

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**GROUP HEALTH COOPERATIVE OF
PUGET SOUND
SEATTLE, WASHINGTON**

**AUDIT OF MEDICARE PAYMENTS MADE
ON BEHALF OF BENEFICIARIES
CLASSIFIED AS INSTITUTIONALIZED**

**FOR THE PERIOD
SEPTEMBER 1994 THROUGH DECEMBER 1995**

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. Final determination on these matters will be made by authorized officials of the HHS operating divisions.



**JUNE GIBBS BROWN
Inspector General**

NOVEMBER 1997
CIN: A-10-97-00002



Region IX
Office of Audit Services
50 United Nations Plaza
Room 171
San Francisco, CA 94102

CIN: A- 1 O-97-00002
November 26, 1997

Phil Nudelman, PhD
President & Chief Executive Officer
Group Health Cooperative of Puget Sound
521 Wall Street
Seattle, WA 98121-1536

Dear Dr. Nudelman:

This report provides you with the results of our audit of enhanced Medicare payments made to Group Health Cooperative of Puget Sound (Group Health) for beneficiaries classified as institutionalized. Our audit included Medicare payments made during the period September 1994 through December 1995.

Group Health is a managed care organization and has been providing services to Medicare beneficiaries under contract with the Health Care Financing Administration (HCFA) since January 1, 1989. Group Health is paid a fixed monthly payment for each enrolled Medicare beneficiary. Enhanced payments are made on behalf of certain high-cost categories of beneficiaries, such as those residing in a nursing home or similar institution. However, when a beneficiary's institutionalized status changes, such as when a beneficiary moves from a nursing home to a private residence, the enhanced payments are to be discontinued.

SUMMARY OF FINDINGS

From a random sample of 100 monthly Medicare payments to Group Health representing 97 beneficiaries classified by Group Health as institutionalized, we identified 4 monthly payments for 4 different beneficiaries who were inappropriately classified as institutionalized. The 4 monthly payments included Medicare overpayments to Group Health totaling \$1,219. We identified additional overpayments totaling \$8,550 for those 4 beneficiaries improperly classified as institutionalized for months prior and/or subsequent to the months included in our sample, or total Medicare overpayments of \$9,769.

Generally, we found that Group Health had adequate controls to ensure that the enhanced payments were discontinued when the institutionalized status of beneficiaries changed.

However, one of the sample cases showed a need for Group Health to process information on changes in beneficiary status in a more timely manner, and three of the cases showed a need for improved procedures to ensure that retroactive adjustments were made upon discovery of Medicare overpayments due to changes in beneficiary status. In our audit, we noted that three of the four overpayment cases resulted from inaccurate information provided to Group Health by the institutions.

We are recommending that Group Health refund \$9,769 in Medicare overpayments. We are also recommending that Group Health reemphasize to its staff the importance of reporting changes in beneficiary institutionalized status in a timely manner to avoid Medicare overpayments, and establish policies and procedures to ensure that retroactive adjustments are made for Medicare overpayments when discovered.

In a written response to the draft report, Group Health agreed with the results of our audit. We have summarized Group Health's comments following the recommendations section of this report. The complete text of Group Health's comments is included as an Appendix to this report.

BACKGROUND

Group Health is paid a fixed monthly payment on a prepaid basis by HCFA to provide, or arrange for, health care services for each enrolled Medicare beneficiary. The Tax Equity and Fiscal Responsibility Act of 1982 provides that the fixed monthly payments to managed care organizations for Medicare beneficiaries be adjusted by a set of risk factors, such as age, gender, and Medicare entitlement status. The monthly advance payments are adjusted after the end of each month for beneficiaries who qualified for special rate classifications, such as those who were institutionalized during the prior month.

In order for a Medicare beneficiary to be classified as institutionalized during the period of our audit, the beneficiary must have met certain requirements outlined in a HCFA Regional Medicare Letter as follows:

“... have been a resident of a skilled nursing facility, swing-bed facility, intermediate care facility, sanatorium, rest home, convalescent home, long-term care hospital, or a domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current month -- i.e., immediately prior to the month the institutionalization is reported by the plan to HCFA. . . .”

