DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date: JAN 14 1999

From: June Gibbs Brown
Inspector General

Subject: Audit of Risk-Based Medicare Health Maintenance Organization Payments for Out-of-Area Beneficiaries (A-06-97-00034)

To: Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report entitled "Audit of Risk-Based Medicare Health Maintenance Organization Payments for Out-of-Area Beneficiaries." The objective of this performance audit was to determine whether payments made for beneficiaries enrolled in Medicare risk-based health maintenance organizations (HMO), who were reported out of the service area, were correct. Incorrect addresses of enrolled beneficiaries can result in either an overpayment or underpayment of Medicare funds. This is because HCFA's prescribed HMO payment formula is based on the beneficiaries' county of residence, and generally, beneficiaries must reside in the plan's approved service area to remain enrolled in the plan.[1]

Our review at one national HMO chain (which had nine different Medicare risk HMO contracts in effect) showed that the Health Care Financing Administration (HCFA) made incorrect HMO payments on behalf of risk-based beneficiaries who were reported out-of-area. Specifically, our statistical sample of payments made to this chain for the 2 months reviewed in 1997 on behalf of HMO beneficiaries who were reported out-of-area were incorrect or inconclusive for 158 of 200 (79 percent) of the beneficiaries. The effect of the address changes as to what the correct Medicare monthly payment should have been was a net underpayment to the HMO of $47,619 for the 2 months reviewed.

We found that:

- payments were incorrectly calculated using an out-of-service area State and county code for beneficiaries who actually resided within the plan's service area,
- payments were erroneously made to ineligible beneficiaries who resided outside of the plan's service area for more than 90 days, and
- questionable payments were made to beneficiaries reported to be out-of-area even though the plan had not verified the beneficiaries' address of residence, as required.

[1]This criteria for out-of-area beneficiaries to remain enrolled in a plan has been modified somewhat with the passage of section 1851(b)(1)(B) of the Balanced Budget Act of 1997.

These payment errors occurred because (1) HCFA had not issued definitive instructions to HMOs specifying requirements for resolving beneficiaries' out-of-area status; (2) the Social Security Administration (SSA) was not processing changes timely, and HCFA did not use the reported SSA changes to correct payment errors retroactively; (3) HCFA's automated systems had limitations that resulted in payment errors and incorrect reporting of out-of-area status; and (4) HCFA's monitoring process to ensure that HMOs disenroll out-of-area beneficiaries was impaired due to deficient reporting.

As a result of incorrect residence information for 158 beneficiaries in our sample, we determined that HCFA made a net underpayment of $103,514 for 109 beneficiaries that were verified to reside in the service area, but were paid an out-of-area rate, and HCFA overpaid $55,895 for 10 ineligible beneficiaries who were not disenrolled even though they resided outside of the plan's service area. For the remaining 39 beneficiaries, an impact could not be computed because the HMO had not determined the beneficiaries' address of residence as required. We were not able to confirm through phone contacts that the beneficiaries resided in the service area; however, the medical records indicated that these 39 beneficiaries were not receiving medical services outside the service area. Under separate cover, we are providing the names of the 39 beneficiaries to HCFA for follow-up confirmation of enrollment and area of residence.

We also found problems with residence addresses for beneficiaries during our audit of HCFA's financial statements for Fiscal Year 1997. This review examined a statistical sample of 291 beneficiaries enrolled in HMOs nationwide. The sample included beneficiaries in all categories of HMO situations and was not limited to only those beneficiaries listed as out-of-area. This review compared beneficiaries' residence address as listed on HCFA systems with the HMO records. We found 17 beneficiary residence addresses on the HMO records did not match HCFA records, and for an additional 30 beneficiaries, the beneficiaries' residence could not be determined since adequate information was not provided by the HMO.

We recommend that HCFA: (1) develop regulations specifying the actions and time frames required by HMOs to resolve the out-of-area status of beneficiaries; (2) delegate authority for processing changes to the HMOs along with adequate HCFA monitoring procedures; (3) ensure that HCFA automated managed care systems are modified to reduce payment errors and incorrect reporting of out-of-area status; (4) revise the monthly Special Status Beneficiaries Report sent to HMOs to include the number of months a beneficiary has been reported out-of-area; (5) work with the national chain we reviewed to correct past payment errors for incorrect State and county codes; and (6) make payment recoveries from the national chain for out-of-area beneficiaries who were not properly disenrolled. The name of the chain will be provided to you under separate cover.

The HCFA concurred with five of our six recommendations in its written response to our draft report. The HCFA agreed with the intent of the first recommendation, but proposed an alternative plan. Instead of developing regulations, HCFA recommended that each enrollment application include the authority for the HMO to submit a residence address change for beneficiaries whose address differs on the enrollment form from SSA's as reported back to the HMO from HCFA at the time of enrollment. We believe that HCFA's plan should be developed further to include establishing regulations specifying how long an HMO has to reconcile an out of area condition. Regarding recommendation number five, HCFA has requested the Office of Inspector General to verify past payment errors made to the national chain for incorrect State and county codes. We have agreed to perform the needed audit work and are coordinating with HCFA staff. The complete text of HCFA's response is presented as Appendix D to this report.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-06-97-00034 in all correspondence related to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF RISK-BASED MEDICARE HEALTH MAINTENANCE ORGANIZATION PAYMENTS FOR OUT-OF-AREA BENEFICIARIES

JUNE GIBBS BROWN
Inspector General

JANUARY 1999
A-06-97-00034

EXECUTIVE SUMMARY

OBJECTIVE

The audit objective was to determine whether payments made for beneficiaries enrolled in Medicare risk-based health maintenance organizations (HMO), who were reported out of the service area, were correct.

