

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**VIRGINIA MADE CAPITATION PAYMENTS
TO MEDICAID MANAGED CARE
ORGANIZATIONS AFTER ENROLLEES'
DEATHS**

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**July 2023
A-03-22-00203**

Office of Inspector General

<https://oig.hhs.gov>

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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.

Report in Brief

Date: July 2023

Report No. A-03-22-00203

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Virginia pays Medicaid managed care organizations (MCOs) to make services available to Medicaid enrollees in return for a monthly fixed payment for each enrollee (capitation payment). Previous OIG audits found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased enrollees. We conducted a similar audit of Virginia.

Our objective was to determine whether Virginia made capitation payments to MCOs on behalf of deceased Medicaid enrollees.

How OIG Did This Audit

Our audit covered 58,351 capitation payments totaling over \$70.8 million that Virginia made to MCOs and claimed for Federal reimbursement during calendar years 2019 through 2021 (audit period) on behalf of 12,054 enrollees whose dates of death, as recorded in one or more of the data sources we consulted, preceded the monthly service periods covered by the capitation payments.

We selected and reviewed a stratified random sample of 100 capitation payments totaling \$319,525 (\$195,219 Federal share) from those 58,351 capitation payments.

Virginia Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees' Deaths

What OIG Found

The State agency made unallowable capitation payments after enrollees' deaths. For 67 of the 100 capitation payments in our sample, Virginia made unallowable capitation payments totaling \$76,939 (\$51,062 Federal share). For 30 of the remaining capitation payments in our sample, Virginia adjusted the capitation payments before our audit. We could not fully confirm that the remaining 3 enrollees associated with 3 of the 100 capitation payments were deceased.

Based on our sample results, we estimated that Virginia made unallowable capitation payments totaling at least \$21.8 million (\$15.7 million Federal share) to MCOs on behalf of 12,054 deceased enrollees during our audit period.

Virginia made unallowable capitation payments on behalf of deceased enrollees because it did not have adequate controls in place to enable it to identify all deceased enrollees and properly cancel their enrollment.

What OIG Recommends and Virginia Comments

We recommend that Virginia: (1) refund \$15.7 million to the Federal Government; (2) identify and recover unallowable capitation payments, which we estimate to be at least \$21.8 million, made to MCOs during our audit period on behalf of deceased enrollees; and (3) identify and recover unallowable capitation payments made on behalf of deceased enrollees in 2018 and 2022 and repay the Federal share of amounts recovered. We also recommended that Virginia continue to pursue development and implementation of an automated matching and eligibility update process and implement additional supervisory review. The full recommendations are in the report.

In written comments on our draft report, Virginia did not specifically indicate whether it concurred with our recommendations, but it provided information about actions it has taken or plans to take to address them. These actions include reconciling data, implementing supervisory review, closing enrollments, and recouping funds.

TABLE OF CONTENTS

INTRODUCTION 1

 Why We Did This Audit 1

 Objective 1

 Background 1

 Medicaid Program..... 1

 Social Security Administration and Death Record Information..... 2

 Federal and State Requirements 2

 Virginia’s Medicaid Managed Care Program 3

 How We Conducted This Audit 3

FINDING..... 4

 The State Agency Made Unallowable Medicaid Capitation Payments to
 Medicaid Managed Care Organizations 4

RECOMMENDATIONS 5

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE 6

APPENDICES

 A: Audit Scope and Methodology 8

 B: Related Office of Inspector General Reports..... 10

 C: Statistical Sampling Methodology 11

 D: Sample Results and Estimates 12

 E: State Agency Comments 13

INTRODUCTION

WHY WE DID THIS AUDIT

The Virginia Department of Medical Assistance Services (State agency) pays Medicaid managed care organizations (MCOs) to make services available to Medicaid enrollees in return for a monthly fixed payment for each enrollee (capitation payment). Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased enrollees.¹ We conducted a similar audit of the State agency, which administers the Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid capitation payments to MCOs on behalf of deceased Medicaid enrollees.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid enrollees. States contract with MCOs to make services available to individuals enrolled with Medicaid MCOs, usually in return for capitation payments. States report capitation payments claimed by Medicaid MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10). During our audit period, the FMAP in Virginia ranged from 50 to 93 percent.²

¹ See Appendix B for related OIG reports.

² FMAP rates varied based on both the quarter in which the capitation payment was paid as well as the program in which the enrollee participated.

