

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE INDIANA STATE MEDICAID  
AGENCY MADE CAPITATION PAYMENTS  
TO MANAGED CARE ORGANIZATIONS  
AFTER BENEFICIARIES' DEATHS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Amy J. Frontz**  
Deputy Inspector General  
for Audit Services

January 2020  
A-05-19-00007

# *Office of Inspector General*

<https://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov>

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

## **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: January 2020

Report No. A-05-19-00007

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



### Why OIG Did This Audit

Previous OIG audits found that States had improperly paid Medicaid managed care organizations (MCOs) capitation payments on behalf of deceased beneficiaries. We conducted a similar audit of the Indiana Family and Social Services Administration, which administers the Medicaid program.

Our objective was to determine whether Indiana made capitation payments on behalf of deceased beneficiaries.

### How OIG Did This Audit

Our audit covered 1,746 monthly capitation payments, totaling \$1.3 million, with service dates during the period January 1, 2016, through December 31, 2017 (audit period), made on behalf of beneficiaries reported as deceased. To identify our population of deceased beneficiaries, we matched Indiana's Medicaid Management Information System (MMIS) data with the Social Security Administration's Death Master File using the beneficiaries' Social Security numbers, names, and dates of birth. We then identified all capitation payments that occurred at least 1 month after the beneficiaries' month of death.

We selected a stratified random sample of 100 capitation payments totaling \$85,657 (\$62,911 Federal share) to confirm that the beneficiaries were deceased and that payments made on behalf of the deceased beneficiaries were recovered.

## The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths

### What OIG Found

Indiana made capitation payments on behalf of deceased beneficiaries. We confirmed that 70 of the 71 beneficiaries associated with the 100 capitation payments in our stratified random sample were deceased. Of the 100 capitation payments, Indiana made 95 unallowable payments totaling \$79,403 (\$58,773 Federal share). On the basis of our sample results, we estimated that Indiana made payments totaling at least \$1.1 million (\$862,097 Federal share) to MCOs on behalf of deceased beneficiaries during our audit period.

Indiana did not always fully process Medicaid beneficiaries' death information in the MMIS. Although the State agency's eligibility systems interfaced with Federal and State data exchanges that identify dates of death, the State agency did not enter the dates of death in the MMIS for 48 of our sampled beneficiaries. Additionally, the State agency did not recover the capitation payments for 22 sampled beneficiaries that did have a date of death in the MMIS.

### What OIG Recommends and Indiana Comments

We recommend that Indiana (1) refund \$862,097 to the Federal Government; (2) identify and recover unallowable payments made to MCOs during our audit period on behalf of deceased beneficiaries, which we estimate to be at least \$1.1 million; (3) identify capitation payments made on behalf of deceased beneficiaries before and after our audit period, and repay the Federal share of amounts recovered; and (4) ensure that dates of death are added to the MMIS and that capitation payments made after the beneficiaries' deaths are recovered.

In written comments on our draft report, Indiana concurred with all of our recommendations. Indiana said that it will recover the capitation payments identified in the audit and return the Federal share, recover capitation payments that were made for deceased beneficiaries during and outside of the audit period, and ensure that dates of death are added to the MMIS.

**TABLE OF CONTENTS**

INTRODUCTION ..... 1

    Why We Did This Audit ..... 1

    Objective ..... 1

    Background ..... 1

        The Medicaid Program..... 1

        Social Security Administration: Date of Death Information ..... 2

        Federal Requirements..... 2

        Indiana’s Medicaid Managed Care Program..... 2

    How We Conducted This Audit ..... 3

FINDINGS..... 4

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

    The State Agency Did Not Have Sufficient Safeguards to Identify and Recover Unallowable Payments ..... 5

        Inadequate Policies and Procedures To Identify Deceased Beneficiaries ..... 5

        Unallowable Payments for Beneficiaries Who Had a Date of Death ..... 6

    Estimate of Unallowable Capitation Payments ..... 6

RECOMMENDATIONS ..... 6

STATE AGENCY COMMENTS ..... 6

APPENDICES

    A: Audit Scope and Methodology ..... 7

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

    C: Statistical Sampling Methodology ..... 11

    D: Sample Results and Estimates ..... 13

    E: Federal and State Requirements ..... 14

F: State Agency Comments ..... 15

## INTRODUCTION

### WHY WE DID THIS AUDIT

The Indiana Family and Social Services Administration (State agency) pays managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payment). Previous Office of Inspector General (OIG) audits<sup>1</sup> found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased beneficiaries. 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 capitation payments on behalf of deceased beneficiaries.

