

**Memorandum**

Date APR 19 1999
From June Gibbs Brown
Inspector General *June G Brown*
Subject Review of Medicare Managed Care Payments for Beneficiaries With Institutional Status
(A-05-98-00046)
To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Medicare Managed Care Payments for Beneficiaries With Institutional Status." The objective of our review was to determine if the Health Care Financing Administration (HCFA) is making accurate capitation payments to risk-based health maintenance organizations (HMOs) for beneficiaries with institutional status.

We estimate that risk-based HMOs received Medicare overpayments of \$22.2 million for beneficiaries incorrectly classified as institutionalized. Our conclusions are based on the combined results of audits at eight statistically selected HMOs, located throughout the country, and work performed at HCFA regional offices. During the audits at the eight HMOs, we determined that 137 of 800 sampled beneficiaries did not meet institutional status requirements for months reported to HCFA.

An HMO is a legal entity that provides or arranges for basic health services for its enrolled members. Under risk-based contracts, HMOs receive payment on a prospective per capita basis. A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. During our audit period, requirements for institutional status were met when a Medicare beneficiary had been a resident of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The majority of the 137 Medicare overpayments that we identified resulted from inadequate internal controls at the audited HMOs. The internal control difficulties were primarily in two areas: (1) verification of beneficiaries' institutional status and (2) reporting of institutional beneficiaries to HCFA. These problems caused 110 beneficiaries to be incorrectly claimed as institutionalized. The HMO Provider Manual requires that risk-based HMOs identify, on a monthly basis, the beneficiaries who meet institutional status requirements and submit a list of the beneficiaries to HCFA.

The HMOs received unallowable institutional payments for 27 other beneficiaries as the result of institutional facilities providing inaccurate residency data to the HMOs, HCFA not processing submitted payment adjustments, and other miscellaneous errors.

Staff from HCFA regional offices conduct biannual reviews at risk-based HMOs that include steps to determine if HMOs are accurately verifying and reporting the institutional status of beneficiaries. The review steps include examining the HMO's documentation supporting single monthly institutional payments for a sample of 30 beneficiaries. The HCFA reviewers also contact the institutional facilities for 10 of the beneficiaries to verify dates of residency. Based on our audit results, we concluded that by reviewing single month periods for each beneficiary, and verifying the residency of only 10 beneficiaries, HCFA is not always able to identify which HMOs have inadequate procedures to verify and report institutional status. We also found that when HCFA knew that an HMO had inadequate procedures for verifying and reporting institutional status, HCFA continued to pay the HMO's institutional claims.

To improve the on-site reviews, HCFA staff should review entire periods of institutional residency for each beneficiary selected, rather than single months. The HCFA reviewers should also verify the dates of residency for more than 10 beneficiaries. We believe that these changes would help HCFA identify HMOs that are unable to accurately verify and report institutional status and allow HCFA to prevent future Medicare overpayments. We also believe that HCFA should suspend institutional payments to HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries until there is some assurance that institutional claims are correct.

We have issued individual reports to the eight audited HMOs which included recommendations, where necessary, to correct areas of concern at the individual HMOs and to refund overpayments to HCFA. In this report, we recommend that HCFA strengthen its on-site review procedures to better identify risk-based HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries. In addition, we recommend that HCFA use the strengthened procedures on the next round of site visits, to identify HMOs which have been incorrectly reporting beneficiaries as institutionalized, and conduct detailed audits to identify and recover Medicare overpayments which we estimate to be \$22.2 million.

In a written response, HCFA officials generally concurred with the recommendations included in our report and are taking action to address the concerns identified through our audit work. The full text of HCFA's response is included with this report as Appendix B.

Please advise us within 60 days on the status of any further action taken or planned on our recommendations. If you have any questions or need clarification on the report, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. To facilitate identification, please refer to Common Identification Number A-05-98-00046 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



JUNE GIBBS BROWN
Inspector General

APRIL 1999
A-05-98-00046

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to determine if the Health Care Financing Administration (HCFA) is making accurate capitation payments to risk-based health maintenance organizations (HMOs) for beneficiaries with institutional status. Our conclusions are based on the combined results of audits completed at eight HMOs, located throughout the country, and work performed at HCFA regional offices.

BACKGROUND

An HMO is a legal entity that provides or arranges for basic health services for its enrolled members. Under risk-based contracts, HMOs receive payment on a prospective per capita basis. A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. During our audit period, requirements for institutional status were met when a Medicare beneficiary had been a resident of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

SUMMARY OF RESULTS

We estimate that risk-based HMOs received Medicare overpayments of \$22.2 million for beneficiaries incorrectly classified as institutionalized. During audits at eight statistically selected HMOs, we determined that 137 of 800 sampled beneficiaries did not meet institutional status requirements for months reported to HCFA. The 800 beneficiaries reviewed consisted of a sample of 100 beneficiaries from each of the audited HMOs. The samples were statistically selected from Medicare beneficiaries reported as institutionalized during our audit period.