Social Security Administration and Death Record Information

The Social Security Administration (SSA) maintains death record information, including the date of death. SSA obtains death information from many sources, such as relatives of deceased enrollees, physicians, lawyers, accountants, and other Federal or State agencies, and processes death notifications through its Death Information Processing System when it receives reports of death.³ SSA records the resulting death information in its Numerical Identification System (the Numident).⁴ SSA then uses information from the Numident to create a national record of death information called the Death Master File (DMF).⁵

Federal and State Requirements

A capitation payment is “a payment the State [agency] makes periodically to [an MCO] on behalf of each beneficiary enrolled under a contract . . . for the provision of services under the State plan. The State [agency] makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment” (42 CFR § 438.2).

The State agency’s contracts with the MCOs provide for the recovery of capitation payments and specify that the State agency will recoup an enrollee’s capitation payment for a given month if an enrollee’s exclusion or disenrollment is effective retroactively due to circumstances such as the enrollee’s death. The contracts also provide for the recovery of additional capitation payments made after an enrollee’s death. The State agency will not recoup an enrollee’s capitation payment for a given month if the member is eligible for any portion of the month (Medallion Medicaid Managed Contract §§ 15.7 and 15.8 and Commonwealth Coordinated Care Plus (CCC Plus) MCO Contract §§ 19.10.9 and 19.9.9).

During the Public Health Emergency (PHE), the State agency made changes to its eligibility and enrollment operations to comply with the continuous enrollment condition under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA), which was in effect from March 18, 2020, through the end of our audit period.⁶ The State agency informed us that it continued to cancel deaths during the PHE and, in response to the FFCRA, the State agency indicated that, “Continuity of coverage will remain in place for Medicaid members through the end of the . . . Maintenance of Effort (MOE). No closures or reduction of coverage will be taken on Medicaid enrollments through the end of the federally declared emergency unless a death is reported, an enrollee moves from Virginia permanently, or an enrollee requests closure of

³ SSA, *Program Operations Manual System*, GN 02602.050 (Oct. 30, 2017).

⁴ The Numident contains personally identifiable information for each individual issued a Social Security number (SSN).

⁵ Data maintained in the DMF include names, SSNs, dates of birth, and dates of death.

⁶ Under the Consolidated Appropriations Act, 2023, the continuous enrollment condition will end on March 31, 2023, and will no longer be linked to the end of the PHE.

coverage.”⁷ Federal regulations at 42 CFR section 435.912(e)(2) provide an exception in meeting timeliness standards for processing Medicaid renewals and changes in circumstances during an emergency beyond the agency’s control, such as the PHE.

Virginia’s Medicaid Managed Care Program

Since 1969, Virginia Medicaid has focused on improving the health and well-being of Virginians. In 1991, CMS approved Virginia’s Medicaid waiver application to begin a Medicaid primary care managed care program. In 1995, this managed care model, known as Medallion, began as a pilot program in five counties and was ultimately expanded statewide; Virginia’s Medicaid program adopted the use of MCOs that same year.

In 2019, the State agency oversaw the largest Medicaid expansion in its history. Enhanced eligibility increased membership, with the majority of these individuals served through the State agency’s two largest managed care programs, Medallion 4.0 and CCC Plus. Virginia’s Medicaid managed care program has continued to expand under the expanded eligibility guidelines. Through its managed care programs, Virginia has six MCOs from which enrollees can elect coverage.

The Enrollment Unit within the State agency is responsible for: (1) enrollment coverage corrections in the Medicaid Management Information System (MMIS)⁸ based on requests from local Departments of Social Services; (2) patient pay corrections in MMIS based on requests from local agencies and providers; (3) cancellation of coverage for deceased individuals based on reporting from the Virginia Department of Health, Office of Vital Records; (4) research and correction of duplicate enrollments; and (5) research and resolution of monthly enrollment reports related to Social Security number (SSN) discrepancies and other related issues.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 58,351 capitation payments totaling \$70.8 million made by the State agency to MCOs and claimed for Federal reimbursement during calendar years 2019 through 2021 (audit period) on behalf of 12,054 enrollees whose dates of death, as recorded in one or more of the data sources we consulted, preceded the monthly service periods covered by the capitation payments.

