



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

June 26, 2003

Region VII  
601 East 12th Street  
Room 284A  
Kansas City, Missouri 64106

Report Number: A-07-03-00151

Mr. Thomas Jones  
Independent Health Association  
511 Farber Lakes Drive  
Buffalo, New York 14221

Dear Mr. Jones:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Medicare Payments for Beneficiaries with Institutional Status at the Independent Health Association for the Period January 1, 2000 through September 30, 2002" A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C.552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world-wide-web at <http://oig.hhs.gov>.

To facilitate identification, please refer to Report Number A-07-03-00151 in all correspondence relating to this report.

Sincerely yours,

*for*   
for James P. Aasmundstad  
Regional Inspector General  
for Audit Services

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

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



**JUNE 2003  
A-07-03-00151**

# *Office of Inspector General*

<http://oig.hhs.gov/>

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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:

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The OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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# **Notices**

**THIS REPORT IS AVAILABLE TO THE PUBLIC  
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In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

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





June 26, 2003

Region VII  
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Kansas City, Missouri 64106

Report Number: A-07-03-00151

Mr. Thomas Jones  
Independent Health Association  
511 Farber Lakes Drive  
Buffalo, New York 14221

Dear Mr. Jones:

This final report provides the results of our audit entitled "Review of Medicare Payments for Beneficiaries with Institutional Status at the Independent Health Association (IHA) for the Period January 1, 2000 through September 30, 2002." Our objective was to determine if capitation payments to IHA (Contract H3362) were appropriate for beneficiaries reported as institutionalized during the audit period.

We determined that IHA received Medicare overpayments totaling approximately \$18,400 for 36 beneficiaries incorrectly classified as institutionalized. The 36 beneficiaries were reported as institutionalized during the audit period. The beneficiaries were incorrectly classified because they were not institutionalized for at least 30 consecutive days immediately prior to the month for which enhanced payments were made (30) or were admitted into hospitals for more than the 14-day limit allowed by the Centers for Medicare & Medicaid Services (CMS) (6).

The overpayments occurred because of lack of oversight of internal control procedures. We are recommending that IHA refund the overpayments and ensure policies and procedures regarding the verification of institutionalized beneficiaries are followed correctly.

In the response to the draft report, IHA concurred with our findings and recommendations. IHA's response, in its entirety, is shown as Appendix A. We commend IHA for agreeing with our recommendations and encourage them to continue to make improvements in the future.

## 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. Its primary goal was to provide a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans have a network of providers under contract to deliver a health benefit package, which has been approved by CMS, including managed care

organizations (MCOs). Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations.

The CMS makes monthly advance payments to MCOs at the per capita rate set for each enrolled beneficiary. Medicare generally pays a higher monthly rate to MCOs for institutionalized beneficiaries. The MCOs receive the enhanced rate for enrollees who are residents of Medicare or Medicaid certified institutions (or the distinct part of an institution), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care, and swing-bed hospitals. Institutional status requirements contained in CMS's Operational Policy Letter number 54 specify that the beneficiary must be a resident of a qualifying facility for at least 30 consecutive days immediately prior to the month for which an institutionalized payment is being made.

Each month, the MCOs are required to submit a list of enrollees meeting institutionalized status requirements to CMS. The advance payments paid to MCOs each month are adjusted by CMS to reflect the enhanced reimbursement for institutionalized status. For example, during 2001, the monthly advance payment for a 94 year old female residing in a non-institutional setting (with no other special status indicator) in Buffalo was about \$588. If the MCO reported the beneficiary as institutionalized, CMS would have adjusted the payment to approximately \$962<sup>1</sup>.

The MCOs have the authority to transmit corrections, or retroactive adjustments, for its enrollees' institutional statuses to CMS. These adjustments are equivalent to a Medicare claim request. In the fee-for-service arena, CMS allows providers up to three years to submit corrections to claims. To ensure consistency in the managed care program, Chapter 7 of the Medicare Managed Care manual requires all retroactive payment adjustments to be "...limited to a three-year period preceding the month in which CMS receives any data indicating a change is needed to a Medicare enrollee's record."