The majority of the Medicare 137 overpayments that we identified resulted from inadequate internal controls at the audited HMOs. The internal control difficulties were primarily in two areas: (1) verification of beneficiaries' institutional status and (2) reporting of institutional beneficiaries to HCFA. These problems caused 110 beneficiaries to be incorrectly claimed as institutionalized. The HMO Provider Manual requires that risk-based HMOs identify, on a monthly basis, the beneficiaries who meet institutional status requirements and submit a list of the beneficiaries to HCFA.

The HMOs received unallowable institutional payments for 27 other beneficiaries as the result of institutional facilities providing inaccurate residency data to the HMOs, HCFA not processing submitted payment adjustments, and other miscellaneous errors.

Staff from HCFA regional offices conduct biannual reviews at risk-based HMOs that include steps to determine if HMOs are accurately verifying and reporting the institutional status of beneficiaries. The review steps include examining the HMO's documentation supporting single monthly institutional payments for a sample of 30 beneficiaries. The HCFA reviewers also contact the institutional facilities for 10 of the beneficiaries to verify dates of residency. Based on our audit results, we concluded that, by reviewing single month periods for each beneficiary and verifying the residency of only 10 beneficiaries, HCFA is not always able to identify which HMOs have inadequate procedures to verify and report institutional status. We also found that when HCFA knew that an HMO had inadequate procedures for verifying and reporting institutional status, HCFA continued to pay the HMO's institutional claims.

To improve the on-site reviews, HCFA staff should review entire periods of institutional residency for each beneficiary selected, rather than single months. The HCFA reviewers should also verify the dates of residency for more than 10 beneficiaries. We believe that these changes would help HCFA identify HMOs that are unable to accurately verify and report institutional status and allow HCFA to prevent future Medicare overpayments. We also believe that HCFA should suspend institutional payments to HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries until there is some assurance that institutional claims are correct.

RECOMMENDATIONS

We have issued individual reports for the eight audited HMOs which included recommendations, where necessary, to correct areas of concern at the individual HMOs and to refund overpayments to HCFA. In this report, we are recommending that HCFA strengthen its on-site review procedures to better identify HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries. In addition, we recommend that HCFA use the strengthened procedures on the next round of site visits, to identify HMOs which have been incorrectly reporting beneficiaries as institutionalized, and conduct detailed audits to identify and recover overpayments which we estimate to be \$22.2 million.

HCFA'S COMMENTS

In a written response, HCFA officials generally concurred with the recommendations included in our report and are taking action to address the concerns identified through our audit work. The full text of HCFA's response is included with this report as Appendix B.

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INTRODUCTION

BACKGROUND

An HMO is a legal entity that provides or arranges for basic health services for its enrolled members. After being certified as eligible by the Department of Health and Human Services, HMOs can contract with HCFA to provide medical services to Medicare beneficiaries. Participating HMOs are to provide all services covered by Parts A and B of the program.

HMO Contracts

The HMOs participating in the Medicare program may contract with HCFA on either a risk or cost basis. Under risk-based contracts, HMOs receive payment on a prospective per capita basis with the HMO required to absorb any losses and permitted to retain any savings. The per capita rates are set at 95 percent of the expected fee-for-service costs that would have been incurred by Medicare had beneficiaries not enrolled in risk-based HMOs. Beneficiaries enrolled in a risk-based HMO must receive medical services, except emergency care when warranted, through the HMO. The risk contract option for HMOs was established through the Tax Equity and Fiscal Responsibility Act of 1982.

Under cost-based contracts, Medicare payments to HMOs are based on the reasonable costs of providing services to Medicare beneficiaries. Beneficiaries enrolled in cost based HMOs are not restricted to receiving medical services through the HMO. Medicare covered medical care can be obtained from any Medicare certified fee-for service provider.

Institutional Status

A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. During our audit period, requirements for institutional status were met when a Medicare beneficiary had been a resident of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month. After the initial month of institutional residency has been established, a beneficiary may leave the facility to go to an acute care hospital for 15 days or less and still be considered institutionalized. The beneficiary must be directly readmitted to an institutional facility following the hospital stay to maintain institutional status.

After our audit period, HCFA changed the definition of an institutional facility for purposes of qualifying for payment at the enhanced institutional rate. As stated, HCFA's definition of an institution had included nursing homes, sanatoriums, rest homes, convalescent homes, long-term care hospitals, and domiciliary homes. This definition was established by the U.S. Census Bureau and adopted by HCFA at the time the original cost factors for institutionalized beneficiaries were developed from Census Bureau data. The old rule was changed because it lacked specific criteria defining each type of facility which resulted in differing views as to what was allowable.