We selected for review a stratified random sample of 100 capitation payments totaling \$319,525 (\$195,219 Federal share) from those 58,351 capitation payments. We provided the list of 100 capitation payments to the State agency for its review. We used the results of this

⁷ The State agency published a document on its website to indicate all of the active flexibilities in place due to the PHE. The document is updated with end dates for the flexibilities and is located at [COVID-19 Public Health Emergency Flexibilities, Updated January 14, 2022 \(virginia.gov\)](https://www.virginia.gov/COVID-19-Public-Health-Emergency-Flexibilities-Updated-January-14-2022).

⁸ An MMIS is a system of software or hardware and used to process Medicaid claims and manage information about Medicaid enrollees and services. This system is operated by the State agency.

review to estimate the total amount and the Federal share of the unallowable capitation payments.

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 findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDING

The State agency made unallowable capitation payments after enrollees' deaths. For 67 of the 100 capitation payments in our sample, the State agency made unallowable capitation payments totaling \$76,939 (\$51,062 Federal share).⁹ For 30 of the remaining capitation payments in our sample, the State agency adjusted the capitation payments before our audit start. Based on SSA and State agency data available to us, we could not fully confirm that the remaining 3 enrollees associated with 3 of the 100 capitation payments were deceased, and therefore we considered these 3 capitation payments allowable.¹⁰

Based on our sample results, we estimated that the State agency made unallowable capitation payments totaling at least \$21.8 million (\$15.7 million Federal share) to MCOs on behalf of the 12,054 deceased enrollees during our audit period.¹¹

The State agency made unallowable capitation payments on behalf of deceased enrollees because it did not have adequate controls in place to enable it to identify all deceased enrollees and properly cancel their enrollment.

THE STATE AGENCY MADE UNALLOWABLE MEDICAID CAPITATION PAYMENTS TO MEDICAID MANAGED CARE ORGANIZATIONS

Contractual agreements between the State agency and the MCOs provide for the recovery of capitation payments made after enrollees' deaths. The recoupment/reconciliation provision in

⁹ The 67 capitation payments were made for enrollees whose dates of death preceded the service month of the capitation payment. Of the 67 capitation payments, 18 did not result in monetary errors because of adjustments, and the remaining 49 resulted in unallowable capitation payment amounts. None of the 67 enrollees for whom the capitation payments were made were marked as deceased in the MMIS system.

¹⁰ Our sample consisted of 100 capitation payments for enrollees identified as deceased in the SSA DMF; however, 3 capitation payments were for enrollees who were erroneously linked to a deceased individual in the DMF due to incorrect information in Virginia's MMIS.

¹¹ We estimated that the State agency made unallowable capitation payments totaling at least \$21,849,401 (\$15,702,584 Federal share).

the State agency's contracts with the MCOs provides for the recovery of capitation payments and specifies that the State agency will recoup a member's capitation payment for a given month in cases in which a member's exclusion or disenrollment was effective retroactively. The State agency will not recoup a member's capitation payment for a given month in cases in which a member is eligible for any portion of the month. This provision applies to cases, such as the death of a member, when the loss of eligibility or exclusion can occur throughout the month (Medallion Medicaid Managed Contract §§ 15.8 and 15.7 and CCC Plus MCO Contract §§ 19.10.9 and 19.9.9).

During our audit period, the State agency made unallowable capitation payments totaling \$76,939 (\$51,062 Federal share) to MCOs for 67 sampled capitation payments for deceased enrollees.¹²

Based on our sample results, we estimate that the State agency did not identify and recover at least \$21.8 million (\$15.7 million Federal share) in unallowable capitation payments to certain MCOs on behalf of deceased enrollees.¹³

The State agency made these unallowable capitation payments because it did not have adequate controls in place to identify deceased enrollees and properly cancel their enrollment. Specifically, although the State agency has policies in place to update enrollee eligibility upon an enrollee's death, the State agency uses a manual process to match, research, and initiate eligibility changes and employs limited resources to complete these processes. During our audit, the State agency mentioned that it was in the process of developing an automated process to match and initiate eligibility changes for those enrollees whose deaths are a direct match to the SSA death records. This combination of a manual process, limited staffing, and a backlog of tasks led to missed cancellations for deceased enrollees. Additionally, the State agency has limited staffing for review of this process, which further contributed to inaccurate or incomplete cancellations.

RECOMMENDATIONS

We recommend that the Virginia Medicaid Department of Medical Assistance Services:

- refund \$15,702,584 to the Federal Government;
- identify and recover unallowable capitation payments, which we estimate to be at least \$21,849,401, made to MCOs during our audit period on behalf of deceased enrollees;

¹² The State agency agreed that these 67 enrollees were deceased and took action to cancel these individuals' enrollment in the MMIS. The cancellations initiated the recoupment of the capitation payments made to MCOs.