### BACKGROUND

#### The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the 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 the 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 beneficiaries. States contract with an MCO to make services available to enrolled Medicaid beneficiaries, usually in return for a periodic payment, known as a capitation payment. States report capitation payments claimed by Medicaid MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. 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 the period January 1, 2016, through December 31, 2017 (audit period), the FMAP in Indiana ranged from 65.59 to 66.74 percent.<sup>2</sup>

---

<sup>1</sup> See Appendix B for related OIG audits.

<sup>2</sup> Because of the Patient Protection and Affordable Care Act's Medicaid expansion, payments for "newly eligible" adults were reimbursed at a 100-percent FMAP during calendar years 2014 through 2016 and are gradually declining to 90 percent by 2020.

## **Social Security Administration: Date of Death Information**

The Social Security Administration (SSA) maintains death record information by obtaining death information from relatives of deceased beneficiaries, funeral directors, financial institutions, and postal authorities. SSA processes death notifications through its Death Alert, Control, and Update System, which matches the information received from external sources against the Master Beneficiary Record and the Supplemental Security Income Record.<sup>3</sup> SSA records the resulting death information in its Numerical Identification System (the Numident).<sup>4</sup> SSA then uses information from the Numident to create a national record of death information called the Death Master File (DMF).<sup>5, 6</sup>

## **Federal Requirements**

A capitation payment is “a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical 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).

## **Indiana’s Medicaid Managed Care Program**

Indiana’s current state-wide, Medicaid Managed Care program was implemented in 1997 and has been expanded over time to include a variety of populations and services. The program covers acute care, primary care, behavioral health, and other specialty services.

During our audit period, approximately 80 percent of Indiana’s Medicaid population received benefits through four MCOs under contract with the State agency. The contracts with the MCOs covered health care services to eligible Medicaid beneficiaries in exchange for a fixed per-member, per-month capitation payment. The contracts require compliance with the provisions in Indiana’s *Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual*, which states that beneficiaries’ enrollment will be terminated upon death and that payments to the MCO will be adjusted for retroactive disenrollment of the

---

<sup>3</sup> SSA, *Programs Operations Manual System*, GN 02602.060 (May 13, 2011). The Master Beneficiary Record is an electronic record of all Title II (of the Act) beneficiaries. The Supplemental Security Income Record is an electronic record of all Title XVI (of the Act) beneficiaries.

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

<sup>5</sup> SSA, *Programs Operations Manual System*, GN 02602.060.B.1 (May 13, 2011).

<sup>6</sup> SSA maintains death data—including names, SSNs, dates of birth (DOBs), and States of death—in the DMF for approximately 98 million deceased individuals.

beneficiaries (sections 16 and 20).<sup>7</sup> The State agency made payments of approximately \$9 billion to Medicaid MCOs during Federal fiscal years 2016 and 2017.

State Medicaid agencies use the Medicaid Management Information System (MMIS) to process payments and maintain beneficiary eligibility and enrollment information. During our audit period, Indiana was in the process of implementing its new MMIS. The new MMIS was designed to provide greater accuracy and efficiency in processing claims for services that align with coverage policies and to prevent the improper payment of claims.

## HOW WE CONDUCTED THIS AUDIT

Our audit covered 1,746 monthly capitation payments, totaling \$1.3 million,<sup>8</sup> with service dates during our audit period,<sup>9</sup> made on behalf of beneficiaries reported as deceased. To identify our population of deceased beneficiaries, we matched Indiana's MMIS data to the DMF using the beneficiaries' SSNs, names, and DOBs. We then identified all capitation payments that occurred at least 1 month after the beneficiaries' month of death.

We selected a stratified random sample of 100 capitation payments, totaling \$85,657 (\$62,911 Federal share), to confirm that the beneficiaries were deceased and that payments made on behalf of the deceased beneficiaries were recovered. Using the results of our sample, we estimated the total value and Federal share of unallowable capitation payments that the State agency did not recover.

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 the details of our audit scope and methodology, Appendix C contains the details of our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal and State requirements.

---

<sup>7</sup> There were several different contracts for Indiana's MCO programs during our audit period. Although the contracts vary among programs, the contracts require compliance with the provisions related to the termination of eligibility and the recovery of capitation payments outlined in Indiana's *Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual*.

<sup>8</sup> The actual amount was \$1,337,676.

<sup>9</sup> The audit period encompassed the most current data available at the time we initiated our audit.