Effective January 1998, the following Medicare or Medicaid certified institutions are included in HCFA's new definition of an institutional facility: 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.

Institutional Payment Process

Under risk-based contracts, HCFA makes monthly advance payments to HMOs at the per capita rate set for each enrolled beneficiary. Variables affecting the advance payments include geographic location (county), Medicare status (aged or disabled), age, and sex.

A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. To receive the higher capitation rate, HMOs are required to submit to HCFA each month a list of beneficiaries meeting the institutional status requirements. The advance payments received by HMOs each month are subsequently adjusted to reflect the enhanced reimbursement. The following is an example of the payment adjustment for institutional status.

Beneficiary Profile: 85 Years Old, Male, Non-Medicaid		
Residence: Los Angeles County, California		
Calendar Year: 1998		
Basic Monthly Payment	Monthly Payment at Institutional Rate	Payment Increase
\$803.21	\$1,347.69	\$544.48

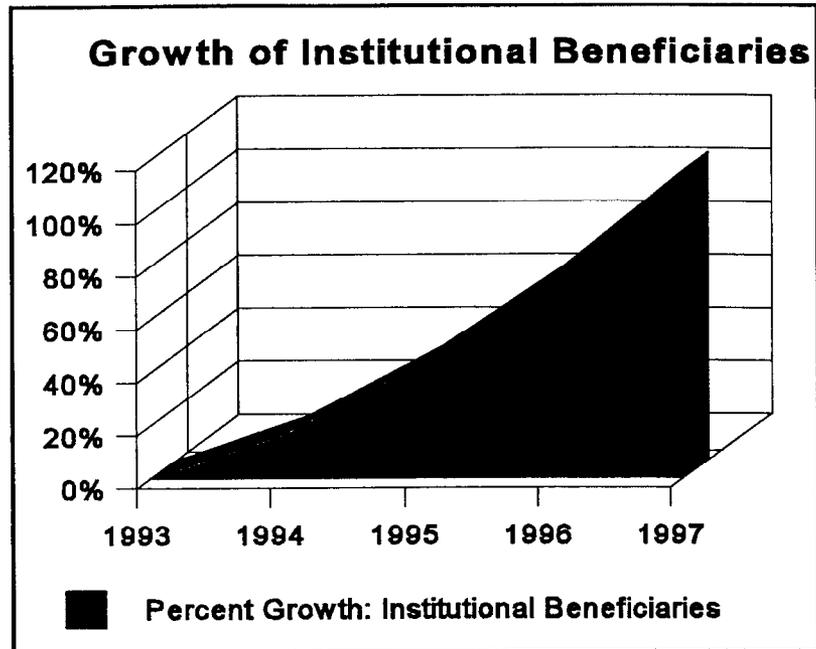
The monthly advance payment of \$803.21 would have been adjusted to \$1,347.69 after the beneficiary was reported to HCFA as having institutional status.

HMO Statistics

A review of HCFA statistics for the past 5 years shows that the number of risk-based HMOs contracting with HCFA has almost tripled. In 1993, 107 HMOs had risk contracts with HCFA, by 1997 the number had risen to 304. The number of Medicare beneficiaries enrolled in risk-based HMOs has grown at a similar rate. In 1993, 1.73 million beneficiaries were enrolled in risk-based HMOs, by 1997 there were 4.96 million. The rapid growth of beneficiary enrollment has resulted in a corresponding increase in Medicare payments to risk-based HMOs. Total Medicare payments to risk-based HMOs have increased 234 percent from \$7.2 billion in 1993 to over \$24 billion in 1997.

The number of beneficiaries reported as institutionalized has also increased greatly during the last 5 years. In December 1993, 30,745 beneficiaries were claimed as institutionalized. By December 1997, the number had grown to 66,361, an increase of almost 120 percent. Medicare payments for institutionalized beneficiaries have likewise increased. In 1997, Medicare paid an additional \$197 million for beneficiaries reported as

institutionalized. This amount represents the difference between the adjusted payment for institutional status and the normal capitation payment the HMO would have received had the beneficiary not been reported as institutionalized. The continued growth of institutional payments to risk-based HMOs makes HCFA's administration of this program area increasingly important.



HCFA's Reviews

Biannual reviews of risk-based HMOs are conducted by HCFA to determine if HMOs are in compliance with Federal regulations. The reviews include an examination of issues concerning institutionalized beneficiaries. The purpose is to determine if HMOs are properly reporting to HCFA only those beneficiaries who meet institutional status requirements. As part of the review HCFA staff:

- Evaluate the HMO's policies and procedures for verifying and reporting the institutional status of enrolled beneficiaries.
- Verify the institutional status of beneficiaries enrolled in the HMO.