SUMMARY OF FINDINGS

Our review at one national HMO chain (which had nine different Medicare risk contracts in effect) showed that the Health Care Financing Administration (HCFA) made incorrect HMO payments on behalf of risk-based beneficiaries who were reported out-of-area. Specifically, for the 2 months reviewed in 1997, HCFA made payments to this chain on behalf of HMO beneficiaries who were reported out of the service area that were incorrect or inconclusive for 158 of 200 (79 percent) of the beneficiaries in our statistical sample. The HCFA's prescribed monthly HMO payment formula is based on the beneficiaries' county of residence, and generally, beneficiaries must reside in the plans' approved service area to remain enrolled in the plan. However, we found payments were incorrectly calculated using an out of service area State and county code (SCC) for beneficiaries who actually resided within the plan's service area, payments were made to ineligible beneficiaries who resided outside of the plan's service area for more than 90 days, and questionable payments were made to beneficiaries reported to be out-of-area even though the plan had not verified the beneficiaries' address of residence as required.

These payment errors occurred because (1) HCFA had not issued definitive instructions to HMOs specifying requirements for resolving beneficiaries' out-of-area status; (2) the Social Security Administration (SSA) was not processing SCC changes timely, and HCFA did not use the reported SSA changes to correct payment errors retroactively; (3) HCFA's automated systems had limitations that resulted in payment errors and incorrect reporting of out-of-area status; and (4) HCFA's monitoring process to ensure that HMOs disenroll out-of-area beneficiaries was impaired due to deficient reporting.

As a result, our sample results showed:

- For 109 beneficiaries that were verified to reside in the service area, but continued to be capitated with an out-of-area SCC rate, HCFA made a net underpayment to the HMO of $103,514.

- For 10 ineligible beneficiaries who resided outside the plan's service area for more than 90 days, HCFA overpaid the HMO $55,895.

- For the remaining 39 beneficiaries, an impact could not be computed because the HMO had not determined the beneficiaries' address of residence as required. We were not able to confirm through phone contacts that the beneficiaries resided in the service area; however, the medical records indicated that these 39 beneficiaries were not receiving medical services outside the service area.

In discussing our audit results with HMO officials, they believe the estimated net effect of the incorrect payments for all beneficiaries with erroneous out-of-area SCCs in their nine Medicare contracts resulted in a $12.8 million underpayment by HCFA from 1991 to 1995. The HMO did not provide detailed support for its estimate. Consequently, the amount of the overall underpayment has not been verified, and no audit procedures have been performed to substantiate the amount. The HCFA and HMO officials have indicated that they are working on a solution to resolve past payment errors for beneficiaries who reside inside the service area, but have out-of-area SCCs. However, this process does not include identifying those beneficiaries who reside outside the service area and should be disenrolled.

We recommend that HCFA:

- Develop regulations specifying the actions and time frames required by HMOs to resolve out-of-area status.

- Delegate authority for processing SCC changes to the HMOs. Assign monitoring procedures to HCFA regional offices to ensure that the HMO initiated changes are valid.

- Ensure that the new automated managed care system being developed by HCFA is implemented with features to reduce payment errors and incorrect reporting of out-of-area status. Specifically, the system should include the beneficiaries' address of residence, nine digit zip code, and exception codes for out-of-area beneficiaries who are valid enrollees. In the interim, if it is cost beneficial, modify the current system to incorporate these features.

- Revise the monthly Special Status Beneficiaries Report (Status Report) sent to the HMOs to include the number of months a beneficiary has been reported out-of-area.

- Review detailed support provided by the national HMO chain substantiating payment errors and adjust the payments accordingly. Establish a process which will ensure that the submissions of payment errors include overpayments as well as underpayments.

- Recover payments totaling $55,895 made on behalf of 10 ineligible beneficiaries who should have been disenrolled for residing outside of the service area. For the remaining beneficiaries listed on the Status Report who the HMO has not contacted, require the HMO to verify the addresses.

The Balanced Budget Act of 1997 was enacted during our audit period. This legislation will allow certain beneficiaries who move outside of a plan's service area to remain enrolled in the plan. This change will increase the number of beneficiaries reported out-of-area in the future. Accordingly, it will be increasingly important for HCFA to establish information systems which allow the plans to efficiently and accurately resolve out-of-area conditions timely.

The HCFA concurred with five of our six recommendations in its written response to our draft report. The HCFA agreed with the intent of the first recommendation, but proposed an alternative plan. Instead of developing regulations, HCFA recommended that each enrollment application include the authority for the HMO to submit a residence address change for beneficiaries whose address differs on the enrollment form from SSA's as reported back to the HMO from HCFA at the time of enrollment. We believe that HCFA's plan should be developed further to include establishing regulations specifying how long an HMO has to reconcile an out of area condition. Regarding recommendation number five, HCFA has requested the Office of Inspector General (OIG), Office of Audit Services (OAS) to verify past payment errors made to the national chain for incorrect State and county codes. The complete text of HCFA's response is presented as Appendix D to this report.

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INTRODUCTION

BACKGROUND

The HCFA contracts with HMOs to provide health care services to Medicare beneficiaries. As of January 1, 1997, more than 4.9 million Medicare beneficiaries were enrolled in a total of 336 managed care plans, accounting for 13 percent of the total Medicare population. Managed care plans can serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans.

Under risk contracts, plans are paid a per capita premium set at approximately 95 percent of the estimated average cost to Medicare of treating the patient in fee-for-service in a given county. The Balanced Budget Act of 1997 [Public Law 105-33] revised the Medicare payment computation for risk-based managed care plans. However, a separate county rate will continue to be computed. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and eyeglasses. During 1997, 86 percent of Medicare beneficiaries in managed care were in risk plans.

The HCFA pays risk-based plans based on the beneficiary's county of record in the Group Health Plan (GHP) System. Therefore, the county of record is very important in calculating the proper monthly Medicare per capita payment. If the county of record is incorrect, either an overpayment or underpayment of Medicare funds may result. The source data for the beneficiary's county is the SCC recorded by SSA in the Master Beneficiary Record (MBR) used in the SSA benefit payment systems. The SSA's MBR updates HCFA's Enrollment Data Base (EDB) System on a daily basis. The EDB provides data to HCFA's GHP system.

