



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VI  
1100 Commerce Street, Room 632  
Dallas, TX 75242

November 6, 2009

Report Number: A-06-09-00065

Mr. Thomas Suehs  
Executive Commissioner  
Texas Health and Human Services Commission  
4900 North Lamar Boulevard – 7th Floor  
Austin, Texas 78751

Dear Mr. Suehs:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled “Review of Medicaid Payments for Services Claimed To Have Been Rendered to Deceased Recipients in Texas.” We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Michelle Richards, Senior Auditor, at (214) 767-9202 or through email at [Michelle.Richards@oig.hhs.gov](mailto:Michelle.Richards@oig.hhs.gov). Please refer to report number A-06-09-00065 in all correspondence.

Sincerely,

/Patricia Wheeler/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Jackie Garner, Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICAID PAYMENTS FOR  
SERVICES CLAIMED TO HAVE BEEN  
RENDERED TO DECEASED RECIPIENTS IN  
TEXAS**



Daniel R. Levinson  
Inspector General

November 2009  
A-06-09-00065

# *Office of Inspector General*

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **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**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. In Texas, the Health and Human Services Commission (the State agency) administers the program.

The Social Security Administration (SSA) maintains comprehensive death records by purchasing death certificate information. This information is available to State and Federal agencies to assist in preventing payments for services purportedly provided to Medicaid recipients after they are deceased. The State agency performs monthly reviews of claims and recipient eligibility to identify and recover these types of payments. The claim reviews exclude claims for which Medicaid was the secondary payer to Medicare (Medicare crossover claims) and primary care case management claims.

### **OBJECTIVE**

Our objective was to identify Texas Medicaid payments made to providers for claims with dates of service that followed recipients' deaths.

### **SUMMARY OF FINDINGS**

We identified Texas Medicaid payments made to providers for claims with dates of service that purportedly followed recipients' deaths. Specifically, for claims with dates of service between July 1, 2005, and June 30, 2006, the State agency paid a total of \$148,598 for 1,370 claims for 84 recipients whose dates of death were reported as having occurred as of June 30, 2005. Of the 84 recipients:

- The State agency paid \$18,695 (\$11,355 Federal share) for 178 claims for 38 recipients who were confirmed deceased as of June 30, 2005. Of the 178 claims, 122 were claims for Medicare crossover claims and 18 were primary care case management claims. The remaining 38 claims were types that were included in the monthly reviews. The State agency had not appropriately identified and recovered these potential overpayments through its normal review process.
- The State agency paid \$18,129 for 344 claims for 16 recipients who died after June 30, 2005. Of the 16 recipients, 11 were alive when the services were performed and 4 were deceased after our claims year. For the remaining recipient, there were two claims totaling \$13 after the date of death. Neither claim was a primary care case management or Medicare crossover claim. We did not determine whether the State agency had identified and recouped the \$13 potential overpayment.
- The State agency paid \$111,774 for 848 claims for 30 recipients who we could not determine to be deceased. Of the 848 claims, 498 were Medicare crossover claims and

41 were primary care case management claims. The remaining 309 claims were types that were included in the monthly reviews.

These overpayments occurred because the State agency did not have adequate controls over the prevention, identification, and recovery of payments for services purportedly provided after recipients' deaths and because the monthly reviews did not include primary care case management or Medicare crossover claims.

## **RECOMMENDATIONS**

We recommend that the State agency:

- review the adequacy of the 178 claims totaling \$18,695 (\$11,355 Federal share) and, for those determined to be erroneous, recover the payments and refund the Medicaid program;
- review claims with dates of service before and after our claims period for additional payments for the 38 recipients;
- expand the scope of its monthly reviews to include all Medicaid recipients and all claim types;
- determine whether the claims for the individual who was confirmed deceased after June 30, 2005, had been identified and recovered; and
- work with SSA to determine whether the 30 recipients whose status could not be verified are deceased.

## **STATE AGENCY COMMENTS**

In its comments on our draft report, the State agency agreed with our recommendations.