## FINDINGS

The State agency made capitation payments on behalf of deceased beneficiaries. We confirmed that 70 of 71 beneficiaries associated with the 100 capitation payments in our sample were deceased. Of the 100 capitation payments, the State agency made 95 unallowable payments totaling \$79,403 (\$58,773 Federal share). The State agency did not recover any of the 95 sampled capitation payments. On the basis of our sample results, we estimated that the State agency made payments totaling at least \$1.1 million<sup>10</sup> (\$862,097 Federal share) to MCOs on behalf of deceased beneficiaries for service dates during our audit period.

These errors occurred because the State agency did not always fully process Medicaid beneficiaries' death information in the MMIS. Although the State agency's eligibility systems interfaced with Federal and State data exchanges that identify dates of death, the State agency did not enter the dates of death in the MMIS for 48 of our sampled beneficiaries. Additionally, the State agency did not recover the capitation payments for 22 sampled beneficiaries that did have a date of death in the MMIS.

### **THE STATE AGENCY MADE UNALLOWABLE PAYMENTS TO MEDICAID MANAGED CARE ORGANIZATIONS**

Contractual agreements with the MCOs provide for the recovery of capitation payments made after the beneficiaries' deaths. However, the State agency did not always recover the capitation payments after the beneficiaries' deaths.

The State agency made capitation payments totaling \$1.3 million on behalf of beneficiaries reported as deceased that we identified by matching the State agency's MMIS data to SSA's DMF. However, based on SSA, State, and other data we had, we could not fully confirm that all of those beneficiaries were deceased. We confirmed that 70 of the 71 beneficiaries associated with the 100 capitation payments in our stratified random sample were deceased.<sup>11</sup>

Of the 100 capitation payments in our sample:

- The State agency made 95 unallowable capitation payments on behalf of the 70 deceased beneficiaries, totaling \$79,403 (\$58,773 Federal share). The State agency made 68 of these capitation payments on behalf of beneficiaries who did not have a date of death in the MMIS. Of the remaining 27 capitation payments, the State agency made 22 payments on behalf of beneficiaries who had a correct date of death in the

---

<sup>10</sup> Without rounding, the estimate was \$1,163,487.

<sup>11</sup> We confirmed the beneficiaries' dates of death using a national investigative database, death certificates, obituaries, or newspapers.

MMIS and 5 payments on behalf of a beneficiary who had an incorrect date of death in the MMIS. The State agency did not recover any of these payments.

- For the remaining 5 capitation payments in our sample, we could not confirm the death of the 1 associated beneficiary and did not treat these payments as errors.

## **THE STATE AGENCY DID NOT HAVE SUFFICIENT SAFEGUARDS TO IDENTIFY AND RECOVER UNALLOWABLE PAYMENTS**

The contracts between the State agency and the MCOs require compliance with the provisions in Indiana's *Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual*, which states that beneficiaries' enrollment will be terminated upon death and that payments to the MCO will be adjusted for retroactive disenrollment of the beneficiaries.

The State agency did not always process Medicaid beneficiaries' death information or recover capitation payments in the MMIS. When the State agency properly processes death information, the MMIS uses that information to identify a beneficiary as deceased, stop future capitation payments, and initiate the recovery process for capitation payments that were made after the beneficiary's month of death.

### **Inadequate Policies and Procedures To Identify Deceased Beneficiaries**

The State agency relies on Federal and State information to determine the eligibility of Medicaid beneficiaries and to identify available death information. To identify dates of death, the State agency relies on several sources of data from SSA: the State On-Line Query (SOLQ),<sup>12</sup> the Beneficiary & Earnings Data Exchange (BENDEX),<sup>13</sup> and the State Data Exchange (SDX).<sup>14</sup> The State agency also has access to the Indiana State Department of Health's death certificate database. Although the State agency's systems interfaced with these data sources, dates of death were not added to the MMIS for 48 of the 70 deceased beneficiaries. This led to 68 capitation payments not being recovered. The State agency stated that it would conduct further research to determine why it did not enter a date of death for these beneficiaries.

---

<sup>12</sup> The SOLQ allows States real-time online access to SSA's SSN verification service and retrieval of data from Title II and Title XVI of the Act. The SOLQ enables State social services agencies, some Federal agencies, and other State benefit program personnel to rapidly obtain information they need to determine whether individuals qualify for programs.

<sup>13</sup> The BENDEX is a batch data exchange that provides Title II and earnings data to State agencies.

<sup>14</sup> The SDX is a batch data exchange that provides Title XVI data to States that administer federally funded income programs or health maintenance programs, or both.