IHA began operations as a Medicare managed care organization in January 1996. Although IHA's total enrollment decreased from 23,800 in June 2001 to 21,600 in July 2002, the number of beneficiaries classified as institutionalized by IHA increased from 153 to 349 during the same period.

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

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if capitation payments to IHA were appropriate for beneficiaries reported as institutionalized during January 1, 2000 through September 30, 2002.

As mentioned in the Background Section, MCOs are required to submit a list of enrollees meeting institutionalized status requirements to CMS each month. While we verified

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<sup>1</sup> This calculation does not include the risk adjustment method implemented January 1, 2000 that accounts for variation in per capita cost that is based on health status and demographic factors. The inclusion of risk adjustment would not have a material impact on the overpayments.

existence of internal controls designed by IHA to ensure the correct classification of beneficiaries, we did not validate that these procedures were followed each month.

To determine if payments had been made, we started by accessing the Group Health Plan and identified 685 beneficiaries classified as institutionalized during our audit period. Based on data from IHA systems and 15 retroactive adjustment letters IHA submitted to CMS, we added 87 beneficiaries to our review for a total of 772 individuals. We then used the beneficiary history information from the Managed Care Option Information System, as of November and December 2002 to identify the months in which the institutionalized status had been claimed during the audit period.

The retroactive adjustments related to IHA requests to CMS on both positive and negative adjustments for 283 of the 772 beneficiaries. These requests included 229 adjustments of at least six months in arrears. We did not validate these claims requests, instead, we reviewed the appropriateness of all enhanced payments made for the audit period as of December 2002, regardless of whether CMS made the adjustments or not.

From IHA, we obtained the names and addresses of the nursing facilities in which the beneficiaries resided. We contacted the facilities to verify that the beneficiaries qualified for institutionalized status for the months that IHA reported to CMS. Based on residency information obtained from the nursing facilities, we identified Medicare beneficiaries who were incorrectly reported as institutionalized. The Medicare overpayment for each incorrectly reported beneficiary was calculated without regard to the risk factors by subtracting the non-institutional payment that IHA should have received from the institutional payment actually received.

Our fieldwork was performed during December 2002 through March 2003 in Buffalo, New York and in our field office in Kansas City, Missouri.

## **FINDINGS AND RECOMMENDATIONS**

IHA received Medicare overpayments of \$18,400 for 36 beneficiaries incorrectly classified as institutionalized. The beneficiaries were incorrectly classified because they were (1) not institutionalized for at least 30 consecutive days immediately prior to the month for which enhanced payments were made, or (2) admitted into hospitals for more than the 14-day limit allowed by CMS.

With regard to the 36 beneficiaries mentioned above, we specifically noted the following:

- 30 beneficiaries did not reside in a certified facility or certified part of the facility for 30 consecutive days immediately prior to the month for which an institutionalized payment was made (overpayments totaling about \$16,600), and
- Six beneficiaries were admitted into hospitals for more than the 14-day limit allowed by CMS (overpayments totaling about \$1,800).

The overpayments, for the most part, occurred because of lack of oversight of internal control procedures. IHA officials generally agreed with our conclusions for these findings and demonstrated their attempts to make corrections to the overall internal control structure. During the audit period, IHA revised its policies and procedures attempting to enhance its controls over classifying beneficiaries as institutionalized. We also note that the 15 previously mentioned retroactive letters included requests from IHA to CMS to correct overpayments. At the beginning of our audit, CMS had not adjusted these overpayments, which included about \$7,300 of the \$18,400 included in this report.

### RECOMMENDATIONS

We recommend that IHA:

- Refund the overpayments identified through our review totaling \$18,400 through a letter written to CMS delineating the beneficiaries to adjust and;
- Ensure policies and procedures regarding the verification of institutionalized beneficiaries are followed.

### IHA'S COMMENTS AND OIG'S RESPONSE

The IHA concurred with the findings as stated and has agreed to implement the recommendations, which includes revision to the policies on tracking and reporting institutionalized beneficiaries.