Additionally, the State agency recommended that all references to “managed care claims” be removed and replaced with “Medicaid claims” to avoid potential confusion. We reviewed primary care case management claims, which are paid on a fee-for-service basis, rather than typical managed care claims, which are paid using a traditional capitated payment model. Therefore, we will replace the term “managed care claims” with “primary care case management claims” in this report.

The State agency’s comments are included in their entirety as the Appendix.

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## INTRODUCTION

### BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. 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 the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, the Health and Human Services Commission (the State agency) administers the program.

The Social Security Administration (SSA) maintains comprehensive death records by purchasing death certificate information from State Governments and obtaining death notifications from funeral homes and friends and family of the deceased. All reported deaths of people who have Social Security numbers are routinely added to SSA's Death Master File. This information is available to State and Federal agencies to assist in preventing payments for services purportedly provided to Medicaid recipients after they are deceased.

The State Bureau of Vital Statistics maintains death records for deaths that occur in Texas. The State agency obtained death information from other State departments or from family members.

From July 2005 through June 2006, the State agency processed more than 42 million Medicaid claims totaling over \$6 billion. The State agency performs monthly reviews of claims and recipient eligibility to identify and recover Medicaid overpayments for services purportedly provided after recipients' deaths. The claim reviews exclude claims for which Medicaid was the secondary payer to Medicare (Medicare crossover claims) and primary care case management claims. Several State agency offices are involved in the monthly review process. The State agency's Office of Inspector General (OIG), Technology Analysis, Development & Support office (TADS) begins the process by comparing Social Security numbers listed in the Texas Medicaid eligibility file that is maintained by the Office of Eligibility Services (OES) with a cumulative list of the monthly SSA Death Master File updates. TADS shares the results of the comparison with the OIG, General Investigations office.

TADS also performs monthly claim reviews by cross referencing paid claims with the death records received from the State Bureau of Vital Statistics. The reviews exclude primary care case management claims and claims for which Medicaid is the secondary payer to Medicare (Medicare crossover claims).

Once General Investigations receives the results from TADS, an investigator verifies whether the recipient has an active case file. If the case is not active and the person on the death match is the only person listed on the case, then the investigator closes the investigation. If the case is active, the investigator attempts to verify the death and, based on the results, notifies the OES regional match coordinator to take the appropriate action.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to identify Texas Medicaid payments made to providers for claims with dates of service that followed recipients' deaths.

### **Scope**

We selected Texas Medicaid recipients who were listed as deceased as of June 30, 2005, in the SSA Death Master File and had payments made on their behalf to providers for claims with dates of service between July 1, 2005, and June 30, 2006. We identified 1,370 claims totaling \$148,598 for 84 recipients.

We compared the dates of death noted in the Texas Medicaid eligibility file or the State Bureau of Vital Statistics' file to SSA's dates of death to confirm whether the recipients were deceased. If the date of a recipient's death that was listed in SSA's file was the same as the date in one of the two State files or was different but both were on or before June 30, 2005, then we accepted the SSA date of death as accurate and determined whether the State agency had already recovered the amounts paid for claims with dates of service between July 1, 2005, and June 30, 2006. If the date of a recipient's death that was listed in one of the State's files was different from the date in SSA's file and was after June 30, 2005, we requested and reviewed supporting documentation from the State and determined whether there were any claims during our claim year that were for services purportedly provided after the recipient's death. If we were able to obtain conclusive evidence of death, such as a death certificate, and the date of death was after June 30, 2005, then we determined that the SSA date of death was incorrect. If the State had no evidence proving a recipient's death, then we set those claims for services aside as inconclusive.

We did not review the overall internal control structure of the State Medicaid program. We limited our internal control review to obtaining an understanding of the State Medicaid program's procedures to identify payments for services claimed to have been provided for deceased individuals and to recover the overpayments.

