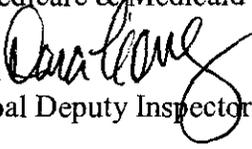




FEB 24 2004

TO: Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan 
Acting Principal Deputy Inspector General

SUBJECT: Review of Medicare Payments for Beneficiaries With Institutional Status
(A-05-02-00078)

Attached is our final report providing the results of our self-initiated review of Medicare payments for beneficiaries with institutional status. This report consolidates the results of our national sample of eight managed care organizations (MCOs) and individual audits of five others.

Our objective was to determine whether Medicare payments to MCOs were appropriate for beneficiaries reported as institutionalized.

Medicare pays a higher monthly rate to MCOs for beneficiaries who are institutionalized. The "Medicare Managed Care Manual" specifies that the beneficiary must have been a resident of a qualifying facility for a minimum of 30 consecutive days immediately before the first day of the month for which the institutional rate is paid. In 1998, the Centers for Medicare & Medicaid Services (CMS) changed the definition of an institutional facility to include only Medicare- or Medicaid-certified facilities, excluding domiciliary facilities (that is, custodial homes that provide no medical care). Medicare- or Medicaid-certified facilities include skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term-care hospitals, and swing-bed hospitals.

Based on the combined result of our national sample and individual audits, we estimate that MCOs received unallowable Medicare payments of \$12.8 million for beneficiaries incorrectly claimed as institutionalized during a 3-year period.

Our statistically valid sample of 8 MCOs found that they had incorrectly claimed 801 beneficiaries as institutionalized from January 1998 through December 2000. The MCOs received \$960,552 in unallowable payments at the enhanced institutional rate for these beneficiaries. The payments were unallowable because the beneficiaries (1) did not meet the required 30-day residency period in an institution, (2) resided in a domiciliary or noncertified facility, or (3) were not in an institution during the period claimed. Based on a statistical projection to our universe of 79 MCOs, we estimate that Medicare overpayments totaled \$9.5 million.

In separate audits of 5 other MCOs, we noted an additional 231 beneficiaries who were incorrectly claimed as institutionalized for the reasons cited above. These MCOs received an estimated \$3.3 million in overpayments (\$3.2 million based on sample results at three MCOs and \$103,650 in identified overpayments at two MCOs).

The major cause of the improper claims sampled was that MCOs did not adequately verify that the beneficiaries had met residency requirements before claiming them as institutionalized.

We recommend that CMS:

- improve oversight procedures to better identify MCOs that inappropriately claim beneficiaries as institutionalized;
- instruct the 8 sampled MCOs to repay the \$960,552 in identified overpayments;
- instruct the remaining 71 MCOs in our sample universe to conduct self-audits to identify and refund overpayments estimated at \$8.5 million (\$9.5 million less \$960,552);
- instruct the 2 separately audited MCOs to repay the identified overpayments totaling \$103,650; and
- ensure that the 3 separately audited MCOs with projected overpayments conduct self-audits, as previously recommended, to identify and refund overpayments estimated at \$3.2 million.

In written comments on our draft report, CMS officials stated that they were considering implementing our recommendations. Their response also included comments on selected technical issues. We have summarized and responded to the CMS comments in the attached report, and we have included the full text of the comments as Appendix C.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions or comments about this report, please do not hesitate to call me or one of your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at greeb@oig.hhs.gov.

To facilitate identification, please refer to report number A-05-02-00078 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
FOR BENEFICIARIES WITH
INSTITUTIONAL STATUS**



**FEBRUARY 2004
A-05-02-00078**

EXECUTIVE SUMMARY

OBJECTIVE

Our objective was to determine whether Medicare payments to managed care organizations (MCOs) were appropriate for beneficiaries reported as institutionalized. MCOs receive a higher rate for enrollees who are residents of Medicare- or Medicaid-certified institutions.

SUMMARY OF FINDINGS

Based on the combined result of our national sample and five individual audits, we estimate that MCOs received unallowable Medicare payments of \$12.8 million for beneficiaries incorrectly claimed as institutionalized.