“Member must require assistance with daily living activities (assistance with bathing, medications, dressing, etc.) and be living in other than his/her own home or the home of relatives.”

In a policy letter, dated July 24, 1997, HCFA revised the definition of institutionalized status to be effective for the months beginning after December 1997. Beginning in 1998, HCFA limited institutionalized status to enrolled beneficiaries who are residents of specific types of Medicare or Medicaid certified institutions, which included skilled nursing facilities, intermediate care facilities for the mentally retarded, psychiatric and rehabilitation hospitals or units, and long-term care and swing-bed hospitals. The requirement for 30 consecutive days remained the same as before; only the types of acceptable facilities were modified.

For a managed care organization to receive payments for institutionalized Medicare beneficiaries, the following events must occur:

- ▶ The managed care organization must notify HCFA when a beneficiary has enrolled in the organization.
- ▶ The managed care organization provides HCFA with demographic (e.g., gender, age, county/state of residence) and status information (e.g., institutionalized) about the enrolled beneficiaries.
- ▶ The HCFA places the above information into a managed care payment data base.
- ▶ Basic monthly payments to the managed care organization for enrolled Medicare beneficiaries are calculated and prepaid by HCFA based on the demographic and status information included in the data base.

The HCFA requires managed care organizations with enrolled beneficiaries to identify and report to HCFA, on a monthly basis, beneficiaries who meet the definition of institutionalized status.

The monthly payment that managed care organizations receive for an institutionalized beneficiary is significantly higher than the monthly payment received for an enrollee with basic Medicare coverage. For example, during 1995 managed care organizations received a monthly payment of about \$717 for each institutionalized non-Medicaid female enrollee aged 85 and over residing in King County, Washington. The corresponding basic Medicare payment during 1995 was about \$413. When a beneficiary is discharged from institutionalized care, the monthly payment to the managed care organization should return to the basic Medicare payment amount. The HCFA data base showed that Group Health reported between 948 and 1,419 Medicare enrollees per month as institutionalized during the period September 1994 through December 1995.

SCOPE

Our audit was made in accordance with generally accepted government auditing standards. The objective of our audit was to determine the appropriateness of the Medicare payments to Group

Health for Medicare beneficiaries classified by Group Health as institutionalized during the period September 1994 through December 1995.

Our review of Group Health's internal controls was limited to evaluating controls and procedures relating to classifying and reporting enrolled institutionalized beneficiaries to HCFA during the period September 1994 through December 1995. We also reviewed the reports of independent public accountants for audits of Group Health's financial statements which covered calendar years 1993, 1994, 1995 and 1996.

From HCFA records of 19,760 monthly Medicare payments to Group Health for beneficiaries classified by Group Health as institutionalized during the period September 1994 through December 1995, we randomly selected 100 for review. Those 100 monthly Medicare payments represented 97 beneficiaries.

Group Health provided us with the names of the institutions which each of the selected beneficiaries resided in during the 30-day period prior to the payment date of the month selected for review. We visited 61 institutions and contacted 11 institutions by phone. We reviewed each institution's records for the month selected to verify the institutionalized status of the beneficiary during the appropriate period. We discussed any exceptions noted with Group Health personnel to determine if additional information was available.

In determining overpayments, we calculated the difference between (1) the enhanced amount paid to Group Health by Medicare, and (2) the amount Medicare should have paid Group Health as determined from HCFA's Group Health Plan Maintenance System Rate Tables for 1994 and 1995. For the beneficiaries identified in our sample as improperly classified as institutionalized during a specific month, we reviewed the Medicare payments for the months prior and/or subsequent to the month included in our sample and identified additional Medicare overpayments.

Our field work was performed at the offices of Group Health and the 61 institutions we visited in the greater Seattle, Washington area from December 1996 through September 1997.