We conducted our audit work from May through August 2009.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Medicaid laws and regulations;
- reviewed the State agency's policies and procedures related to death notification and to preventing payments or recovering payments for services purportedly provided subsequent to the recipients' death dates;

- matched the Texas Medicaid eligibility file to the SSA Death Master File by Social Security number, date of birth, and name to identify potentially deceased Texas Medicaid recipients;
- limited the universe to those recipients who had paid claims from July 1, 2005, to June 30, 2006;
- compared SSA death information to State agency or State Bureau of Vital Statistics data to determine whether the SSA date of death was accurate for each recipient;
- determined whether the State agency had identified and recovered overpayments for recipients who were confirmed deceased as of June 30, 2005, or whether the payments remained outstanding; and
- coordinated our review with the State agency.

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 objective.

## **FINDINGS AND RECOMMENDATIONS**

We identified Texas Medicaid payments made to providers for claims with dates of service that purportedly followed recipients' deaths. Specifically, for claims with dates of service between July 1, 2005, and June 30, 2006, the State agency paid a total of \$148,598 for 1,370 claims for 84 recipients whose dates of death were reported as having occurred as of June 30, 2005. Of the 84 recipients:

- The State agency paid \$18,695 (\$11,355 Federal share) for 178 claims for 38 recipients who were confirmed deceased as of June 30, 2005. Of the 178 claims, 122 were Medicare crossover claims and 18 were primary care case management claims. The remaining 38 claims were types that were included in the monthly reviews. The State agency had not appropriately identified and recovered these overpayments through its normal review process.
- The State agency paid \$18,129 for 344 claims for 16 recipients who died after June 30, 2005. Of the 16 recipients, 11 were alive when the services were performed and 4 were deceased after our claims year. For the remaining recipient, there were two claims totaling \$13 after the date of death. Neither claim was a primary care case management or Medicare crossover claim. We did not determine whether the State agency had identified and recouped the \$13 potential overpayment.

- The State agency paid \$111,774 for 848 claims for 30 recipients who we could not determine to be deceased. Of the 848 claims, 498 were Medicare crossover claims and 41 were primary care case management claims. The remaining 309 claims were types that were included in the monthly reviews

These overpayments occurred because the State agency did not have adequate controls over the prevention, identification, and recovery of payments for services purportedly provided after recipients' deaths and because the monthly reviews did not include primary care case management or Medicare crossover claims.

## **RESULTS OF REVIEW**

Federal regulations (42 CFR § 433.304) state that an overpayment is the amount that a Medicaid agency pays to a provider in excess of the amount that is allowable for furnished services. Payments for services claimed to have been rendered after Medicaid recipients' deaths are overpayments.

Of the 84 recipients:

- Thirty-eight recipients were deceased as of June 30, 2005.
  - For 34 recipients, SSA's records had the same dates of death as the State Bureau of Vital Statistics records.
  - For four recipients, SSA's dates of death did not match the State Bureau of Vital Statistics dates of death, but both dates were before June 30, 2005.

The State agency paid providers \$18,695 (\$11,355 Federal share) for 178 claims for 38 recipients after their dates of death. Of the 178 claims, 122 were Medicare crossover claims and 18 were primary care case management claims. The remaining 38 claims were types that were included in the monthly reviews. The State agency had not appropriately identified and recovered these potential overpayments through its normal review process.

- Sixteen recipients died after June 30, 2005. The State agency paid providers \$18,129 for 344 claims for services provided to the 16 recipients. We confirmed that SSA's dates of death were not correct by reviewing death certificates or other supporting documentation. For the 12 recipients who died between July 1, 2005, and June 30, 2006, we compared the dates of service of the claims to the dates of death and determined that 11 recipients were alive when the services were performed and that there were two claims for 1 recipient totaling \$13 after the date of death. Neither claim was a primary care case management or Medicare crossover claim. We did not determine whether the State agency had identified and recouped the \$13 potential overpayment. The four remaining recipients died after June 30, 2006; therefore, we were not able to review their claim histories.