¹³ The full estimated amount is at least \$21,849,401 (\$15,702,584 Federal share).

- identify and recover unallowable capitation payments made on behalf of deceased enrollees in 2018 and 2022 (the years before and after our audit period) and repay the Federal share of amounts recovered;
- continue to pursue development and implementation of an automated matching and eligibility update process; and
- implement additional supervisory review to ensure that State agency personnel completely and accurately update the State agency's eligibility system based on information provided by the Virginia Department of Health's Office of Vital Statistics.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not specifically indicate whether it concurred with our recommendations, but it provided information about actions it has taken or plans to take to address them. Regarding our first recommendation, the State agency noted that it will work with CMS's Center for Medicaid and CHIP Services Audit and Review Branch and will repay any outstanding debit that has not been repaid through the recoupment process.¹⁴ For our second recommendation, the State agency stated that, as of June 9, 2023, all of the capitation payments made on behalf of deceased enrollees during the audit period were recouped except for \$95,677. For our third recommendation, the State agency reported that, as of June 9, 2023, all of the capitation payments made in 2018 on behalf of deceased enrollees have been recouped except for \$226,023 and all payments made in 2022 have been recouped. The State agency stated that it will recoup the remaining balances noted above.

For our fourth recommendation, the State agency is continuing to explore additional options to strengthen processes to use death information as reported by the managed care plans and, potentially, SSA data as well as other reliable data sources to proactively determine whether enrollees are deceased but not reported as such in the Virginia Department of Health's Office of Vital Statistics data exchange process. In addition, for our fourth and fifth recommendations, the State agency described a newly implemented process that it states will increase the timeliness of the death match review process while reducing human error. The State agency stated that, in January of 2023, it implemented a system change to automatically close the enrollment of individuals identified as a 100-percent match using information provided by the Virginia Department of Health's Office of Vital Statistics. The State agency also noted that it has implemented an additional supervisory review to ensure that any enrollment closures that were not acted on through the automated process are reviewed and accurately updated within the State agency's eligibility system.

The State agency provided additional clarifying comments, which we reviewed. We determined that no additional changes to the report were necessary as a result of those comments. We

¹⁴ CHIP is the Children's Health Insurance Program.

maintain that our recommendations are valid and that the State agency should continue to work with CMS until the balances are recouped and the Federal Government is refunded.

The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 58,351 capitation payments totaling \$70,836,654 made by the State agency to MCOs and claimed for Federal reimbursement on behalf of 12,054 enrollees whose dates of death, as recorded in one or more of the data sources we consulted, preceded the monthly service periods during January 1, 2019, through December 31, 2021, (audit period) covered by the capitation payments. We selected for review a stratified random sample of 100 capitation payments totaling \$319,525 (\$195,219 Federal share) from those 58,351 capitation payments.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the control activities designed and implemented to prevent and detect capitation payments made to MCOs on behalf of deceased enrollees. However, because our audit was limited to this internal control component and underlying principles, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

We performed our audit work from March 2022 through February 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments after an enrollee's death;
- reviewed the State agency's contracts with the MCOs during the audit period;
- obtained from the State agency a file of capitation payments made to MCOs on behalf of Medicaid enrollees for the audit period;
- requested that the State agency reconcile the 82,283,328,467 capitation payments totaling \$32,260,367,958 that it made to MCOs during the audit period to the Forms CMS-64 that the State agency had prepared and submitted to CMS;
- used both Medicaid claims data from the Transformed Medicaid Statistical Information System, and capitation payment data provided by the State agency and matched that data to the SSA DMF to confirm the list of deceased enrollees;
- created a sampling frame consisting of 58,351 capitation payments totaling \$70,836,654 claimed for Federal reimbursement and made on behalf of enrollees who had dates of death preceding the capitation service dates;