We commend IHA for agreeing with our findings and recommendations and encourage them to continue its efforts of improving their oversight of classifying beneficiaries as institutionalized.

IHA's response, in its entirety, is presented as Appendix A.

Sincerely yours,



James P. Aasmundstad  
Regional Inspector General  
for Audit Services



April 30, 2003

Mr. James P. Aasmundstad  
Regional Inspector General for Audit Services  
Region VII  
601 East 12<sup>th</sup> Street, Room 284A  
Kansas City, Missouri 64106

Dear Mr. Aasmundstad:

Thank you for the opportunity to reply to the findings from the recent audit conducted by your office relative to the institutional status of our Medicare+Choice members.

We concur with your recommendations and propose to do the following:

Follow up with CMS on the previously submitted requests for adjustments totaling \$7,300.

Initiate the remaining adjustments with CMS in the amount of \$11,100.

Revise our policy on tracking and reporting institutionalized members (see attached)

I look forward to receiving your final audit report in the near future.

Sincerely,

Thomas F. Jones  
Director, Product Operations

Attachment

cc: Carol Cassell  
Mike Faso



<b>POLICY:</b> Encompass 65 Institutionalized Process		<b>DEPT/TYPE:</b> Enrollment Department
<b>IMPLEMENTED BY:</b> Pam Neal		<b>EFFECTIVE DATE:</b> September 1, 2001
<b>REVISED DATE:</b> March 2003	<b>REVIEWED DATE:</b> March 2003	<b>PROCEDURE FILED IN</b> DEPT. Y ___ N

**Policy:** To comply with CMS regulations regarding the payment of an institutional rate for members in a qualifying institution and CMS Operational Policy Letter (OPL) #54, Independent Health will identify, verify, accrete, and reconcile institutionalized members. The institutional status of these members is verified on a monthly basis and accreted with institutional status each month that the CMS definition of institutionalized is met. As a result, the plan payment from CMS to Independent Health is calculated at an institutionalized rate. Each monthly plan payment is reconciled to verify that an institutional rate is received for each member accreted with institutional status and that all variances are reported in the CMS monthly plan payment attestation.

**Definition:** An institutionalized member is one who has been a resident of a qualifying facility for a minimum period of thirty consecutive days that includes the last day of the month (for February, must verify residency from January 30 thru February 28, or January 31 thru February 29) for which Independent Health is requesting payment at the institutionalized rate. To qualify for this monthly payment, there may be no more than fourteen days during which the member has moved to an acute facility, otherwise called a break in service. Per CMS, bed hold does not need to be verified. A qualifying facility is defined as a skilled facility (SNF), a nursing facility (NF), an intermediate care facility for the mentally retarded, a psychiatric hospital, a rehabilitation hospital, a long-term care hospital, or a swing-bed hospital where the enrolled member is receiving post hospital extended care services. Assisted Living does not meet the CMS definition of institutionalized status.

**Procedure:** **Identification.** No less than weekly a report is run of all pre-authorizations for skilled nursing care. This report will identify individuals who had a preauthorization for a qualified facility with a creation date within the month. This report is run from Power CL6071 and it is called Authorization Analysis Report.

Institutionalized members are also identified through the new member enrollment application. When new members are identified as institutionalized, the Special Status Coordinator will place a call to the facility to verify the member is in a Medicare/Medicaid certified bed and will obtain the admission date.

Institutionalized members are also identified through notification by the facilities during the monthly faxing process.

**Verification.** These Independent Health members are the institutionalized prospects that need to be investigated to ascertain whether they meet the CMS definition of institutionalized members as described above. If a member moves to an Assisted Living facility, that member does not meet the definition and cannot be accreted. In addition to the 30-day length of stay guidelines, the member must be institutionalized in one of the following facilities to qualify for institutional reimbursement:

- Skilled Nursing Facility (SNF)
- Nursing facility (NF)
- Intermediate Care Facility for the mentally retarded,
- Psychiatric hospital,
- Rehabilitation Hospital
- Long Term Care Hospital.