Institutional status requirements in the “Medicare Managed Care Manual” specify that a beneficiary must have been a resident of a qualifying facility for a minimum of 30 consecutive days immediately before the first day of the month for which the institutional rate is paid. In Operational Policy Letter 54, effective January 1998, the Centers for Medicare & Medicaid Services (CMS) changed the definition of an institutional facility to include only Medicare- or Medicaid-certified facilities, excluding domiciliary facilities that provide no medical care. Medicare- or Medicaid-certified facilities comprise skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term-care hospitals, and swing-bed hospitals.

Sampled MCOs

We found that 8 statistically selected MCOs had incorrectly claimed as institutionalized 801 of 10,406 beneficiaries reviewed. The MCOs received \$960,552 in unallowable payments at the higher institutional rate for these beneficiaries. Based on our sample results, we estimate that the 79 MCOs in our universe received Medicare overpayments totaling \$9.5 million from January 1998 to December 2000.

Of the 801 beneficiaries incorrectly claimed as institutionalized:

- 487 beneficiaries did not meet the required 30-day residency period in an institution,
- 168 beneficiaries resided in a domiciliary or noncertified facility, and
- 146 beneficiaries were not institutionalized during the period claimed.

The major cause of these improper claims was that MCOs did not adequately verify that the beneficiaries had met residency requirements before claiming them as institutionalized.

Separately Audited MCOs

Our previous audits of 5 other MCOs found that they incorrectly claimed 231 beneficiaries as institutionalized, resulting in estimated Medicare overpayments of \$3.3 million. We questioned the institutionalized status of the 231 beneficiaries for the same reasons noted at the 8 sampled MCOs. For three of the five audits, estimated overpayments of \$3.2 million were based on statistical projections; for the two remaining audits, overpayments totaling \$103,650 were based on our evaluation of the total universe of institutionalized beneficiaries.

RECOMMENDATIONS

We recommend that CMS:

- improve oversight procedures to better identify MCOs that inappropriately claim beneficiaries as institutionalized;
- instruct the 8 sampled MCOs to repay the \$960,552 in identified overpayments;
- instruct the remaining 71 MCOs in our sample universe to conduct self-audits to identify and refund overpayments estimated at \$8.5 million (\$9.5 million less \$960,552);
- instruct the 2 separately audited MCOs to repay the identified overpayments totaling \$103,650; and
- ensure that the 3 separately audited MCOs with projected overpayments conduct self-audits, as previously recommended, to identify and refund overpayments estimated at \$3.2 million.

CMS COMMENTS

In written comments on our draft report, CMS officials stated that they were considering implementing our recommendations. Their response also included comments on selected technical issues. We have summarized and responded to the CMS comments at the end of this report, and we have attached the full text of the comments as Appendix C.

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INTRODUCTION

BACKGROUND

The Balanced Budget Act of 1997 (Public Law 105-33) added sections 1851 through 1859 to the Social Security Act and established the Medicare+Choice Program. The primary goal of the program is to offer to Medicare beneficiaries a wider range of health plan choices, including coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans contract with a network of providers to deliver a health benefit package approved by CMS. Coordinated care plans, commonly referred to as MCOs, include health maintenance organizations, provider-sponsored organizations, and preferred provider organizations.

CMS makes monthly advance payments to MCOs at the per capita rate set for each enrolled beneficiary. Generally, Medicare pays a higher monthly rate for beneficiaries who are institutionalized, that is, residents of Medicare- or Medicaid-certified institutions: skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term-care hospitals, and swing-bed hospitals.

CMS requires MCOs to submit a monthly list of enrollees meeting institutional status requirements. CMS subsequently adjusts the advance payments received by MCOs each month to reflect the enhanced reimbursement for institutional status. For example, during 2001, MCOs in the Boston area received a monthly advance payment of \$499 for each 75-year-old female beneficiary residing in a noninstitutional setting. If the MCO reported the beneficiary as institutionalized, CMS adjusted the advance payment to \$1,020 (without applying risk adjustment factors).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments to MCOs were appropriate for beneficiaries reported as institutionalized.

Scope

This report consolidates our audit results at 13 MCOs. (See Appendix B for a list of the individual reports.) We statistically selected a sample of 8 MCOs from a universe of 79 Medicare MCOs that reported at least 100 beneficiaries as institutionalized during December 1999. For these 8 MCOs, we reviewed the documentation supporting institutional residency for all 10,406 beneficiaries reported as institutionalized from January 1998 to December 2000.