- selected for review a stratified random sample of 100 capitation payments totaling \$319,525 (\$195,219 Federal share) on behalf of deceased enrollees;
- obtained, for each sampled capitation payment, current documentation from the State agency to determine:
 - whether the enrollees' first and last names, SSNs, dates of birth (ensuring that the information matched the DMF), and Medicaid identification numbers were correct,
 - whether the MMIS identified the enrollees' dates of death,
 - whether a capitation payment occurred for the service month (ensuring the accuracy of the paid amount), and
 - whether any adjustments were made for the sampled capitation payments;
- determined, for each of the sampled capitation payments, the Federal share of the unallowable payments made after an enrollee's death by:
 - obtaining the annual FMAP rates from the Federal Register,
 - obtaining the FMAP rates from the State agency for each enrollee for whom a payment was sampled and matched the applicable rates to those corresponding capitation payments reviewed using the date each payment was made, and
 - calculating the Federal payment by multiplying the payments by the applicable FMAP rate;
- used OIG/OAS statistical software to estimate the total amount and Federal share of unallowable capitation payments made on behalf of deceased enrollees who had a date of death recorded in the DMF that preceded the service month covered by the capitation payment;
- provided State agency officials with data supporting the results of our findings and solicited the State agency's input on these findings to determine their causes; and
- discussed the results of our audit with State agency officials.

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 findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Kansas Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-07-20-05125</u>	9/01/2021
<i>North Carolina Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths</i>	<u>A-04-16-00112</u>	9/25/2020
<i>The New York State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-04-19-06223</u>	7/27/2020
<i>Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths</i>	<u>A-05-17-00048</u>	2/14/2020
<i>The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-05-19-00007</u>	1/29/2020
<i>The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-05-17-00049</u>	10/1/2019
<i>Illinois Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-18-00026</u>	8/20/2019
<i>Georgia Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-04-15-06183</u>	8/9/2019
<i>California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-04-18-06220</u>	5/7/2019
<i>Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-17-00008</u>	10/4/2018
<i>Wisconsin Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-17-00006</u>	9/27/2018
<i>Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-04-15-06190</u>	12/22/2017
<i>Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-06-16-05004</u>	11/14/2017
<i>Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-04-15-06182</u>	11/30/2016

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 58,351 capitation payments totaling \$70,836,654 that were made to MCOs and claimed for Federal reimbursement on behalf of deceased enrollees for service dates during calendar years 2019 through 2021.

SAMPLE UNIT

The sample unit was a monthly capitation payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as depicted in Table 1.

Table 1: Strata Based on Medicaid Capitation Payments

Stratum	Payment Range	Number of Capitation Payments	Total Payment Amount	Sample Size
1	\$1 to \$900	37,659	\$18,385,036	25
2	\$901 to \$2,110	13,318	19,999,860	25
3	\$2,111 to \$4,499	5,100	17,667,799	25
4	\$4,500 to \$21,321	2,274	14,783,958	25
	Totals*	58,351	\$70,836,654	100

*Amounts may not add exactly due to rounding.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted items in each stratum by “Claim Line Paid Amount,” “Claim Recipient State Medicaid ID,” and “Claim From Date,” and then we consecutively numbered the sample units within strata 1 through 4. After generating the random numbers for each stratum, we selected the corresponding sample units in the sampling frame.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total dollar value and Federal share of unallowable capitation payments in our sampling frame made to MCOs and claimed for Federal reimbursement on behalf of enrollees whose dates of death preceded the monthly service periods (during the audit period) covered by the capitation payments. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Number of Payments in Frame	Total Value of Frame	Sample Size	Total Value of Sample	Number of Unallowable Payments	Total Value of Unallowable Payments	Value of Unallowable Payments (Federal Share)
1	37,659	\$18,385,036	25	\$11,869	18	\$7,876	\$6,265
2	13,318	19,999,860	25	37,708	20	15,874	11,498
3	5,100	17,667,799	25	87,487	15	16,932	10,918
4	2,274	14,783,958	25	182,461	14	36,257	22,381
Totals*	58,351	\$70,836,654	100	\$319,525	67	\$76,939	\$51,062

*Amounts may not add exactly due rounding.

**Table 3: Estimated Value of Unallowable Payments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)**

	Total Amount	Federal Share
Point estimate	\$27,071,915	\$19,826,162
Lower limit	\$21,849,401	\$15,702,584
Upper limit	\$32,294,430	\$23,949,739

APPENDIX E: STATE AGENCY COMMENTS



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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June 13, 2023

Nicole Freda
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Washington, DC 20201

Report Number: A-03-22-00203

Dear Ms. Freda:

In February 2023 the Office of the Inspector General (OIG) provided a file identifying 12,055 Virginia Medicaid members as being potentially deceased, but not closed in the state's enrollment system, the Medicaid Enterprise System (MES). The Virginia Medicaid agency, the Department of Medical Assistance Services (DMAS), researched the members on this report to determine the accuracy of the findings.