Each month HCFA provides HMOs a listing of beneficiaries with addresses outside the HMO's service area on the Status Report. As of May 1997, 68,000 beneficiaries enrolled in Medicare risk-based HMOs were reported to be outside of the service area. These 68,000 beneficiaries, representing approximately 1.5 percent of beneficiaries enrolled in risk-based HMOs, were capitated with an out-of-area SCC.

The Balanced Budget Act of 1997 relaxed the requirement for residing in the plan's geographic area. Beneficiaries who move out of a plan's service area may be allowed to remain enrolled in the plan, provided the plan provides reasonable access to the full range of covered services as part of the basic benefit package.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

The audit objective was to determine whether payments made for beneficiaries enrolled in Medicare risk-based HMO's who were reported out of the service area were correct.

Scope

We limited the audit to beneficiaries of one national chain which had nine different Medicare risk contracts in effect. These beneficiaries were reported by HCFA to reside outside of the HMO's service area. Specifically, we randomly selected 100 beneficiaries out of 445 beneficiaries listed on the May 1997 Status Report for 1 contract. In addition, we randomly selected 100 beneficiaries out of 6,500 beneficiaries listed on the July 1997 Status Report for the remaining 8 HCFA contracts that the HMO operated.

We did not review the overall internal control structure of the HMO or the Medicare managed care program. The internal control review was limited to obtaining an understanding of the HMO's and HCFA's enrollment, disenrollment, and address validation processes. We did not test the internal controls because the objective of the review was accomplished through substantive testing.

Methodology

We obtained supporting documentation related to enrollment, disenrollment, and address verification maintained by the national HMO chain for the 200 beneficiaries to determine the actions taken by the HMO to substantiate the beneficiaries' place of residence. In 51 instances in which the HMO had not verified the beneficiaries' address of residence, we contacted the beneficiaries or their relatives and confirmed the address.

In 39 instances in which the HMO had not verified the beneficiaries' address of residence, we were unsuccessful in our efforts to locate the beneficiaries' current address. To determine if these beneficiaries resided outside of the service area and should be disenrolled, we reviewed HMO medical claims.

We discussed the audit objectives with representatives of the 10 HCFA regional offices and the HCFA central office to identify requirements placed on HMOs for disenrolling out-of-area beneficiaries and correcting SCC errors.

Field work was performed at the national HMO chain's centralized enrollment office. In addition, field work was performed at another HMO to aid in the development of the causes and recommendations. Finally, field work was conducted in our offices in Dallas and Austin, Texas. Field work was conducted from June 1997 to March 1998.

Our audit was performed in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Our review at one national HMO chain (which had nine different Medicare risk contracts in effect) showed that HCFA made incorrect payments on behalf of HMO risk-based beneficiaries who were reported out of the service area. Specifically, for the 2 months reviewed in 1997, HCFA made incorrect payments to this chain for 158 of the 200 (79 percent) beneficiaries reviewed who were reported out of the service area. This review showed that:

- For 109 beneficiaries that were verified to reside in the service area, but continued to be capitated with an out-of-area SCC rate, HCFA made a net underpayment to the HMO of $103,514.

- For 10 ineligible beneficiaries who resided outside the plan's service area for more than 90 days, HCFA overpaid the HMO $55,895.

- For the remaining 39 beneficiaries, an impact could not be computed because the HMO had not determined the beneficiaries' address of residence as required, and we were unable to confirm through phone contacts that these beneficiaries resided in the service area.

This occurred because (1) HCFA had not issued definitive instructions to HMOs specifying requirements for resolving beneficiaries' out-of-area status; (2) according to HMO and HCFA officials, SSA was not processing SCC changes timely, and HCFA did not use the reported SSA changes to correct payment errors retroactively; (3) HCFA's automated systems had limitations that resulted in payment errors and incorrect reporting of out-of-area status; and (4) HCFA's monitoring process to ensure that HMOs disenroll out-of-area beneficiaries was impaired due to deficient reporting.

CRITERIA

Two specific categories of criteria apply:

(1) HMO Payment Rates

Medicare risk-based payment rates are adjusted for the geographic location of the beneficiaries' residence as prescribed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Specifically, TEFRA authorized prospective per capita payments to HMOs under risk contracts at a rate equal to 95 percent of the adjusted average per capita cost Medicare pays for beneficiaries under the traditional fee-for-service system within a geographic area.

The HCFA has issued the following guidelines pertaining to SCC corrections.

- Sections 6003.1 and 6004 of HCFA's HMO Manual require the HMO to review the HCFA Monthly Transaction Replies/Monthly Activity Report which includes a listing of beneficiaries with addresses outside its service area.
- Several HCFA regional offices including Regions I, IV, and IX issued guidance to HMOs reinforcing the requirement to prompt the beneficiary to contact SSA with address changes. Two of these three regions advised HMOs to issue a letter to beneficiaries who are reported outside of the service area on HCFA's Reply Report in order to verify the beneficiaries' address. Finally, one region requires the HMO to forward written address verification forms signed by the beneficiary to SSA.

(2) Disenrolling Out-of-Area Beneficiaries

Section 2004.3 of HCFA's HMO Manual states that:

"A beneficiary must be disenrolled if he/she moves permanently out of the geographic area and does not voluntarily disenroll.[2] The HMO should initiate a disenrollment as soon as it becomes aware that the beneficiary has moved permanently outside the service area. An uninterrupted absence of more than 90 days is deemed to be a permanent move. Prior to disenrolling a member that has moved outside the geographic area, the HMO is required to obtain a written statement or other reasonable evidence that establishes that the beneficiary has moved outside the geographic area."

CONDITION

Incorrect Payments Were Made for 158 Beneficiaries in the Sample of 200

Payments made to this chain on behalf of HMO beneficiaries who were reported out of the service area by HCFA were incorrect for 79 percent (158 of 200) of the beneficiaries reviewed in our statistical sample. Of the 200 beneficiaries, 98 were reported out of the service area for more than 1 year without corrective action.

