AUG 10 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of Duplicate Capitation Payments to Medicare Advantage Organizations and Programs of All-Inclusive Care for the Elderly Organizations (A-07-08-01052)

The attached final report provides the results of our review of duplicate capitation payments to Medicare Advantage organizations and Programs of All-Inclusive Care for the Elderly (PACE) organizations. (For purposes of this report, Medicare Advantage organizations and PACE organizations are referred to collectively as "organizations.")

At the beginning of each month, the Centers for Medicare & Medicaid Services (CMS) makes a capitation payment to organizations for medical services provided to each individual enrolled in a Medicare Advantage or PACE plan. CMS may make only one capitation payment per month for each Medicare enrollee. Both before and after making a payment, CMS follows a validation process to ensure the accuracy of the payment. If the validation process identifies an inaccurate payment after the payment has been made, CMS makes a retroactive adjustment to correct the payment amount.

Our objective was to determine whether CMS made only one capitation payment per month for each Medicare enrollee.

Of the approximately 218 million capitation payments totaling approximately $158 billion that CMS made for Medicare enrollees from January 2006 through March 2008, only 373 payments totaling $300,894 were duplicate payments for 1 month of health care coverage. Although CMS had correctly paid organizations for the vast majority of enrollees, the validation process that CMS used to ensure the accuracy of payments did not identify and prevent these improper payments.

We recommend that CMS:

- recoup the $300,894 in improper payments;

- determine whether enhancements to its validation process would be cost effective and, if so, implement the enhancements; and

- periodically review, on a postpayment basis, payments made to organizations to detect and recover any duplicate payments.

In written comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov. Please refer to report number A-07-08-01052 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF DUPLICATE CAPITATION PAYMENTS TO MEDICARE ADVANTAGE ORGANIZATIONS AND PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY ORGANIZATIONS

Daniel R. Levinson
Inspector General

August 2009
A-07-08-01052

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Under Medicare Part C, the Centers for Medicare & Medicaid Services (CMS) contracts with Medicare Advantage organizations and approves their plans to provide health care coverage to Medicare enrollees. In addition, CMS contracts with organizations under Programs of All-Inclusive Care for the Elderly (PACE) to provide comprehensive medical and social services to the elderly. For purposes of this report, Medicare Advantage organizations and PACE organizations are referred to collectively as "organizations."

At the beginning of each month, CMS makes a capitation payment to organizations for medical services provided to each individual enrolled in a Medicare Advantage or PACE plan. Federal regulations state that an individual may be enrolled in only one Medicare Advantage or PACE plan at any given time. In addition, Federal law states that an individual may not be enrolled simultaneously in both a Medicare Advantage plan and a PACE plan.

CMS may make only one capitation payment per month for each Medicare enrollee. Both before and after making a payment, CMS follows a validation process to ensure the accuracy of the payment. If the validation process identifies an inaccurate payment after the payment has been made, CMS makes a retroactive adjustment to correct the payment amount.

OBJECTIVE

Our objective was to determine whether CMS made only one capitation payment per month for each Medicare enrollee.

SUMMARY OF FINDING

Of the approximately 218 million capitation payments totaling approximately $158 billion that CMS made for Medicare enrollees from January 2006 through March 2008, only 373 payments totaling $300,894 were duplicate payments for 1 month of health care coverage. Although CMS had correctly paid organizations for the vast majority of enrollees, the validation process that CMS used to ensure the accuracy of payments did not identify and prevent these improper payments.

RECOMMENDATIONS

We recommend that CMS:

- recoup the $300,894 in improper payments;

- determine whether enhancements to its validation process would be cost effective and, if so, implement the enhancements; and

- periodically review, on a postpayment basis, payments made to organizations to detect and recover any duplicate payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicare Advantage Program

The Balanced Budget Act of 1997, P.L. No. 105-33 § 4001, Social Security Act (the Act), § 1851(a), 42 U.S.C. § 1395w-21, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 201, 42 U.S.C. § 1395w-21 note, revised Medicare Part C and changed the name of the Medicare+Choice program to the Medicare Advantage program. The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare Advantage organizations and approves their plans to provide health care coverage to Medicare enrollees. A Medicare Advantage organization may offer more than one plan.

Programs of All-Inclusive Care for the Elderly

Section 1894 of the Act, 42 U.S.C. § 1395eee, established the Programs of All-Inclusive Care for the Elderly (PACE), which is an optional benefit under both Medicare and Medicaid. CMS contracts with PACE organizations to provide comprehensive medical and social services to the elderly. The Act requires PACE organizations to offer all items and services provided under the Medicare program.