- Thirty recipients did not have a date of death noted by the State Bureau of Vital Statistics. The State agency's records did not show dates of death for 24 recipients and showed different dates of death from SSA for 6 recipients. We were not able to verify whether these recipients were deceased. The State agency paid providers \$111,774 for 848 claims for services provided to the 30 recipients. Of the 848 claims, 498 were Medicare crossover claims and 41 were primary care case management claims. The remaining 309 claims were types that were included in the monthly reviews

## **CAUSES OF OVERPAYMENTS**

The overpayments occurred because the State agency did not have adequate controls over the prevention, identification, and recovery of payments made for services purportedly provided after recipients' deaths. Although procedures were in place, they were not successful in identifying overpayments, partially because the monthly reviews did not include primary care case management or Medicare crossover claims. We could not determine why TADS did not identify overpayments for claims that were not primary care case management or Medicare crossover claims. Additionally, we could not determine whether General Investigations had investigated the recipients who were deceased.

## **RECOMMENDATIONS**

We recommend that the State agency:

- review the adequacy of the 178 claims totaling \$18,695 (\$11,355 Federal share) and, for those determined to be erroneous, recover the payments and refund the Medicaid program;
- review claims with dates of service before and after our claims period for additional payments for the 38 recipients;
- expand the scope of its monthly reviews to include all Medicaid recipients and all claim types;
- determine whether the claims for the individual who was confirmed deceased after June 30, 2005, had been identified and recovered; and
- work with SSA to determine whether the 30 recipients whose status could not be verified are deceased.

## **STATE AGENCY COMMENTS**

In its comments on our draft report, the State agency agreed with our recommendations.

Additionally, the State agency recommended that all references to "managed care claims" be removed and replaced with "Medicaid claims" to avoid potential confusion. We reviewed primary care case management claims, which are paid on a fee-for-service basis, rather than

typical managed care claims, which are paid using a traditional capitated payment model. Therefore, we will replace the term “managed care claims” with “primary care case management claims” in the report.

The State agency’s comments are included in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: STATE AGENCY COMMENTS



### TEXAS HEALTH AND HUMAN SERVICES COMMISSION

THOMAS M. SUEHS  
EXECUTIVE COMMISSIONER

October 30, 2009

Ms. Patricia Wheeler  
Regional Inspector General for Audit Services  
Office of Inspector General, Office of Audit Services  
1100 Commerce, Room 632  
Dallas, Texas 75242

Reference Report Number A-06-09-00065

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Review of Medicaid Payments for Services Claimed to Have Been Rendered to Deceased Recipients in Texas" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated September 30, 2009, requested that HHSC provide written comments, including the status of actions taken or planned in response to the report recommendations.

The report identified recommendations for HHSC to consider, and address:

- Reviewing the adequacy of claim payments identified by the auditors; and (a) recovering from providers, and (b) refunding to the Medicaid program any payments for services determined to have been provided after a recipient's death, including any payments occurring outside the scope of the audit.
- Expanding the scope of death match reviews to include all Medicaid recipients and all claim types.
- Validating date of death information with the Social Security Administration (SSA) on selected recipients identified by the auditors.

Please consider the following clarifications to information provided in the draft report:

The draft report references "managed care claims" in the 'Background' and 'Summary of Findings' on page i and in other sections. However, the auditors did not review what HHSC typically refers to as managed care claims - those within a traditional capitated payment model. The auditors reviewed traditional Medicaid (Program 100) and Primary Care Case Management (Program 200) claims. During the course of the audit, Program 200 claims

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were at times referred to as “managed care claims,” but both Medicaid Program 100 and 200 claims are paid on a fee-for-service basis. Referring to Program 200 claims as “managed care claims” may be misleading to a reader, who could incorrectly interpret the reference to mean capitated Medicaid managed care payments. To avoid this potential confusion, HHSC recommends all references to “managed care claims” be removed and replaced with “Medicaid claims.”

Actions HHSC has completed or planned to address the recommendations contained in the report are described in the management responses below.

**DHHS/OIG Recommendation:** *We recommend that the State agency review the adequacy of the 178 claims totaling \$18,695 (\$11,355 Federal share) and, for those determined to be erroneous, recover the payments and refund the Medicaid program.*

**HHSC Management Response**

**Actions Planned:**

HHSC will conduct an analysis of the 178 claims identified in the audit. Once completed, HHSC will refund the federal share of claims determined to have been rendered after a recipients’ death.