(1) Payments Were Incorrectly Calculated Using an Out-of-Area SCC for 109 Beneficiaries

Payments for 109 beneficiaries were calculated using an out-of-area SCC even though the beneficiary resided within the service area.

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[2]As previously discussed, the Balanced Budget Act of 1997 relaxes this requirement.

SCC Corrections Not Processed - Incorrect payments based on out-of-area SCCs were made for 61 beneficiaries who the HMO had confirmed resided in the plan's service area. The plan contacted beneficiaries who appeared as out-of-area on the Status Report to verify the beneficiary's residence. In most instances, the address verifications were accomplished via a phone conversation. The HMO notified SSA about a need to change an SCC for only one beneficiary in the sample. To illustrate, the HMO sent a beneficiary a letter in November 1996, requesting an address verification to be returned via mail. In response to the letter, the beneficiary phoned the HMO in December 1996 informing the HMO officials that he had not relocated. He informed the HMO that the out-of-area address in the SSA system was a mailing address. Without the HMO forwarding a written authorization from the beneficiary to SSA, the HMO could not make an SCC correction.

Beneficiaries Not Prompted to Change SCC - Incorrect payments based on out-of-area SCCs were made for 48 beneficiaries who resided in the service area, but the plan had not verified their residence or prompted the beneficiaries to correct their address. The HMO should have contacted these beneficiaries who appeared as out-of-area on the HCFA Status Report to determine if disenrollment action was necessary or to prompt the beneficiaries to correct their SCC with SSA. We contacted these beneficiaries and confirmed that they resided within the plan's service area. For example, HCFA reported a beneficiary as out-of-area on the Status Report each month from January 1995 through July 1997. The HMO did not contact this beneficiary to determine if disenrollment action was necessary or to prompt the beneficiary to contact SSA with a SCC correction. We contacted the beneficiary and verified that she resided within the plan's service area for the entire time she was enrolled in the HMO. Because she lived within the service area, her SCC should have been changed to reflect the correct geographic adjustment for payment.

(2) Payments Were Made for 10 Ineligible Out-of-Area Beneficiaries

The HMO received payments on behalf of 10 ineligible out-of-area beneficiaries who were not disenrolled timely.

Disenrollment Action Not Taken - The HMO did not take disenrollment action for eight out-of-area beneficiaries who resided outside of the plan's service area for more than 90 days. Four of these beneficiaries were not contacted by the HMO to determine their eligibility. For the remaining four beneficiaries, the HMO verified an out-of-area status but did not take disenrollment action. One of these beneficiaries was correctly enrolled as an out-of-area commercial exception, but was not disenrolled as required after relocating to a new out-of-area address. For seven of the eight beneficiaries that should have been disenrolled, the out-of-area status began on the effective date of enrollment, and the out-of-area period ranged from 5 to 71 months.

Disenrollment Action Untimely - Payments were made for two out-of-area beneficiaries who were disenrolled untimely. Beneficiaries residing outside of the service area for 90 days should be disenrolled. The HMO did not routinely follow-up with beneficiaries appearing on the Status Report to ensure that disenrollment would be processed within 90 days of the HMO becoming aware that an out-of-area condition may exist.

(3) Payments Were Made for 39 Beneficiaries with No Eligibility Verification

Payments on behalf of 39 beneficiaries who HCFA reported out-of-area were made even though the HMO had not verified the beneficiaries' residence to determine eligibility. These beneficiaries were reported out-of-area between 4 and 52 months. We were not able to confirm through phone contacts that the beneficiaries resided in the service area; however, the medical records indicated that these 39 beneficiaries were not receiving medical services outside the service area. If these beneficiaries do reside in the service area, then the payments to the HMO were capitated with an incorrect out-of-area SCC.

CAUSE

(1) HCFA Instructions

The HCFA has not issued definitive instructions to HMOs specifying actions and time frames for resolving beneficiaries' out-of-area status. As a result, resolutions vary among HMOs, and allow HMOs to submit selective corrections. Currently, the HMOs in all but one HCFA region are required to "prompt" beneficiaries to notify SSA of address changes. One HCFA region has instructed HMOs to send address verification forms, signed by the beneficiaries, to SSA to initiate SCC corrections. Compliance with these requirements do not ensure that corrections will be made. Consequently, HMO actions vary. For example, another HMO (not affiliated with the national HMO chain) has disenrolled any beneficiary who does not respond within 90 days to the HMO's address verification letter. In contrast, the national HMO chain allowed beneficiaries to continue their enrollment even if they do not contact SSA as long as they inform the plan that they reside within the service area. The lack of definitive instructions affords the HMOs the opportunity to selectively resolve cases in which the HMO is underpaid while simultaneously withholding information from HCFA and SSA on cases that result in an overpayment.

(2) SSA Changes

The SSA was not making SCC changes timely and while the SSA changes correct the payment errors prospectively, incorrect payments already processed must be corrected by HCFA. Beneficiaries and the HMOs on the beneficiaries' behalf forward address changes to the relevant SSA field office for SCC correction, but SSA was not making changes. The national HMO chain provided letters it had written to SSA to initiate SCC changes that were not corrected. The HCFA regional office officials indicated that they are aware of problems with SSA's ability to process SCC changes, and SSA problems vary among locations. Also, because SCC changes affect only future payments, payments processed prior to the SCC change can only be fixed by submitting a request to the HCFA regional office to process a correction on the GHP. As a result of these problems, most HCFA regional offices have informally agreed to process SCC changes for the HMOs. However, the HCFA regional offices are not encouraging plans to forward SCC changes because the officials indicated that they do not have resources to process the volume of changes. To streamline the process, officials from the majority of HCFA regional offices indicated a preference for delegating, to the HMOs, the authority for processing SCC changes on the GHP. This authority would be consistent with HCFA's current design of its new managed care system. The new system will rely on the HMOs as the source for the beneficiaries' address information.

(3) Automated Systems Limitations

The HCFA's automated systems have limitations that result in payment errors and incorrect reporting of out-of-area status, but a new managed care system is being designed which HCFA contends will correct these deficiencies. Specifically, HCFA's current system does not:

- capture the residence address;
- identify legitimate out-of-area exceptions; and
- assign the correct SCC to zip codes which overlap more than one county.