We separately selected five other MCOs for detailed review: two based on profiling for possible domiciliary patients, one based on the need for followup on prior work, and one based on the size

of its Medicare enrollment. We audited the documented institutional status of all beneficiaries at two MCOs and took statistical samples to evaluate institutional status at the other three. The audit periods and sampling approaches are presented in Table 3.

Our review of internal controls was limited to the MCOs' procedures for verifying institutional residency.

Methodology

We verified that beneficiaries met institutional status requirements by reviewing documentation on institutional residency provided by the MCOs. We calculated the Medicare overpayment for each incorrectly reported beneficiary by subtracting the noninstitutional payment that the MCOs should have received from the institutional payment actually received. We projected the results for the 8 MCOs to the nationwide universe of 79 MCOs to estimate total Medicare overpayments for beneficiaries incorrectly claimed as institutionalized.

Before we selected our sample, we removed from our universe the five Medicare MCOs that we had separately audited. We evaluated the MCOs' documentation supporting institutional residency in certified facilities. We then added the results of these individual audits to our national projection to estimate total Medicare overpayments that resulted from incorrectly classifying beneficiaries as institutionalized.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We identified 801 beneficiaries whom the 8 statistically selected MCOs had incorrectly claimed as institutionalized. The MCOs received unallowable payments for these beneficiaries at the higher institutional rate. Five separately audited MCOs incorrectly claimed an additional 231 beneficiaries as institutionalized. We estimate, based on the combined result of our national sample and the five individual audits, that MCOs received unallowable Medicare payments of \$12.8 million.

REQUIREMENTS FOR CLAIMING INSTITUTIONAL RATE

Medicare MCOs receive a monthly payment at the higher institutional rate for each beneficiary residing in a qualifying institutional facility. The "Medicare Managed Care Manual" specifies that a beneficiary must have been a resident of the institutional facility for a minimum of 30 consecutive days immediately before the first day of the month for which the institutional rate is paid. Temporary absences for hospital visits or therapeutic leave of fewer than 15 days count toward the 30-day residency requirement if the beneficiary returns to an institutional facility upon discharge from the hospital.

Effective January 1998, CMS Operational Policy Letter 54 changed the definition of an institutional facility to include only Medicare- or Medicaid-certified facilities, excluding domiciliary facilities that provide no medical care.

BENEFICIARIES INCORRECTLY CLASSIFIED AS INSTITUTIONALIZED

The 8 sampled MCOs incorrectly classified 801 beneficiaries as institutionalized. As detailed in Table 1, payments on behalf of these beneficiaries were unallowable because the beneficiaries:

- did not meet the required 30-day residency period in an institution,
- resided in a domiciliary or noncertified facility, or
- were not in an institution during the period claimed.

Table 1: Beneficiaries Incorrectly Classified at the Sampled MCOs									
Reason	MCO Sampled								Total
	1	2	3	4	5	6	7	8	
30-Day Requirement Not Met	23	4	1	271	48	44	36	60	487
Resident of Domiciliary or Noncertified Facility	9	47	26	16	42	18	9	1	168
Not in an Institution	5	2	0	28	0	37	9	65	146
Total	37	53	27	315	90	99	54	126	801

Payments on behalf of the 231 beneficiaries that the 5 separately audited MCOs incorrectly classified as institutionalized were unallowable for the same reasons.

CAUSES OF INCORRECT CLASSIFICATION

We attribute the incorrect classification of beneficiaries primarily to inadequate verification procedures. Untimely implementation of CMS guidance and human and system errors also contributed to the problem.

Inadequate Verification Procedures

All eight of the MCOs sampled had procedures requiring staff to contact institutional facilities each month to verify the residency of beneficiaries before reporting them to CMS as

institutionalized. However, MCO staff did not always fully implement the verification procedures. We also found that some MCOs verified institutional residency before the month's end. Although beneficiaries discharged in the period between the MCO's verification and the end of the month did not meet the 30-day residency requirement, they were claimed as institutionalized.

In addition, MCOs did not adequately verify whether institutions qualified under CMS guidelines. One MCO incorrectly claimed 25 beneficiaries who resided in the assisted living section of a facility that provided both assisted living and skilled nursing care. When verifying residency, the MCO staff did not effectively communicate to the institutional facility that only the nursing patients met institutional status requirements. As a result, the MCO received more than \$300,000 in Medicare overpayments.