FINDINGS AND RECOMMENDATIONS

Of 100 randomly selected monthly Medicare payments for 97 beneficiaries classified by Group Health as institutionalized, we identified 4 monthly payments for 4 different beneficiaries who were inappropriately classified as institutionalized. The sample was taken from 19,760 monthly payments made to Group Health by HCFA for beneficiaries classified as institutionalized during the period September 1994 through December 1995. The 4 monthly payments included Medicare overpayments to Group Health totaling \$1,219. We identified additional overpayments totaling \$8,550 for the 4 beneficiaries improperly classified as institutionalized for the months prior and/or subsequent to the months included in our sample, for a total of \$9,769.

HCFA PROVISIONS

A HCFA Regional Medicare Letter provides that, in order for a beneficiary to qualify as institutionalized, the beneficiary must be a resident of an institution (e.g., skilled nursing facility, intermediate care facility, rest home, long-term care hospital, domiciliary home) for a minimum of 30 consecutive days immediately prior to the first day of the current month. The HCFA also requires that the beneficiary must need assistance with daily living activities (e.g., bathing, medications, dressing) and be living in other than his/her own home or the home of relatives. From a data base, HCFA generates monthly status reports which list the beneficiaries classified as institutionalized, and requires managed care organizations to review the reports and inform HCFA in a timely manner of any changes in a beneficiary's status.

OVERPAYMENT ANALYSIS

The following is a schedule of the \$9,769 in Medicare overpayments we identified in our audit listed by beneficiary:

<u>Beneficiary</u>	<u>Sample Information</u>				<u>Total Overpayment³</u>
	<u>Sample Month</u>	<u>Amount Paid¹</u>	<u>Amount Due²</u>	<u>Over-Payment</u>	
A	04/95	\$ 717	\$ 413	\$ 304	\$ 913
B	06/95	717	413	304	1,522
C	09/95	717	413	304	2,740
D	10/94	<u>686</u>	<u>379</u>	<u>307</u>	<u>4,594</u>
Totals		<u>\$2,837</u>	<u>\$1,618</u>	<u>\$1,219</u>	<u>\$9,769</u>

Beneficiary A

The sample month for Beneficiary A was April 1995. The required 30-day period to qualify for institutionalized status and the enhanced payment for April 1995 was March 2 through March 31, 1995. We found that the beneficiary had resided in a nursing home and was discharged in February 1995. Thus, the beneficiary no longer qualified for institutionalized status beginning in

¹This is the enhanced amount paid to Group Health by Medicare for a beneficiary that was inappropriately classified as institutionalized.

²This is the amount that should have been paid to Group Health because the beneficiary did not meet the institutionalized status requirements.

³This is the amount of overpayments for the sample month and the months prior and/or subsequent to that sample month.

March 1995. We determined that, in addition to April 1995, Group Health inappropriately received enhanced payments for Beneficiary A for the months of March and May 1995. Group Health received \$304 in Medicare overpayments for the sample month of April 1995 and total overpayments of \$913 for the 3 months.

The nursing home where the beneficiary resided until February 1995 received regular visits from a Group Health nurse. In this type of situation, it was Group Health's practice to require the nurse to report any change in the beneficiary's residency to the personnel responsible for monitoring institutionalized status of beneficiaries. However, according to Group Health officials, the nurse did not provide discharge information on this beneficiary until May 1995. At that time, Group Health reported the change in status to HCFA, and the enhanced payments were discontinued. The reporting delay indicates a need for Group Health to reemphasize to its staff the importance of reporting changes in beneficiary institutionalized status in a timely manner to avoid Medicare overpayments.

We also found that Group Health did not reimburse HCFA upon discovery of the overpayments for this beneficiary. Group Health did not have procedures in place to ensure that overpayments were reimbursed to HCFA when errors were discovered, indicating a need for policies and procedures to be established in this area.

Beneficiary B

The sample month for Beneficiary B was June 1995. The required 30-day period to qualify for institutionalized status and the enhanced payment for June 1995 was May 2 through May 31, 1995. We found that the beneficiary had resided in a nursing home and was discharged in January 1995. Therefore, the beneficiary no longer qualified for institutionalized status beginning in February 1995. We determined that, in addition to June 1995, Group Health inappropriately received enhanced payments for Beneficiary B from February through May 1995. Group Health received \$304 in Medicare overpayments for the sample month of June 1995 and total overpayments of \$1,522 for the 5 months.