Capture residence address: The current payment system does not capture the beneficiaries' address of residence. The residential address controls whether the beneficiary is eligible to enroll in the plan, and is used to calculate the capitation rate. However, the primary SSA system that HCFA relies on to generate SCCs has a system default which uses the mailing address to create an SCC. The SCC can be overridden manually to reflect the SCC for the beneficiaries' residence. Frequently, beneficiaries have a different mailing address than residential address because they may have a representative payee who is authorized to receive their SSA benefit check or they may use a post office box.

Identify legitimate out-of-area exceptions: During the audit period, legislation allowed for certain Medicare beneficiaries to enroll in Medicare HMOs even if they reside outside of the approved service area. Specifically, beneficiaries who are enrolled in an HMO's commercial plan can be grandfathered into the Medicare HMO even if they reside outside of the service area. The Balanced Budget Act of 1997 (BBA) creates further out-of-area exceptions. The BBA allows Medicare HMO beneficiaries to be retained by the plan if they move outside the service area as long as those beneficiaries have reasonable access to the full range of basic benefits. However, the HCFA payment system does not identify these exceptions. Currently, commercial beneficiaries who reside outside the service area are included as out-of-area on HCFA's monthly reports without any indicator distinguishing an exception to the general requirements. A HCFA working group studying the out-of-area problems has recommended that an out-of-area indicator be displayed on the Transaction Reply Report to identify commercial exceptions. The Transaction Reply Report should also be modified to identify the out-of-area exceptions created by the BBA.

Assign the correct SCC to zip codes which overlap more than one county: The primary SSA system HCFA relies on for assigning SCCs does not assign correct SCCs to certain counties that share zip codes. Specifically, the SSA system generates the SCC from the beneficiaries' zip code. Some United States Postal Service zip codes overlap more than one county. The SSA system default assigns the SCC to the first incidental zip code match regardless of the county in which the beneficiary resides.

A HCFA official indicated that the new managed care system will correct these deficiencies. Specifically, the new system will include a residential address field, will flag legitimate out-of-area exceptions, and will capture nine digit zip codes. However, the official estimated that the new system will not be operational for 2 to 3 years. In the interim, the HCFA official indicated that the GHP could be modified and the processes changed to correct some of the deficiencies more timely.

4) HCFA's Monitoring Process

The HCFA's monitoring process for reviewing the HMO's compliance with disenrolling out-of-area beneficiaries is impaired because the majority of beneficiaries on the Status Report listed as out-of-area reside in the area, and the Status Report does not show the number of months a beneficiary has been reported out-of-area. The HCFA is required to perform a comprehensive monitoring review of each HMO every 2 years which includes a determination of the HMO's compliance with involuntary disenrollment of enrollees who move outside the service area for more than 90 days. By improving the reliability of the out-of-area data on the Status Report, HCFA can use the Status Report to directly evaluate the HMO's compliance with disenrollment requirements.

EFFECT

As a result of incorrect residence information for 158 beneficiaries in our sample of 200:

- For 109 beneficiaries that were verified to reside in the service area, but continued to be capitated with an out-of-area SCC rate, HCFA made a net underpayment to the HMO of $103,514 (See Appendix A).

- For 10 ineligible beneficiaries who resided outside the plan's service area for more than 90 days, HCFA overpaid the HMO $55,895 (See Appendix B).

- For the remaining 39 beneficiaries, an impact could not be computed because the HMO had not determined the beneficiaries' address of residence as required, and we were unable to confirm through phone contacts that these beneficiaries resided in the service area (See Appendix C).

Officials from the national HMO chain estimate the effect of incorrect payments for all beneficiaries with erroneous out-of-area SCCs in the 9 Medicare contracts resulted in an underpayment by HCFA from 1991 to 1995. The underpayment was estimated by the HMO to be $12.8 million. However, this amount has not been verified, nor was any detailed support provided to us. We have not performed audit procedures to substantiate the amount, the sample indicated that the majority of payment errors that have occurred are underpayments. The HMO estimates an additional $390,000 in underpayments continues to accumulate each month the problems persist.

The HCFA and HMO officials have advised us that they are working on a solution to resolve past payment errors for beneficiaries who reside inside the service area, but have out-of-area SCCs. However, this process does not include identifying those beneficiaries who reside outside the service area and should be disenrolled.

RECOMMENDATIONS

We recommend that HCFA:

- Develop regulations specifying the actions and time frames required by HMOs to resolve out-of-area status.

- Delegate authority for processing SCC changes to the HMOs. Assign monitoring procedures to HCFA regional offices to ensure that the HMO initiated changes are valid.

- Ensure that the new automated managed care system being developed by HCFA is implemented with features to reduce payment errors and incorrect reporting of out-of-area status. Specifically, the system should include the beneficiaries' address of residence, nine digit zip code, and exception codes for out-of-area beneficiaries who are valid enrollees. In the interim, if it is cost beneficial, modify the current system to incorporate these features.

- Revise the monthly Status Report sent to the HMOs to include the number of months a beneficiary has been reported out-of-area.

- Review detailed support provided by the national HMO chain substantiating payment errors and adjust the payments accordingly. Establish a process which will ensure that the submissions of payment errors include overpayments as well as underpayments.

- Recover payments totaling $55,895 made on behalf of 10 ineligible beneficiaries who should have been disenrolled for residing outside of the service area. For the remaining beneficiaries listed on the Status Report who the HMO has not contacted, require the HMO to verify the addresses.