Untimely Implementation of CMS Guidance

As previously stated, effective January 1998, CMS eliminated domiciliary and noncertified facilities as qualifying institutions. However, some of the sampled MCOs did not immediately implement this CMS guidance. As a result, in 1998 they incorrectly claimed as institutionalized residents of domiciliary facilities or nursing facilities that were not certified by Medicare or Medicaid.

Human and System Errors

Institutional facility officials sometimes provided MCOs with incorrect information on the residency of beneficiaries, and MCO staff made some clerical errors while preparing the monthly lists of institutionalized beneficiaries for submission to CMS. In addition, two MCOs experienced difficulties with computer systems used to track institutional residency. Both of these problems caused beneficiaries to be incorrectly claimed as institutionalized.

MEDICARE OVERPAYMENTS

Audits at the eight sampled MCOs identified Medicare overpayments of \$960,552. Based on our sample results, we estimate that the 79 MCOs in our universe received Medicare overpayments totaling \$9.5 million from January 1998 to December 2000.

Table 2 presents the identified overpayments to each sampled MCO.

Table 2: Medicare Overpayments to Sampled MCOs			
MCO Reviewed	Beneficiaries Reviewed	Beneficiaries With Overpayments	Overpayments
1	386	37	\$ 18,645
2	772	53	21,233
3	486	27	319,355
4	5,571	315	229,656
5	611	90	87,516
6	1,115	99	62,432
7	293	54	100,692
8	1,172	126	121,023
Total	10,406	801	\$960,552

In addition, we estimated Medicare overpayments of \$3,320,565 in the five audits we conducted separately from our national sample. Based on the combined results of our national sample and the five individual audits, we estimate that MCOs received unallowable Medicare payments of \$12.8 million for beneficiaries incorrectly claimed as institutionalized.

Table 3 summarizes the combined results from our national sample and the five additional audits. The estimated overpayments for audits 1, 2, and 3 represent our projection of sample results, while overpayments for audits 4 and 5 were based on our evaluation of the total universe of institutional beneficiaries claimed by each plan and were not estimated.

Table 3: Total Estimated Medicare Overpayments				
MCO Reviewed	Audit Period	Beneficiaries Reviewed	Beneficiaries With Overpayments	Overpayments
National Sample	Jan. 1998- Dec. 2000	10,406	801	\$ 9,485,436*
Audit 1 (A-09-01-00056)	Jan. 1998- Feb. 1998	200	111	2,389,029*
Audit 2 (A-03-00-00010)	Jan. 1997- Dec. 1999	100	34	544,558*
Audit 3 (A-03-98-00034)	Jan. 1996- June 1998	100	15	283,328*
Audit 4 (A-05-01-00071)	Jan. 1998- Dec. 2000	1,041	27	84,808
Audit 5 (A-05-01-00100)	Jan. 1998- Dec. 2000	2,215	44	18,842
Total		14,062	1,032	\$12,806,001

*Statistical projections.

RECOMMENDATIONS

We recommend that CMS:

- improve oversight procedures to better identify MCOs that inappropriately claim beneficiaries as institutionalized;
- instruct the 8 sampled MCOs to repay the \$960,552 in identified overpayments;
- instruct the remaining 71 MCOs in our sample universe to conduct self-audits to identify and refund overpayments estimated at \$8.5 million (\$9.5 million less \$960,552);
- instruct the 2 separately audited MCOs to repay the identified overpayments totaling \$103,650; and
- ensure that the 3 separately audited MCOs with projected overpayments conduct self-audits, as previously recommended, to identify and refund overpayments estimated at \$3.2 million.

CMS COMMENTS AND OIG RESPONSE

Responding to our draft report, CMS officials provided comments on our recommendations and selected technical issues. We have summarized their comments and responded to each below. CMS's comments are provided in full in Appendix C.

Recommendation To Improve Oversight Procedures

CMS Comments. CMS said that improving oversight procedures would require increased sampling of Medicare+Choice institutional records and that it would consider this idea.