For institutions where Medicare beneficiaries reside which are not visited by Group Health nurses, it is Group Health's policy to contact the institutions by phone each month to determine each enrolled beneficiary's residency. A Group Health representative advised us that monthly phone calls were made to the nursing home during the months of January through May 1995 to verify Beneficiary B's institutionalized status. In January, February, and March, the nursing home informed Group Health that she was a resident of the facility. In April, Group Health left two messages which went unreturned. In May, the nursing home informed Group Health that Beneficiary B was discharged in January 1995.

Although Group Health officials had adequate procedures in place to verify the residency of institutionalized beneficiaries, they were provided with incorrect information by the nursing

home. However, we found that Group Health did not reimburse HCFA upon discovery of the overpayments for this beneficiary. As noted above for Beneficiary A, Group Health needs to establish policies and procedures for reimbursing HCFA when overpayment errors are discovered.

Beneficiary C

The sample month for Beneficiary C was September 1995. The required 30-day period to qualify for institutionalized status and the enhanced payment for September 1995 was August 2 through August 31, 1995. We found that the beneficiary was in a retirement center during the month of August 1995. This retirement center provided varying degrees of service to its residents depending on their needs. Beneficiary C was a resident during the required period; however, she did not receive assistance with daily living during that time, nor at any time during her stay, as required by HCFA in order to qualify for institutionalized status. We determined that, in addition to September 1995, Group Health inappropriately received enhanced payments for Beneficiary C from March through August and October and November 1995. Group Health received \$304 in Medicare overpayments for the sample month of September 1995 and total overpayments of \$2,740 for the 9 months.

As noted above for Beneficiary B, Group Health's policy was to verify institutionalized status by monthly phone calls for beneficiaries at institutions which are not visited by Group Health nurses. Group Health's records showed that it had made monthly phone calls to Beneficiary C's retirement center during the months of February through October 1995. For February through August 1995, the institution reported that Beneficiary C was receiving assisted living services. In September 1995, the institution's employee that was contacted was unsure whether the beneficiary was receiving assisted living services. In October, the institution reported that Beneficiary C was discharged during that month and that she had never received assistance with daily living during her stay at the retirement center.

As stated previously, Group Health had adequate procedures in place to determine the residency of institutionalized beneficiaries, but was provided incorrect information by the retirement center. However, we found that Group Health did not reimburse HCFA upon discovery of the overpayments for this beneficiary. As noted above, Group Health needs to establish policies and procedures for reimbursing HCFA when overpayment errors are discovered.

Beneficiary D

The sample month for Beneficiary D was October 1994. The required 30-day period to qualify for institutionalized status and the enhanced payment for October 1994 was September 1 through September 30, 1994. We found that the beneficiary was in a retirement center during the month of September 1994. This retirement center provided varying degrees of service to its residents depending on their needs. Beneficiary D was a resident during the required period; however, she

did not receive assistance with daily living during that time, nor at any time during her stay, as required by HCFA in order to qualify for institutionalized status. We determined that, in addition to October 1994, Group Health inappropriately received enhanced payments for Beneficiary D from January through September 1994 and November 1994 through March 1995. Group Health received \$307 in Medicare overpayments for the sample month of October 1994 and total overpayments of \$4,594 for the 15 months.

Group Health's records showed that monthly phone calls were made to the institution during the months of December 1993 through March 1995. In September and October 1994, the institution reported Beneficiary D as receiving assisted living services. Our audit showed that Beneficiary D never received assisted living even though she lived in the facility through March 1995. Again, Group Health was provided with incorrect information by the retirement facility.

RECOMMENDATIONS

We recommend that Group Health:

1. Refund the \$9,769 in Medicare overpayments.
2. Reemphasize to its staff the importance of reporting changes in beneficiary institutionalized status in a timely manner to avoid Medicare overpayments.
3. Establish policies and procedures to ensure that retroactive adjustments are made for Medicare overpayments when discovered.