**The member must be receiving care in a Medicaid or Medicare certified bed within the Institution. The institution must be listed in the CMS Nursing Home Compare which can be found at [www.Medicare.gov](http://www.Medicare.gov).**

From the ACCESS Database, the Enrollment staff runs a report by facility to be sent to each facility to verify admission status of the member. (see Attachment #1, Institutional Verification). This report will show the members who appear on the monthly institutionalized report discussed above and also members in this facility verified from the prior month (unless there is a discharge status with the prior month's date). Facilities for which there is no match in the data maintenance file will appear in an unmatched facility list. These facilities will be used to correct the preauthorization data or add the facility to the database where required.

The facility specific reports are faxed to each facility no earlier than the first day of the month. Because the facility is asked to identify Independent Health members who are in the facility through the last day of the month, it is not advisable to fax this information any earlier in the month. The form requests each facility to verify admit and discharge date and provide room for their comments such as date of death, dates of

transfer to and from the facility as well as the name of the facility to which the member was transferred. The form also requests the facility to add other Independent Health members residing at the facility that may not have been identified through preauthorization data. Attachment #2 is a sample of the cover memo accompanying each report that explains how the facility should complete the form. Independent Health requests a return fax by noon of the second business day following our fax.

If the facility does not comply with the request to fax the information, they are called to verify over the phone. The Independent Health employee that gathers the information will clearly document the date, time, and facility staff person with which they spoke to verify this information.

**Accretion.** Once Independent Health has received all faxes back from the institutions and completed all phone verifications, all information will be entered into the Access database. A report will be generated from the database to determine who can be accreted to CMS per their definition of eligible institutional members. This report will be reviewed and approved by the department manager prior to submission to CMS. For Independent Health to be paid the institutional rate for a member, the transaction must be sent to CMS by the cutoff date published in the CMS GHP Monthly Schedule. Institutional data will be accreted in batch mode through Acxiom Medicare Services (see Attachment #3- Steps to Create And Load Institutional Batch File to Acxiom).

To minimize rejection errors, prior to transmission to CMS the monthly accretion file is compared to the CMS monthly membership file to identify any other special status flags present on the member file which would prevent CMS for reimbursing Independent Health at the Institutionalized rate. If the Working Aged flag is currently set on an institutionalized member file, MSP is pulled and open Working Aged lines are closed in McCoy or submitted to the Carrier for deletion. Members with Hospice flags set will not be reported as Institutionalized.

HIC# and Name are pulled from CMS data in the accretion process to ensure the accretion data matches CMS data. This will ensure "No Match on Name" rejection errors. Also, if no data is found for the member in the prior month CMS payment file, this matching will identify members who might have recently terminated their coverage with Independent Health. In this event, Independent Health will update their eligibility files and not accrete this member to CMS.

Once an individual is accreted to CMS as an institutional member, Independent Health must continue to verify on a monthly basis and

accrete each month in which the CMS definition of institutionalized member is met to continue receiving the correct adjustment to payment.

**Reconciliation.** To ensure the validity of payments by CMS, Independent Health will conduct an Institutional reconciliation. Each month, the report that is sent to CMS to request Institutional rates for identified members will be compared with the CMS Monthly Membership file for the same month. This process will ensure that Independent Health receives the correct rate for those submitted for payment, as well as identify members that did not receive the institutional adjustment.

CMS payments are reviewed through the Member Payment History reports. For example, if a member were institutionalized during the month of May, payment would come in July payment file with payment start and end dates of June 1 – June 30. The adjustment code for institutionalized payments is “09”.

Any variances in payment will be tracked and submitted to IntegriGuard (revised November 2002) and the CMS regional office via the Attestation report. This report will include the HIC number of the member, the member name, payment start and end date, and the reason for the error. This information will be reviewed prior to submission by the manager of the department and maintained in a separate and secure file for audit purposes.

ACKNOWLEDGEMENTS

This report was prepared under the direction of James P. Aasmundstad, Region 7 Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Thomas Suttles, *Audit Manager*

Chris Bresette, *Senior Auditor*

Joe Mickey, *Senior Auditor*

Debra Keasling, *Auditor*

Technical Assistance

Anne Lowe, *Senior Auditor*