OIG Response. We encourage CMS to increase sampling of institutional records to identify MCOs that incorrectly claim beneficiaries as institutionalized. Our audit results indicate that current sampling levels are not sufficient to identify these MCOs.

Recommendations To Instruct Eight Sampled MCOs and Two Separately Audited MCOs To Repay \$960,552 and \$103,650, Respectively

CMS Comments. CMS said that it was working on OIG clearance documents that would show the status of overpayments identified in our reports. To complete a review of the overpayments, CMS requested beneficiary-specific information for 10 reports listed in the draft report.

OIG Response. We appreciate CMS's efforts to provide documentation that overpayments have been returned. We have provided beneficiary-specific information for the audits listed in the draft report.

Recommendation To Instruct MCOs Not in Our Sample To Conduct Self-Audits

CMS Comments. CMS said that it would consider asking the 71 Medicare+Choice organizations for self-audits. However, CMS was concerned that we had made extrapolations of overpayments at the beneficiary level when the distribution of questioned beneficiaries at the MCOs was highly skewed. CMS officials noted that 56 percent of the 487 beneficiaries identified as not fulfilling the 30-day requirement were from one MCO.

From our exit conference, CMS believed that we had not investigated or estimated any retroactive corrections submitted for enrollees determined to have been incorrectly classified. CMS said that this could change our count of incorrectly classified beneficiaries and that self-audits could identify underpayments which would reduce the amount owed.

OIG Response. We encourage CMS to require self-audits at the 71 MCOs so that the estimated \$8.5 million in overpayments can be recovered. We disagree that our results are in any way skewed. The MCO that accounted for 56 percent of the errors had a very large enrollment which accounted for 54 percent of the beneficiaries in our sample. Our projection was based on a sample of 8 of 79 MCOs in the universe, and we reviewed all of the beneficiaries that the 8 MCOs claimed at the institutionalized rate. Given the sampling methodology, it is incorrect to characterize our projection as “at the beneficiary level.”

We disagree with the comments regarding retroactive corrections and believe that CMS officials misunderstood statements made during the exit conference. We allowed the MCOs an opportunity to provide documentation that they had submitted retroactive adjustments to CMS. Further, before questioning any monthly institutional payment, we verified, in the CMS payment system, whether the institutional payment had been reversed. During our audits, we fully investigated the possibility of retroactive adjustments.

We also disagree that MCOs could identify significant underpayments during self-audits. The individual MCOs did not provide any evidence that they had not claimed institutionalized beneficiaries. Based on our audits, we believe that the MCOs have developed effective procedures for identifying institutionalized beneficiaries to legitimately maximize their Medicare reimbursement.

Recommendation To Ensure That Three MCOs Conduct Self-Audits

CMS Comments. CMS stated that it had requested beneficiary information for the reports listed in our December 12, 2002 letter and that our draft report had included three of those reports (A-03-00-00010, A-03-98-00034, and A-09-01-00056). CMS said that it would officially update the status of these overpayments through the OIG clearance document process.

OIG Response. The CMS comments did not address our recommendation that three MCOs conduct self-audits to identify actual overpayments. While we appreciate CMS’s efforts to document that identified overpayments have been recovered, the identified overpayments are a

small portion of the overpayments that we estimate would be found through the recommended self-audits.

Evidence of Institutional Residency

CMS Comments. CMS stated that the report was unclear as to how we determined that 146 beneficiaries had no evidence of institutional residency. Based on comments during the exit conference, CMS suggested that the report be amended to reflect that the issue was not whether the enrollee was institutionalized but whether the MCO had documentation of institutional residency.

OIG Response. There was no documentation of residency because the 146 beneficiaries were not institutionalized. Of the 146 beneficiaries, 93 were incorrectly reported as institutionalized because 2 MCOs had problems with computer systems used to track residency. The remaining 53 were claimed because of human error or inadequate verification procedures at the MCOs.

Therapeutic Leave

CMS Comments. CMS said that our report should state that therapeutic leave is an allowable reason for a temporary absence. CMS also said that any beneficiaries who were disallowed institutional status due to temporary therapeutic leave should be removed from our counts.

OIG Response. We amended our report to include therapeutic leave as an allowable temporary absence. None of the questioned payments involved a temporary period of therapeutic leave.