GROUP HEALTH RESPONSE

Group Health responded that it was in agreement with the results of our audit and is prepared to submit requests for retroactive adjustments to the HCFA Regional Office in Seattle. However, Group Health officials noted that HCFA informed them that the Regional policy is to not require retroactive adjustments for the institutionalized beneficiaries. Group Health stated that it has reserved the \$9,769 overpayment and is awaiting resolution of the issues related to retroactive adjustments. A copy of the letter from Group Health responding to our findings and recommendations is included as an Appendix to this report.

OFFICE OF INSPECTOR GENERAL COMMENTS

Our recommendations for a refund and for improved procedures relating to retroactive payment adjustments are in accordance with HCFA Central Office policy. Accordingly, Group Health should work with the HCFA Regional Office in Seattle for guidance on procedures for refunding

the \$9,769 overpayment identified in our audit, and for making future adjustments for overpayments relating to institutionalized beneficiaries as outlined above in recommendation 3.

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We request that you respond within 30 days from the date of this letter to the HHS official named below, presenting any comments or additional information that you believe may have a bearing on the final determination. Final determinations as to actions taken on all matters reported will be made by the HHS action official named below.

Regional Administrator
Health Care Financing Administration
220 1 Sixth Avenue, Mailstop: RX-43
Seattle, WA 98121

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, 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.) To facilitate identification, please refer to the common identification number (CIN) A-1 O-97-00002 in all correspondence relating to this report.

Sincerely,



Lawrence Frelot
Regional Inspector General
for Audit Services

Attachment

APPENDIX



Medicare Administration
1730 Minor Avenue, MPE 1270
PO Box 34750
Seattle, Washington 98124-1750

November 11, 1997

Department of Health & Human Services
OIG Office of Audit Services
2201 Sixth Avenue, M/S RX-80
Seattle, WA 98 12 1-2500

**RE: GROUP HEALTH COOPERATIVE OF PUGET SOUND - H5050
AUDIT OF MEDICARE PAYMENTS MADE ON BEHALF OF
BENEFICIARIES CLASSIFIED AS INSTITUTIONALIZED**

Dear Sirs:

Group Health Cooperative of Puget Sound is in receipt of your draft report of the "OIG Audit of Medicare Payments Made On Behalf Of Beneficiaries Classified As Institutionalized" for the period of September 1994 through December 1995.

We are in agreement with the results of your audit. Group Health has prepared to submit requests for retroactive capitation adjustment to the Health Care Financing Administration's Region X office in Seattle.

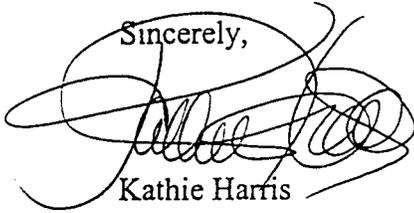
Upon contacting the Region X office and speaking with Barbara Clark-Elliott and Ed Madden, Group Health has been informed that the Health Care Financing Administration has not in the past, and does not at this time, accept any retroactive adjustments for the institutional beneficiaries.

I contacted Barry Diamond-Johnson in the Office of the Inspector General once this information was received from the Health Care Financing Administration. It is currently my understanding that the OIG and HCFA will work together to resolve the issues related to retroactive adjustment of institutionalized beneficiaries.

Group Health will await further word from HCFA and the OIG as to what appropriate action we should take. In the meantime, Group Health has reserved the \$9,769 requested as an overpayment by the OIG on our institutional population.

If you have questions, may I please ask that you contact me directly at (206) 287-2.5 10.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kathie Harris', written over the word 'Sincerely,'.

Kathie Harris

Assistant Administrator, Government Programs
Director of Medicare Administration
Group Health Cooperative of Puget Sound

cc: Barbara Clark-Elliott, Health Care Financing Administration, Regional office
Ed Madden, Health Care Financing Administration, Regional office
Eileen O'Donnell, Group Health Cooperative of Puget Sound
Cheryl Scott, Chief Executive Offices, Group Health Cooperative of Puget Sound
Shieleen Wood, Group Health Cooperative of Puget Sound