Capitation Payments to Medicare Advantage Organizations and Programs of All-Inclusive Care for the Elderly Organizations

At the beginning of each month, CMS makes a capitation payment to Medicare Advantage organizations for medical services provided to each enrollee. Similarly, CMS makes a capitation payment at the beginning of each month to PACE organizations for medical and social services provided to each Medicare enrollee. Because of the similarities in payment methodologies for these two programs, this report collectively refers to Medicare Advantage organizations and PACE organizations as "organizations."

Federal regulations (42 CFR §§ 422.50(b) and 460.90(b)) state that an individual may be enrolled in only one Medicare Advantage or PACE plan at any given time. Section 1894(1)(B)(i) of the Act provides that an individual may not be enrolled simultaneously in both a Medicare Advantage plan and a PACE plan.

To calculate a capitation payment, CMS considers each enrollee's most currently available demographic and health status information. If CMS receives demographic or health status information on a particular enrollee that would change the previous month's payment, it makes retroactive adjustments to correct the payment level. CMS adjusts payments monthly, on both a prospective basis and a retrospective basis to the beginning of the year. Thus, CMS routinely makes multiple payment adjustments. However, CMS may make only one capitation payment per month for each Medicare enrollee.

CMS records payments made to organizations in the Medicare Advantage Prescription Drug (MARx) system. The payment history in the MARx system shows the months for which CMS made a payment, including adjustments, to an organization for each enrollee.

CMS follows the policies and procedures specified in the "Medicare Advantage Cycle Memo" to ensure the accuracy of monthly capitation payments both before and after making the payments. These procedures include validating the accuracy of data transferred to the MARx system from CMS data systems, validating the accuracy of the payment calculations as they apply to the specific organization, and tracking payment issues through resolution. If the validation process identifies inaccurate payments after the capitation payments have been made, CMS makes retroactive adjustments to correct the payment levels.

During our audit period, January 2006 through March 2008, CMS made approximately 218 million capitation payments totaling approximately $158 billion to organizations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether CMS made only one capitation payment per month for each Medicare enrollee.

Scope

We reviewed the records for all of the approximately 218 million Medicare Part C and PACE payments in the MARx system for the period January 2006 through March 2008. We identified 760 instances totaling $569,372 in which the MARx system showed that CMS had made two capitation payments on behalf of an enrollee for 1 month of coverage (duplicate payments). Because CMS made retroactive adjustments through its validation process to correct 387 of the duplicate payments, we limited our review to the 373 duplicate payments that remained uncollected as of June 2008.

We reviewed the internal controls at CMS to the extent necessary to accomplish the audit objective. We did not review or test the accuracy or completeness of the MARx system.

We performed our fieldwork from February through August 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS's policies and procedures,

- accessed the MARx system to identify duplicate payments for the audit period,

- discussed the results of our review with CMS officials and provided them with detailed data that identified each of the duplicate payments, and

- calculated the dollar amount of duplicate payments that remained uncollected as of June 2008.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the approximately 218 million capitation payments totaling approximately $158 billion that CMS made for Medicare enrollees from January 2006 through March 2008, only 373 payments totaling $300,894 were duplicate payments for 1 month of health care coverage. Although CMS had correctly paid organizations for the vast majority of enrollees, the validation process that CMS used to ensure the accuracy of payments did not identify and prevent these improper payments.

FEDERAL REQUIREMENTS

Federal regulations (42 CFR § 422.304(a)) state that ". . . CMS makes advance monthly payments . . . for coverage of original fee-for-service benefits for an individual in an MA [Medicare Advantage] payment area for a month." (Emphasis added.) In addition, 42 CFR § 422.50(b) states that "[a]n MA eligible individual may not be enrolled in more than one MA plan at any given time."

Federal regulations (42 CFR § 460.180(a)) state that ". . . CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in a payment area based on the rate it pays to a Medicare Advantage organization." (Emphasis added.) Also, 42 CFR § 460.90(b) states that a participant, ". . . while enrolled in a PACE program, must receive Medicare and Medicaid benefits solely through the PACE organization." Accordingly, 42 CFR § 460.154(i) states that if an eligible participant wants to enroll in a PACE plan, he or she must sign an enrollment agreement that contains:

> [n]otification that enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit, after enrolling as a PACE participant is considered a voluntary disenrollment from PACE.

DUPLICATE PAYMENTS

In 373 instances, CMS made two capitation payments to organizations for 1 month of health care coverage for a particular enrollee. Specifically, for the period January 2006 through March 2008, CMS made 746 capitation payments for 373 months of health care coverage under Medicare Advantage or PACE plans.[1] These duplicate payments consisted of payments to two different organizations on behalf of a single individual or two payments for different plans within one organization on behalf of a single individual.