Effective Date of Operational Policy Letter 54

CMS Comments. CMS stated that many Medicare+Choice organizations had interpreted Operational Policy Letter 54 to mean that the new definition of institutional status became effective for the January 1998 institutional status month, rather than the January 1998 payment month. CMS said that it understood why the wording in the letter could have confused Medicare+Choice organizations and that the letter was not intended to be effective in December 1997. Thus, CMS questioned the accuracy of our statement that some MCOs incorrectly claimed beneficiaries as institutionalized in 1998 because they did not immediately implement CMS's guidance.

OIG Response. Our statement that some MCOs did not immediately implement CMS guidance is accurate. Operational Policy Letter 54 specified that the revised definition of institutional status was effective for all institutional payment rate adjustments made for months beginning after December 1997. We questioned institutional rate adjustments to January 1998 payments forward for beneficiaries not meeting the revised definition.

APPENDICES

APPENDIX A

VARIABLE APPRAISAL OF STATISTICAL SAMPLE (TWO-STAGE)

Primary Units Sampled:	8
Primary Units Not Sampled:	71
Primary Units in Population:	79

Projection at 90-Percent Confidence Level

Point Estimate of Population Total:	\$9,485,436
Standard Error:	\$2,768,765
Lower Limit:	\$4,931,232
Upper Limit:	\$14,039,640
Precision Amount:	\$4,554,204

INDIVIDUAL REPORTS ON AUDITED MCOS

<u>Report Number and Date</u>	<u>Auditee</u>
A-05-01-00071, Dec. 2001	Kansas City Market--Humana Health Plan Kansas City, MO
A-05-01-00078, Apr. 2002	Health Net of Arizona, Inc. Phoenix, AZ
A-05-01-00079, June 2002	Blue Care Network Southfield, MI
A-05-01-00086, May 2002	BlueCross of Northeastern Pennsylvania Wilkes-Barre, PA
A-05-01-00090, July 2002	Aetna U.S. Healthcare King of Prussia, PA
A-05-01-00091, Sept. 2002	UnitedHealthcare of Florida Sunrise, FL
A-05-01-00094, Oct. 2002	Kaiser Foundation Health Plan, Inc. Oakland, CA
A-05-01-00095, June 2002	Humana Health Plans, Inc. Phoenix, AZ
A-05-01-00096, May 2002	Inter Valley Health Plan Pomona, CA
A-05-01-00100, May 2002	Fallon Community Health Plan Worcester, MA
A-03-00-00010, Jan. 2001	Penn State Geisinger Health Plan Danville, PA
A-03-98-00034, Mar. 1999	FreeState Health Plan, Inc. Timonium, MD
A-09-01-00056, Sept. 2001	PacifiCare of California Santa Ana, CA



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

RECEIVED

2003 JUL 15 PM 4:13

Administrator
Washington, DC 20201

OFFICE OF INSPECTOR
GENERAL

DATE: JUL 14 2003

TO: Dara Corrigan
Acting Principal Deputy Inspector General

FROM: Thomas A. Scully *Tom Scully*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of Medicare Payments for Beneficiaries with Institutional Status (A-05-02-00078)*

Thank you for the opportunity to review and comment on the above-referenced draft report concerning beneficiaries with institutional status. We appreciate the effort that went into this report. We look forward to working with OIG on this and other issues pertinent to beneficiaries with institutional status. Our responses to the recommendations are discussed below.

The Centers for Medicare & Medicaid Services (CMS) supports OIG's effort to ensure that appropriate beneficiary status payments are being made under the Medicare+Choice (M+C) program. We have had several discussions with OIG on institutional status audits. In order to be more responsive to OIG, we implemented instructions to centralize CMS review and comment on OIG reports. The CMS is also working to document actions taken on previous OIG institutional status reports.

On December 12, 2002, OIG sent a letter to CMS requesting OIG Clearance Documents (OCDs) for 13 reports related to M+C institutional status payments. Only 3 of the 13 reports mentioned in the new draft report were listed in the December 12, 2002, letter. The CMS is unsure about OIG's rationale for including reports in the December 12th letter, the draft report, or both. One OIG report that includes an overview of all institutional audit reports would be useful.

OIG Recommendation #1

Improve oversight procedures to better identify managed care organizations (MCOs) that are inappropriately claiming beneficiaries are institutionalized.