The HCFA's Comments and OIG Response

The HCFA concurred with five of our six recommendations in its written response to our draft report. The HCFA agreed with the intent of the first recommendation, but proposed an alternative plan. Instead of developing regulations, HCFA recommends that each enrollment application include the authority for the HMO to submit a residence address change for beneficiaries whose address differs on the enrollment form from SSA's as reported back to the HMO from HCFA at the time of enrollment. We believe HCFA's plan should be developed further to include establishing regulations specifying how long an HMO has to reconcile an out of area condition. Regarding recommendation number five, HCFA has requested the Office of Inspector General (OIG), to verify past payment errors made to the national chain for incorrect SCCs. We have agreed to perform the needed audit work and are coordinating with HCFA staff. The complete text of HCFA's response is presented as Appendix D to this report.

OTHER MATTERS

We also found problems with residence addresses for beneficiaries during our audit of HCFA's financial statements for Fiscal Year 1997. This review examined a statistical sample of 291 beneficiaries enrolled in HMOs nationwide. The sample included beneficiaries in all categories of HMO situations and was not limited to only those beneficiaries listed as out-of-area. This review compared beneficiaries' residence address as listed on HCFA systems with the HMO records. We found 17 beneficiary residence addresses on the HMO records did not match HCFA records, and for an additional 30 beneficiaries, the beneficiaries' residence could not be determined since adequate information was not provided by the HMO.

CAPITATION INCORRECTLY CALCULATED

		SAMPLE NUMBER	CAPITATION PERIOD	AMOUNT RECEIVED	SCC USED FOR PAYMENT	CORRECT SCC	CORRECT AMOUNT	OVER/UNDER PAYMENT
First 100 Sampled	1	3	2/96 - 5/97	$ 5,227.43	45953	45130	$ 6,710.62	($ 1,483.19)
	2	12	2/97 - 5/97	1,265.08	10630	45610	1,797.40	(532.32)
	3	16	6/96 - 5/97	5,678.66	10630+10480	45610	7,701.13	(2,022.47)
	4	18	11/96 - 5/97	2,795.06	10090	45180	3,155.88	(360.82)
	5	20	11/96 - 5/97	2,388.28	45240	45130	2,948.48	(560.20)
	6	22	6/95 - 5/97	8,782.43	15440	45130	7,156.74	1,625.69
	7	33	3/97 - 5/97	902.52	45580	45610	1,336.14	(433.62)
	8	35	6/96 - 5/97	2,811.74	45581	45130	3,683.18	(871.44)
	9	37	3/97 - 5/97	2,122.95	45581	45130	2,814.51	(691.56)
	10	44	10/96 - 5/97	5,552.38	10120	45550	4,034.97	1,517.41
	11	50	2/97 - 5/97	1,639.80	45320	45130	2,171.60	(531.80)
	12	57	3/95 - 5/97	11,307.10	45953	45130	13,980.17	(2,673.07)
	13	58	12/95 - 5/97	3,975.44	45734	45130	4,148.45	(173.01)
	14	60	7/95 - 5/97	5,631.21	45541	45130	6,196.10	(564.89)
	15	63	10/96 - 5/97	2,044.83	45060	45130	2,269.88	(225.05)
	16	65	12/96 - 5/97	1,555.62	45949	45610	2,064.85	(509.23)
	17	72	5/96 - 5/97	4,619.45	45792	45130	5,390.12	(770.67)
	18	82	1/96 - 5/97	10,044.57	45830	45130	9,662.35	382.22
	19	86	3/95 - 5/97	7,570.16	45734	45130	10,189.22	(2,619.06)
	20	87	1/96 - 5/97	4,960.28	45060	45130	5,501.16	(540.88)
	21	88	11/96 - 5/97	2,646.97	45060	45130	2,948.48	(301.51)
	22	89	1/95 - 5/97	6,021.33	45734	45130	6,514.77	(493.44)
	23	93	2/95 - 5/97	7,257.39	35500	45130	8,775.21	(1,517.82)
	24	94	11/95 - 4/97	5,794.08	45770	45310	5,181.78	612.30
	25	100	1/95 - 5/97	13,544.48	45090	45130	15,801.51	(2,257.03)
	26	2	11/95 - 5/97	7,549.73	45650	45130	9,377.79	(1,828.06)
	27	6	11/95 - 5/97	8,542.69	45240	45130	10,402.13	(1,859.44)
	28	8	6/96 - 5/97	4,228.42	45731	45130	5,568.84	(1,340.42)
	29	10	1/96 - 5/97	4,232.69	33750	45130	5,589.32	(1,356.63)
	30	11	11/96 - 5/97	2,499.40	45850	45550	2,756.74	(257.34)
	31	14	2/96 - 5/97	6,536.45	45581	45130	8,676.06	(2,139.61)
	32	15	9/95 - 5/97	7,180.81	45581	45130	9,527.39	(2,346.58)
	33	26	1/95 - 5/97	8,547.77	45731	45130	11,421.76	(2,873.99)
	34	31	1/95 - 5/97	11,297.41	45320	45130	14,935.13	(3,637.72)