Because Federal regulations specify that individuals may be enrolled in no more than one Medicare Advantage or PACE plan at any given time and that only one capitation payment per month may be made for each Medicare enrollee, the 373 duplicate payments totaling $300,894 were improper.

In well over 99 percent of the payments during our audit period, CMS made only one monthly capitation payment for each enrollee, as required. However, CMS officials explained that the validation process that they used to ensure the accuracy of payments did not identify and prevent all duplicate payments.

RECOMMENDATIONS

We recommend that CMS:

- recoup the $300,894 in improper payments;

- determine whether enhancements to its validation process would be cost effective and, if so, implement the enhancements; and

- periodically review, on a postpayment basis, payments made to organizations to detect and recover any duplicate payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. Specifically, CMS stated that it would recoup the duplicate payments and that it had implemented or was finalizing appropriate controls for its validation process to minimize duplicate payments.

CMS's comments are included in their entirety as the Appendix.

[1]Of the 373 duplicate capitation payments, 345 were payments to Medicare Advantage organizations and 28 were payments to PACE organizations.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUN 16 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Duplicate Capitation Payments to Medicare Advantage Organizations and Programs of All-Inclusive Care for the Elderly Organizations" (A-07-08-01052)

Thank you for the opportunity to review and comment on the OIG's draft report entitled "Review of Duplicate Capitation Payments to Medicare Advantage Organizations and Programs of All-Inclusive Care for the Elderly Organizations" (A-07-08-01052). The OIG studied capitation payments to Medicare Advantage organizations and Programs of All-Inclusive Care for the Elderly Organizations to determine whether the Centers for Medicare & Medicaid Services (CMS) made only one capitation payment per month for each Medicare enrollee. The OIG noted that CMS correctly paid organizations for the vast majority of enrollees but made three recommendations.

OIG Recommendation

The OIG recommended CMS recoup the $300,894 in improper payments.

CMS Response

The CMS concurs with the OIG that these funds should be recouped. CMS will recoup these excess payments through system fixes, subsequent clean-ups and scheduled adjustments. CMS is analyzing what caused the error and will correct the system which then automatically adjusts prior and subsequent payments.

Furthermore, as discussed below, CMS will implement the necessary checks to minimize duplicate payments in the future.

OIG Recommendation

The OIG recommended CMS determine whether enhancements to its validation process would be cost effective and, if so, implement the enhancements.

CMS Response

The CMS concurs with this recommendation. Discussion of a control to identify duplicate payments began in the summer of 2008 and, since November 2008, CMS has been formally testing a new control as part of the monthly Beneficiary Payment Validation (BPV) procedure to identify duplicate payments. The BPV is conducted in the monthly payment authorization process and involves validating the beneficiary-level Medicare Advantage-Prescription Drug System (MARx) payment files. This new control is being implemented as phase five of the BPV, entitled "Multiple Enrollment Analysis." This analysis identifies beneficiaries on whose behalf CMS may be making an excess number of payments for a given month due to enrollment in multiple contracts. The analysis identifies original health insurance claim numbers with multiple prospective payment records on the Monthly Membership Report. Beneficiaries' enrollment patterns are then categorized by organization type and records are flagged. In cases where the combination of multiple contracts is not valid, these occurrences are counted as a mismatch and are identified as potential duplicate payments to be further analyzed and corrected if necessary. Each month a spreadsheet is produced, which lists all instances of potential duplicate payments that may not be permitted according to enrollment rules by organization type and contract/plan number. In addition to the current month's findings, total potential duplicate payment figures for the previous 2 months are also provided.

For April 2009 payments, a total of 70 beneficiaries were identified as having potentially questionable enrollments in multiple plans. These cases have been forwarded to enrollment staff for further investigation and enrollment resolution. While CMS is using this control to identify potential duplicate payments, it is finalizing the format of the monthly spreadsheet to make it more user-friendly. CMS expects to finalize the spreadsheet in the next few months.

Furthermore, CMS implemented the Common Medicare Environment and the Beneficiary Link Key Cross-Reference Solution in July 2007, which CMS believes significantly decreases the chance of actual duplicate payments.

OIG Recommendation

The OIG recommended CMS periodically review, on a post-payment basis, payments made to organizations to detect and recover any duplicate payments.

CMS Response

The CMS concurs that it should detect and recover duplicate payments. As discussed above, CMS believes it has in place, or is finalizing, appropriate controls to minimize future duplicate payments. It also believes that the funds paid out for duplicate payments will be recouped through system fixes.

Again, thank you for the opportunity to provide review and comment on this draft report.