## **Unallowable Payments for Beneficiaries Who Had a Date of Death**

Dates of death were recorded in the MMIS for 22 of the 70 deceased beneficiaries. Nevertheless, the State agency made unallowable payments on behalf of these deceased beneficiaries. The State agency stated that it would conduct further research to determine why it did not recover the 27 capitation payments for these beneficiaries.

## **ESTIMATE OF UNALLOWABLE CAPITATION PAYMENTS**

On the basis of our sample results, we estimated that the State agency made payments totaling at least \$1.1 million (\$862,097 Federal share) to MCOs on behalf of deceased beneficiaries for service dates during our audit period.

## **RECOMMENDATIONS**

We recommend that the Indiana Family and Social Services Administration:

- refund \$862,097 to the Federal Government;
- identify and recover unallowable payments made to MCOs during our audit period on behalf of deceased beneficiaries, which we estimate to be at least \$1,163,487;
- identify capitation payments made on behalf of deceased beneficiaries before and after our audit period, and repay the Federal share of amounts recovered; and
- ensure that dates of death are added to the MMIS and that capitation payments made after the beneficiaries' deaths are recovered.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with all of our recommendations. The State agency said that it will recover the capitation payments identified in the audit and return the Federal share, recover capitation payments that were made for deceased beneficiaries during and outside of the audit period, and ensure that dates of death are added to the MMIS.

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

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 1,746 monthly capitation payments, totaling \$1,337,676, made on behalf of beneficiaries reported as deceased in SSA's DMF. We reviewed capitation payments with service dates during the period January 1, 2016, through December 31, 2017 (audit period). We selected a stratified random sample of 100 capitation payments totaling \$85,657 (\$62,911 Federal share) for review.

We did not review the overall internal control structure of the State agency or its Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our audit to determining whether MCOs in Indiana received capitation payments on behalf of beneficiaries whose month of death preceded the capitation payment month.

We conducted our fieldwork from November 2018 through September 2019.

### METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance;
- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments after a beneficiary's death;
- reviewed the State agency's contracts with the MCOs for our audit period;
- obtained from the State agency a list of MCO beneficiaries who were eligible during our audit period;
- matched the list of eligible MCO beneficiaries to SSA's DMF and identified 19,206 deceased beneficiaries;
- provided that list of 19,206 deceased beneficiaries to the State agency and requested all associated MCO capitation payments with service dates during the period January 1, 2016, through March 1, 2019;
- obtained from the State agency a file containing 220,796 capitation payments that were made on behalf of deceased beneficiaries with a service date during the period January 1, 2016, through March 1, 2019, totaling \$178,196,187 (the State agency file);

- limited use of the State agency file to capitation payments with paid amounts greater than \$0 and service dates after the beneficiaries' month of death, and identified 2,428 capitation payments totaling \$1,989,265 (capitation payment data);
- limited use of the capitation payment data to capitation payments with a service date during our audit period, and created a sampling frame containing 1,746 capitation payments, totaling \$1,337,676, that the State agency made to MCOs on behalf of beneficiaries whose month of death preceded the capitation payment service date;
- selected for review a stratified random sample of 100 capitation payments totaling \$85,657 (\$62,911 Federal share);
- for each sampled capitation payment, obtained current documentation from the State agency to support:
  - the beneficiaries' first and last names, SSNs, DOBs (ensuring that the information matched the DMF), and Medicaid identification numbers;
  - whether the MMIS identified the beneficiaries' dates of death;
  - that a capitation payment occurred for the capitation payment month (ensuring the accuracy of the paid amount); and
  - whether any adjustments were made for the sample capitation payments;
- compared the dates of death in the MMIS and the DMF for the 100 sample items;
- used Accurint,<sup>15</sup> death certificates on file with the Indiana State Department of Health, obituaries, or newspapers as alternative information sources to independently confirm the dates of death on file with the DMF;
- estimated the total value and Federal share of unallowable capitation payments that the State agency did not recover by using OIG, Office of Audit Services (OAS), statistical software; 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

---

<sup>15</sup> Accurint is a LexisNexis data depository that contains more than 40 billion records from more than 10,000 data sources. Accurint's identity repository contains death records from multiple sources, including the DMF, State deceased records, and other proprietary sources.