CMS Response:

The CMS supports efforts to protect M+C program payments. To “improve oversight procedures” would require increased sampling of M+C institutional records. This idea will be considered by CMS.

We do have a requirement now that all institutional corrections come in within 45 days as a part of the enrollment attestation. This results in correcting any overpayments as well as underpayments resulting from institutional reporting.

OIG Recommendation #2

Instruct the 71 MCOs in the OIG sample universe, but not directly audited, to conduct self-audits to identify and refund overpayments that OIG estimates to be \$8.5 million.

CMS response

We will consider asking the 71 Medicare+Choice organizations (M+COs) for self-audits. Before asking contractors to undertake this activity, however, we request some information from OIG. We are concerned that OIG made extrapolations of overpayments at the beneficiary level, when the distribution of incorrect statuses at the M+CO level is highly skewed. For example, the table on page 3 shows that 56 percent of the 487 beneficiaries incorrectly identified as fulfilling the 30-day requirement were from one of the 8 M+COs.

We also understand from our exit conference that any retroactive corrections M+COs may have submitted for enrollees identified in this report were not investigated or estimated, which could change OIG’s count of beneficiaries incorrectly identified as institutionalized. Another important point is that self-audits by MCOs would also reveal situations where the MCO was underpaid. Factoring in these payments could reduce, perhaps dramatically, the amount OIG claims is owed.

OIG Recommendation #3

Instruct the 8 sampled MCOs OIG directly audited, to repay the identified \$960,552 in overpayments.

CMS response

The CMS is working on OCDs to document the status of overpayment recommendations made in OIG reports. Some of these funds have already been returned. It is not uncommon for M+COs to work with Regional Offices (ROs) to process identified overpayments before OIG finalizes an audit report. In other cases, direct action by CMS is needed. After receiving the beneficiary-specific data from OIG, we have worked with CMS ROs and Central Office staff to document the status of overpayments. The CMS will show the status of these overpayments in the OCDs that will be submitted to OIG.

Page 3 – Dara Corrigan

In order to complete our review of overpayments, CMS is requesting beneficiary-specific information for the 10 other reports listed in the draft report.

OIG Recommendation #4

Ensure that the 5 separately audited MCOs conducted self-audits, as previously recommended, to identify and refund overpayments that OIG estimates to be \$3.3 million.

CMS Response

As a result of OIG's December 12, 2002, letter, CMS requested beneficiary information for the reports listed on that letter. Three of those 13 reports are included in the draft report. All three of these reports were part of the 5 reports listed in recommendation #4. The three reports are: A-03-00-00010, A-03-98-00034, and A-09-01-00056. The CMS will officially update the status of these overpayments through the OCD process.

Technical Comments

On page 3 of the draft report, OIG determined that 146 beneficiaries had "No Institutional Residency." The report is unclear how this finding was made, and we suggest that the clarification OIG provided in our exit conference be included in the final report. That is, we understand that this is not a finding about whether the member actually is or is not institutionalized; rather, it is a finding that the M+C organization had no documentation of institutional residence. (Note also that CMS' policy does not define residence at the level of bed, but at the level of facility or part of facility.)

Also on page 3, the draft report states, "Temporary absences for hospital visits of less than 15 days count toward the 30-day residential requirement if the beneficiary returns to an institutional facility upon discharge from the hospital." The OIG should amend this statement to indicate that both hospitalization and therapeutic leave can be reasons for temporary absences. Per Section 170.2 of Chapter 7 of the Managed Care Manual, CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave, where "therapeutic" means requested or supported by a physician; the site is irrelevant. If any beneficiaries in Table 3 were disallowed institutional status due to temporary therapeutic leave, they should be removed from the counts.

On page 4, OIG states, "Many of the beneficiaries were incorrectly claimed as institutionalized in 1998 because some MCOs did not immediately implement CMS guidance." Many M+COs interpreted Operational Policy Letter (OPL) #54 to mean the new definition of institutional status became effective for the January 1998 institutional *status* month, rather than the January 1998 *payment* month (December 1997). The CMS understands why wording in the OPL could have confused M+COs. Thus, we do not believe OIG's statement is accurate. The OPL was not intended to be effective in December 1997.