Background

DMAS utilizes death information as obtained from the Virginia Department of Health (VDH) through a monthly data exchange. This exchange contains individuals for whom a death certificate was filed with the state serving as a source of truth of individuals positively identified as deceased in the Commonwealth. Historically, the state has run this information through algorithm which cross references Medicaid enrollees into categories of those that are 100% match and those who are possible matches to information contained in MES. After proper notification, state staff within the Eligibility and Enrollment Services Division would manually close all 100% matches and research those enrollments with a lesser match rate. This process was found to be inefficient as the level of manual work would often take up to a month to complete.

In January of 2023, the Commonwealth implemented a system change to automatically close individuals identified as a 100% match. This new process has increased the timeliness of this process, while reducing human error. All enrollments are retroactively closed back to the individual's date of death, which then initiates the states recoupment of any managed care capitation payments or fee-for-service claims. Any matches that are less than a 100% match still require manual research by staff to confirm accuracy.

OIG Audit Results

Upon receipt of the file provided by the OIG, the Medicaid agency's review of the 12,055 members found the following results:

- 8,787 members identified on the OIG list were previously closed retroactively to the member's date of death with no additional action required by the state. The requested screen shots and verification will be provided to the CMCS Audit and Review Branch.
 - Through the state's normal automated process, capitation payments for this population were recouped and federal funding has been/will be returned to CMS using the CMS-64 process.
- The remaining 3,296 members were run against previously received VDH death files to determine the accuracy of the deceased information provided by the OIG.
 - 1,460 members were found on the VDH death file that had not been previously closed by the Medicaid agency. Using the agency's new automated closure process, action was taken to immediately close these enrollments back to the member's date of death. All capitation payments were recouped through the normal process. This recoupment occurred in April 2023. Federal funding will be/has been returned to CMS using the CMS-64 process by June 30, 2023.
 - The remaining 1,836 members did not match any records on the VDH death file, and therefore, required a manual review to confirm the death information found on the OIG file.
 - To date, 1,836 members have been researched with the following findings:

246 individuals found on the OIG file were confirmed as not deceased.

681 individuals on the OIG file did not have a date of death listed by SSA although SSA did show the individual in a deceased status. DMAS cannot close these individuals without confirming the individual is deceased and if so, confirming the individual's date of death. This listing has been sent to the local Department of Social Services (DSS) where the case is maintained for further research.

850 individuals on the OIG file were confirmed as deceased. Action has been taken to close each of these enrollments back to the date of death as reported in the SSA findings.

59 individuals on the OIG file did not have a date of death listed by SSA. Upon manual review, these individuals were identified as no longer meeting Virginia residency requirements (out-of-state addresses). Case closure requires confirmation of out-of-state address.

The State's Responses to the Recommendations

- DMAS will work with the CMCS Audit and Review Branch and will repay any outstanding debit that has not been repaid through the recoupment process.
- As of June 9, 2023, all of the capitation payments made to deceased enrollees during the audit period of 2019, 2020, and 2021 were recouped except for \$95,677.
- As of June 9, 2023, all of the capitation payments made in 2018 on behalf of deceased enrollees have been recouped except for \$226,023 while all payments made in 2022 have been recouped.
- DMAS will be recouping the remaining balances above as well.
- In January of 2023, the Commonwealth implemented a system change to automatically close individuals identified as a 100% match utilizing information provided by the Virginia Department of Health's Office of Vital Statistics through a monthly data exchange. This new process has increased the timeliness of this process, while reducing human error. All enrollments are retroactively closed back to the individual's date of death, which then initiates the recoupment of any managed care capitation payments or fee-for-service claims.
- Since implementing the automated process utilizing the monthly data file from the Virginia Department of Health's Office of Vital Statistics, the state has experienced a 98% - 100% match rate and automated closure each month. Any matches that are not acted on through the automated process require manual action. DMAS has implemented an additional supervisory review to ensure any closures which were not acted on through the automated process are reviewed and accurately updated within DMAS's eligibility system.
- DMAS is continuing to explore additional options to strengthen processes to include utilizing death information as reported by the managed care plans and the potential use of SSA data as well as other reliable data sources to proactively determine members who may be deceased, yet not reported on through the Virginia Department of Health's Office of Vital Statistics data exchange process.

Sincerely,



Cheryl Roberts, JD
Agency Director