**Estimated Completion Date:** November 30, 2009

**Title of Responsible Person:** Deputy Director, Medicaid/CHIP Claims Administrator  
Operations

**DHHS/OIG Recommendation:** *We recommend that the State agency review claims with dates of service before and after our claims period for additional payments for the 38 recipients.*

**HHSC Management Response**

**Actions Planned:**

HHSC will conduct a review of claims payments for the 38 recipients with dates of service before and after the period reviewed by the auditors. Once completed, HHSC will refund the federal share of any claims for services determined to have been rendered after a recipients’ death.

**Estimated Completion Date:** November 30, 2009

**Title of Responsible Person:** Director, Technology Analysis, Development and Support,  
HHSC OIG

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**DHHS/OIG Recommendation:** *We recommend that the State agency expand the scope of its monthly reviews to include all Medicaid recipients and all claim types.*

**Management Response**

HHSC receives date of death information from the Social Security Administration and the State Bureau of Vital Statistics, and uses this information to regularly identify and recover Medicaid payments for services rendered after a recipient's date of death. Additionally, HHSC will expand the scope of the monthly death matching as outlined below.

**Actions Planned:**

HHSC will expand the scope of the monthly death match process by: (a) including Medicare crossover claims and; (b) identifying recipients whose eligibility had been terminated for another reason before the death match information was received. For those recipients whose eligibility had been terminated for another reason, a process to update the recipient's status codes and eligibility end date in the eligibility systems to reflect with matched information will be implemented. HHSC will use the updated information to identify and recover any Medicaid payments for services rendered after a recipient's date of death.

In addition, HHSC will ensure staff is aware of the appropriate eligibility system processing codes used to identify deceased recipients, and will send a policy reminder to staff assigned to Medicaid for the Elderly and Persons with Disabilities section to use appropriate codes.

These improvements will further strengthen the matching process used to identify and recover Medicaid payments for services rendered after a recipients' date of death.

**Estimated Completion Date:**

- November 30, 2009 – Initiate crossover claims matching, identifying recipients with terminated eligibility, and send the policy reminder.
- December 31, 2009 – Implement process to update system status codes and enter eligibility dates.
- March 31, 2010 – Initiate claim recoveries resulting from the expanded matching process.

**Titles of Responsible Persons:**

- Director, General Investigations, HHSC OIG
- Director, Centralized Operations, OES
- Director, Technology Analysis, Development and Support, HHSC OIG

**DHHS/OIG Recommendation:** *We recommend that the State agency determine whether the claims for the individual who was confirmed deceased after June 30, 2005, had been identified and recovered.*

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**HHSC Management Response**

**Actions Planned:**

HHSC will review the claims payments identified by the auditors for this recipient and will refund the federal share of any claims determined to have been rendered after the recipients' death.

**Estimated Completion Date:** November 30, 2009

**Title of Responsible Person:** Director, Technology Analysis, Development and Support,  
HHSC OIG

**DHHS/OIG Recommendation:** *We recommend that the State agency work with SSA to determine whether the 30 recipients whose status could not be verified are deceased.*

**HHSC Management Response**

**Actions Planned:**

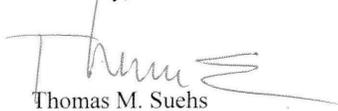
HHSC will coordinate with SSA to determine whether the recipients are deceased. Once completed, HHSC will refund the federal share of any claims for services determined to have been rendered after a recipient's death.

**Estimated Completion Date:** November 30, 2009

**Title of Responsible Person:** Director, General Investigations, HHSC OIG

If you have any questions or require additional information, please contact David M. Griffith, HHSC Internal Audit Director. Mr. Griffith may be reached by telephone at (512) 424-6998 or by e-mail at David.Griffith@hhsc.state.tx.us.

Sincerely,

  
Thomas M. Suehs