas, Texas 75202

Dear Ms. Williams:

This correspondence is regarding beneficiaries, who have continued to reflect as ESRD status per the Special Status Report after losing eligibility. As a result, we have received overpayment in reimbursements.

Eligibility information was verified with ESRD Network, Richardson, Texas and ineligibility determined as indicated below:

NAME	HIC#	EFF-DATE OF INELIG

OIG NOTE: Identifying information deleted.

Based on this data, I would appreciate an adjustment to these records with an effective date as indicated above.

Should you require additional information, or have any questions regarding this matter, please call me at (210) 979-2453.

Sincerely,

Elsa Soliz
HCFA Reconciliation Representative

* ESRD ineligibility when beneficiary has had a kidney transplant and has been sucessful for 36 consecutive months.

** ESRD ineligibility when beneficiary has not received dialysis for 12 consecutive months.

cc: Emily McDonald/Case Manager
Finance Dept.

cc: Pat Day