CAPITATION INCORRECTLY CALCULATED

		SAMPLE NUMBER	CAPITATION PERIOD	AMOUNT RECEIVED	SCC USED FOR PAYMENT	CORRECT SCC	CORRECT AMOUNT	OVER/UNDER PAYMENT
	35	34	2/97 - 5/97	$1,333.48	36310	45130	$ 1,355.04	($ 21.56)
	36	38	1/95 - 5/97	8,098.36	45581	45130	10,643.18	(2,544.82)
	37	41	7/96 - 5/97	2,985.46	45810	45801	4,203.11	(1,217.65)
	38	43	1/96 - 5/97	5,354.78	45420	45130	6,914.32	(1,559.54)
	39	46	11/96 - 5/97	1,811.14	5090	45130	2,328.36	(517.22)
	40	48	5/97	248.34	45290	45390	386.64	(138.30)
	41	49	2/96 - 5/97	3,809.39	45754	45312	3,912.20	(102.81)
	42	55	4/96 - 5/97	3,898.46	45581	45130	5,109.23	(1,210.77)
	43	56	3/96 - 5/97	6,714.50	5460	45130	6,117.70	596.80
	44	61	7/96 - 5/97	1,946.85	45581	45130	2,571.69	(624.84)
	45	62	12/95 - 5/97	7,167.54	45020	45610	8,991.96	(1,824.42)
	46	64	3/97 - 5/97	914.73	36260	45130	1,016.28	(101.55)
	47	73	11/96 - 5/97	1,526.96	45581	45130	1,997.42	(470.46)
	48	75	4/96 - 5/97	4,839.63	45820	45130	5,797.06	(957.43)
	49	77	5/96 - 5/97	3,121.07	45754	45130	4,232.04	(1,110.97)
	50	78	1/95 - 5/97	8,662.47	45320	45130	11,421.76	(2,759.29)
	51	96	3/97 - 5/97	932.79	24170	45180	1,376.04	(443.25)
	52	97	5/96 - 5/97	3,477.63	45320	45130	4,596.04	(1,118.41)
	53	13	5/97	369.10	34910	45130	426.92	(57.82)
	54	21	5/97	309.89	45949	45801	397.09	(87.20)
	55	27	5/97	349.47	19340	45610	703.11	(353.64)
	56	67	5/97	340.47	45830	45130	338.76	1.71
	57	98	5/97	319.86	49060	45130	338.76	(18.90)
Second 100 Sampled	58	3	8/96 - 7/97	$ 3079.79	10340	10500	$ 3,702.16	($ 622.37)
	59	8	5/97 - 7/97	1035.63	30060	10630	1,167.51	(131.88)
	60	18	4/95 - 7/97	8266.62	33260	10630	9,705.43	(1,438.81)
	61	20	8/96 - 7/97	8236.92	06290	10510	9,415.60	(1,178.68)
	62	35	8/95 - 7/97	15053.45	33400	10050	15,881.81	(828.36)
	63	46	6/97 - 7/97	858.7	06200	10540	941.04	(82.34)
	64	47	7/97	397.05	10340	10470	463.47	(66.42)
	65	48	12/95 - 7/97	12873.35	31000	10490	13,389.44	(516.09)
	66	54	12/96 - 7/97	4331.69	10620	10250	4,319.91	11.78

CAPITATION INCORRECTLY CALCULATED

	SAMPLE NUMBER	CAPITATION PERIOD	AMOUNT RECEIVED	SCC USED FOR PAYMENT	CORRECT SCC	CORRECT AMOUNT	OVER/UNDER PAYMENT
67	55	6/95 - 7/97	7907.81	36010	10510	10,613.34	(2,705.53)
68	58	1/97 - 7/97	2061.78	36600	10270	2,855.48	(793.70)
69	59	1/97 - 7/97	$ 2851.31	14580	10050	$ 5,069.40	($ 2,218.09)
70	65	4/97 - 7/97	1578.44	10270	10510	1,780.16	(201.72)
71	69	4/95 - 7/97	9226.31	37610	10120	17,083.42	(7,857.11)
72	71	1/97 - 7/97	2484.37	23710	10350	2,386.51	97.86
73	73	8/95 - 7/97	7104.51	10080	10470	8,390.28	(1,285.77)
74	80	9/95 - 7/97	5934.08	14640	14141	7,982.32	(2,048.24)
75	89	7/97	256.11	03120	3060	371.76	(115.65)
76	96	5/97 - 7/97	924.36	05400	29010	853.62	70.74
77	1	1/95- 7/97	15223.97	33420	10050	13,276.01	1,947.96
78	2	2/97 - 7/97	3160.68	33331	10250	2,238.72	921.96
79	12	3/97 - 7/97	2676.25	22040	10550	2,935.90	(259.65)
80	21	5/97 - 7/97	987.54	45030	10350	1,022.79	(35.25)
81	31	1/95 - 7/97	17685.09	33700	10050	20,003.75	(2,318.66)
82	33	5/95 - 7/97	5856.06	33520	10510	7,543.61	(1,687.55)
83	41	4/96 - 7/97	7463.77	39480	10500	8,844.00	(1,380.23)
84	43	4/96 - 7/97	7454.48	21020	10090	5,936.05	1,518.43
85	72	1/95 - 7/97	12510.47	36310	10580	13,077.62	(567.15)
86	81	1/95 - 7/97	6000.62	52630	14250	7,985.98	(1,985.36)
87	91	5/96 - 7/97	5508.61	18801	18550	7,140.68	(1,632.07)
88	100	8/96 - 7/97	3561	45711	45830	3,444.27	116.73
89	17	9/95 - 7/97	9722.03	22070	10490	12,307.15	(2,585.12)
90	42	12/96 - 6/97	2994.41	33710	10050	4,044.34	(1,049.93)
91	63	1/97 - 7/97	2762.27	10270	10120	4,706.17	(1,943.90)
92	74	9/95 - 6/97	4438.46	40720	10580	11,053.20	(6,614.74)
93	85	1/95 - 7/97	9502.24	39280	3060	10,188.94	(686.70)
94	11	11/96 - 7/97	3,387.72	47020	10350	5,006.63	(1,618.91)
95	13	1/95 - 7/97	11,439.40	22070	10490	14,746.80	(3,307.40)
96	16	5/97 - 7/97	909.87	10530	10090	837.24	72.63
97	24	1/95 - 7/97	16,206.61	33020	10470	11,157.66	5,048.95
98	28	4/97 - 7/97	1,211.04	10340	10470	1,429.68	(218.64)
99	37	5/96 - 7/97	9,000.58	31320	10260	9,186.93	(186.35)
100	44	6/97 - 7/97	608.74	49800	10350	852.02	(243.28)