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**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	A-05-17-00049	10/1/19
<i>Illinois Managed Care Organizations Received Medicaid Capitation Payments After Beneficiaries' Deaths</i>	A-05-18-00026	8/20/19
<i>Georgia Managed Care Organizations Received Medicaid Capitation Payments After Beneficiaries' Deaths</i>	A-04-15-06183	8/9/19
<i>California Managed Care Organizations Received Medicaid Capitation Payments After Beneficiaries' Deaths</i>	A-04-18-06220	5/7/19
<i>Ohio Managed Care Organizations Received Medicaid Capitation Payments After Beneficiaries' Deaths</i>	A-05-17-00008	10/04/18
<i>Wisconsin Managed Care Organizations Received Medicaid Capitation Payments After Beneficiaries' Deaths</i>	A-05-17-00006	9/27/18
<i>Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	A-04-15-06190	12/22/17
<i>Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	A-06-16-05004	11/14/17
<i>Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	A-04-15-06182	11/30/16

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

Our sampling frame consisted of 1,746 monthly capitation payments that the State agency made on behalf of deceased beneficiaries<sup>16</sup> with a service date during the audit period, January 1, 2016, through December 31, 2017, totaling \$1,337,676.

### SAMPLE UNIT

The sample unit was a capitation payment.

### SAMPLE DESIGN AND SAMPLE SIZE

We used the following stratified random sample (Table 1):

**Table 1: Sample Design Summary**

Stratum	Frame Information			Sample Size
	Payment Range	Number of Payments	Amount of Payments	
1	\$25.71 through \$1,002.36	1,056	\$444,547	50
2	\$1,081.18 through \$6,442.87	690	893,129	50
	<b>Total</b>	<b>1,746</b>	<b>\$1,337,676</b>	<b>100</b>

### SOURCE OF RANDOM NUMBERS

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

### METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units within strata 1 and 2. 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 value and Federal share of unallowable payments made on behalf of deceased beneficiaries during our audit period. To be conservative, we recommend recovery of unallowable payments at the lower limit of a

---

<sup>16</sup> We restricted the sampling frame to capitation payments that we identified through data analytics as having service dates after the month of the beneficiaries' deaths.

two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual total of unallowable payments in the sampling frame 95 percent of the time.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Total Value of Sample</b>	<b>Incorrectly Billed Sample Items</b>	<b>Value of Over-payments in Sample</b>
1	1,056	\$444,547	50	\$22,400	50	\$22,400
2	690	893,129	50	63,257	45	57,003
<b>Total</b>	<b>1,746</b>	<b>\$1,337,676</b>	<b>100</b>	<b>\$85,657</b>	<b>95</b>	<b>\$79,403</b>

**Table 3: Estimates of Unallowable Payments for the Audit Period  
(Limits Calculated for a 90-Percent Confidence Interval)**

	<b>Total Amount</b>	<b>Federal Share</b>
<b>Point estimate</b>	\$1,259,727	\$935,362
<b>Lower limit</b>	1,163,487	862,097
<b>Upper limit</b>	1,355,967	1,008,628

## APPENDIX E: FEDERAL AND STATE REQUIREMENTS

### FEDERAL REQUIREMENTS

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income, as calculated by a defined formula (42 CFR § 433.10).

In connection with the Medicaid managed care program, providers are defined as "any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services" (42 CFR § 400.203).

A capitation payment is "a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical 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).

### STATE REQUIREMENTS

The State agency entered into contractual agreements with the MCOs. The contracts require compliance with the provisions in Indiana's *Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual*, which states that beneficiaries' enrollment will be terminated upon death and that payments to the MCO will be adjusted for retroactive disenrollment of the beneficiaries (sections 16 and 20).



Eric Holcomb, Governor  
State of Indiana

*Office of Medicaid Policy and Planning*  
402 W. WASHINGTON STREET, ROOM W374, MS 07  
INDIANAPOLIS, IN 46204-2739

January 3, 2020

Sheri Fulcher  
Regional Inspector General  
Office of Audit Services, Region V  
233 North Michigan Avenue, Suite 1360  
Chicago, IL 60601

Re: A-05-19-00007

Dear Ms. Fulcher:

Thank you for the opportunity to review and comment on the draft audit report entitled *The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths*.

Indiana Medicaid has reviewed the findings and concurs with the OIG recommendations. Indiana will 1) recoup the capitation payments from managed care entities identified in the audit returning federal share of \$862,097; 2) identify and recoup capitation payments for periods after date of death during the audit period; 3) identify and recoup similar capitation payments outside the audit period; 4) ensure that dates of death are added to the MMIS.

If you have questions on this response or require more information on the corrective action, please contact David Nelson, Agency Controller, [David.Nelson@fssa.in.gov](mailto:David.Nelson@fssa.in.gov).

Sincerely,

Allison Taylor  
Medicaid Director