CAPITATION INCORRECTLY CALCULATED

	SAMPLE NUMBER	CAPITATION PERIOD	AMOUNT RECEIVED	SCC USED FOR PAYMENT	CORRECT SCC	CORRECT AMOUNT	OVER/UNDER PAYMENT
101	51	12/96 - 7/97	2,846.75	10360	10460	4,998.28	(2,151.53)
102	60	9/95 - 7/97	8,965.60	10520	10280	11,501.64	(2,536.04)
103	82	3/97 - 7/97	1,497.60	52690	14141	2,459.85	(962.25)
104	84	6/97 - 7/97	1,008.78	5060	3060	871.10	137.68
105	86	1/96 - 7/97	5,957.86	14250	14250	5,932.06	25.80
106	88	4/96 - 7/97	4,559.42	3020	3060	5,857.29	(1,297.87)
107	90	7/96 - 7/97	2,873.29	3020	3060	3,828.99	(955.70)
108	15	1/95 - 7/97	7,954.12	03110	10500	12,505.45	(4,551.33)
109	36	1/97 - 6/97	1,768.50	31310	10490	2,108.64	(340.14)
						Total	($103,513.59)

SCC - State and County Code
AAPCC - Average Actuarial Per Capita Cost

PAYMENTS FOR INELIGIBLE BENEFICIARIES

		SAMPLE NUMBER	CAPITATION PERIOD	AMOUNT RECEIVED	MONTHS DISALLOWED	OVERPAYMENT
First 100 Sampled	1	30	5/94 - 8/97	$12,443.80	8/94 - 8/97	$11,752.78
	2	42	9/95 - 5/97	8,407.43	6/96 - 5/97	4,677.46
	3	51	2/97 - 8/97	2,022.30	5/97 - 8/97	1,155.60
	4	68	10/91 - 8/97	19,280.92	1/92 - 8/97	18,724.27
	5	70	6/96 - 8/97	3,565.70	5/97 - 8/97	887.20
	6	71	12/95 - 8/97	5,276.39	3/96 - 8/97	4,551.76
	7	74	1/96 - 5/97	8,104.91	4/96 - 5/97	6,737.57
Second 100 Sampled	8	50	12/96 - 10/97	5,856.48	5/97 - 10/97	3,213.60
	9	52	3/97 - 10/97	3,067.12	3/97 - 10/97	3,067.12[1]
	10	76	6/97 - 10/97	2,820.00	9/97 - 10/97	1,128.00
					Total	$55,895.36

1] Plan enrolled an out-of-area beneficiary, therefore, the 90 day grace period was not applied.

PAYMENTS FOR BENEFICIARIES WITH NO ELIGIBILITY VERIFICATION

FIRST 100 SAMPLED		SECOND 100 SAMPLED	
	SAMPLE NUMBER		SAMPLE NUMBER
1	5	15	6
2	24	16	7
3	32	17	14
4	53	18	19
5	76	19	22
6	79	20	23
7	80	21	25
8	83	22	26
9	84	23	27
10	85	24	32
11	90	25	38
12	91	26	39
13	92	27	49
14	99	28	53
		29	62
		30	64
		31	66
		32	75
		33	78
		34	83
		35	87
		36	93
		37	94
		38	95
		39	98

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: OCT 13 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Audit of Risk-Based Medicare Health Maintenance Organization Payments for Out-of-Area Beneficiaries," (A-06-97-00034)

We reviewed the above-referenced report that examines whether payments made for beneficiaries enrolled in Medicare risk-based health maintenance organizations (HMOs), who were reported out of the service area, were correct. We appreciate your recommendations and believe they will strengthen our stewardship of the managed care program.

Our detailed comments to the report recommendations follow:

OIG Recommendation #1
HCFA should develop regulations specifying the actions and time frames required by HMOs to resolve out-of-area status.

HCFA Response
We concur with the intent of the recommendation. As an alternative to developing regulations, we recommend that each enrollment application include authority for the managed care plan to submit to the Social Security Administration (SSA), a residence address change for each beneficiary whose address on the enrollment form differs from SSA's (excluding permitted exemptions) as reported back to the plan from HCFA at the time of enrollment.

OIG Recommendation #2
HCFA should delegate authority for processing state and county code (SCC) changes to the HMOs. Assign monitoring procedures to HCFA regional offices to ensure that the HMO initiated changes are valid.

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HCFA Response
We concur. The HMO or Medicare Plus Choice plan is in a better situation to verify the beneficiaries' address of residence and we are not opposed to delegating that authority to them for processing SCC changes. A beneficiary verification/confirmation, e.g., a signed statement, should also be required for all SCC changes. Without this, it would be difficult for HCFA regional offices to verify the legitimacy of a service code change during the monitoring process. We also agree with the development of new monitoring procedures to ensure the accuracy of any HMO initiated changes.

OIG Recommendation #3
HCFA should ensure that the new automated managed care system being developed is implemented with features to reduce payment errors and incorrect reporting of out-of-area status. Specifically, the system should include the beneficiaries' address of residence, nine digit zip code, and exception codes for out-of-area beneficiaries who are valid enrollees. In the interim, modify the current system to incorporate these features if it is cost beneficial.

HCFA Response
We concur. However, modifications to the current system will not be feasible until after 1999 due to the implementation of the Balanced Budget Act of 1997 and Year 2000 (Y2K) projects.

OIG Recommendation #4
HCFA should revise the monthly status report sent to the HMOs to include the number of months a beneficiary has been reported out-of-area.

HCFA Response
We concur. The Special Status Report is obsolete. It has been replaced by the current Monthly Membership Report which shows each beneficiary in the plan with his or her state and county code.

OIG Recommendation #5
HCFA should review detailed support provided by the national HMO chain substantiating payment errors and adjust the payments accordingly. Establish a process which will ensure that the submissions of payment errors include overpayments as well as underpayments.

HCFA Response
We concur. This issue will be addressed by the new Group Health Payment System or the new Beneficiary Database Prototype.

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OIG Recommendation #6
HCFA should: (1) recover payments totaling $55,895 made on behalf of 10 ineligible beneficiaries who should have been disenrolled for residing outside of the service area; and (2) For the remaining beneficiaries listed on the status report whom the HMO has not contacted, require the HMO to verify the addresses.

HCFA Response
We concur with recouping any payments made in error. However, in order to make a determination of the total dollars to be recovered, more information regarding the 10 ineligible beneficiaries is needed, e.g., were any services provided and were the services provided in-network?

We concur with the second part of the recommendation to require the HMO to complete the verification of beneficiary addresses.