To verify institutional status, HCFA staff select for review a sample 30 beneficiaries who were enrolled in the HMO and reported as institutionalized during a 6-month review period. The HMO's documentation supporting an institutional month for each of the 30 beneficiaries is examined. The HCFA reviewer determines if the supporting documents identify a qualifying facility and that dates of residency meet the 30-day requirement. As a final step, the institutional facilities where 10 of the beneficiaries resided are contacted to verify the dates of residency. The reviewers are instructed to contact at least three different institutional facilities.

SCOPE

Our audit was performed in accordance with generally accepted government auditing standards. The objective was to determine if HCFA is making accurate capitation payments to risk-based HMOs for beneficiaries reported as institutionalized. Our audit included a review of internal controls at each HMO in our primary sample, focusing on procedures for verifying the institutional status of Medicare beneficiaries.

A primary sample of 8 was selected from a universe of 74 risk-based HMOs that had contracts with HCFA during April 1996. Our universe did not include HMOs that reported less than 30 institutionalized beneficiaries in April 1996, or HMOs which were the subject of recent Office of Inspector General audits involving Medicare payments for institutionalized beneficiaries. A weighted sample selection process was used to choose our eight primary units. The probability of each of the 74 HMOs being selected was proportional to the number of beneficiaries reported as institutionalized during April 1996.

A simple random sample of 100 was selected for each of the eight HMOs from a universe of Medicare beneficiaries reported as institutionalized during the period October 1, 1994 through September 30, 1996.

Number of Beneficiaries in Each HMO's Sample Universe							
HMO 1	HMO 2	HMO 3	HMO 4	HMO 5	HMO 6	HMO 7	HMO 8
1,211	10,393	1,334	635	219	2,427	2,391	328

The names and addresses of the institutions in which the beneficiaries in each sample resided were obtained from the HMOs. Confirmation letters were sent to institutional facilities to verify that the sample beneficiaries were institutionalized for the periods reported to HCFA. Based on responses received from institutional facilities, we identified Medicare beneficiaries who were incorrectly reported as having institutional status. We calculated the Medicare overpayment for each beneficiary incorrectly reported as institutionalized by subtracting the non-institutional payment that an HMO should have received from the institutional payment actually received. Using the overpayments identified in our eight samples, we projected the probable value of Medicare overpayments in the universe of beneficiaries for each HMO. The sample results for the eight HMOs were then used to project the probable value of Medicare overpayments in our primary universe of HMOs. Details of our statistical sample and projection are shown on Appendix A.

Our field work was completed during 1998 at the HMO offices, various HCFA offices, and our field office in Columbus, Ohio.

RESULTS OF AUDIT

MEDICARE OVERPAYMENTS

We estimate that risk-based HMOs received Medicare overpayments of \$22.2 million for beneficiaries incorrectly classified as institutionalized. Our results are based on audits of 8 statistically selected HMOs, where we determined that 137 of 800 sampled beneficiaries did not meet institutional status requirements for months reported to HCFA. During our audit period, requirements for institutional status were met when a Medicare beneficiary had been a resident of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

Results at Individual HMOs

The results from the individual audits of eight HMOs are being combined in this report to allow us to estimate, on a national basis, the total amount of Medicare overpayments to risk-based HMOs for beneficiaries incorrectly reported as institutionalized. The 800 beneficiaries reviewed consisted of a sample of 100 beneficiaries from each of the audited HMOs. The beneficiary samples were randomly selected from universes of all Medicare beneficiaries reported as institutionalized by each of the eight HMOs during our audit period. The schedule below provides the results of the individual audits which found that all eight HMOs had incorrectly reported beneficiaries as institutionalized. The error rates ranged from a low of 5 percent to a high of 41 percent.

Audit Results From Individual HMOs			
Audited HMOs	Unallowable Beneficiaries ¹	Identified Medicare Overpayments	Statistically Projected Overpayments (Point Estimates)
HMO 1	5	\$4,037	*
HMO 2	14	\$9,700	\$1,008,141
HMO 3	41	\$167,630	\$2,236,187
HMO 4	6	\$7,022	\$44,590
HMO 5	31	\$27,201	\$59,571
HMO 6	13	\$8,941	\$216,988
HMO 7	20	\$10,472	\$250,389
HMO 8	7	\$4,754	\$15,594
Totals	137	\$239,757	\$3,831,460

(* Less than six errors are not projected in accordance with OAS policy.)

¹A total sample of 100 beneficiaries was reviewed at each HMO.

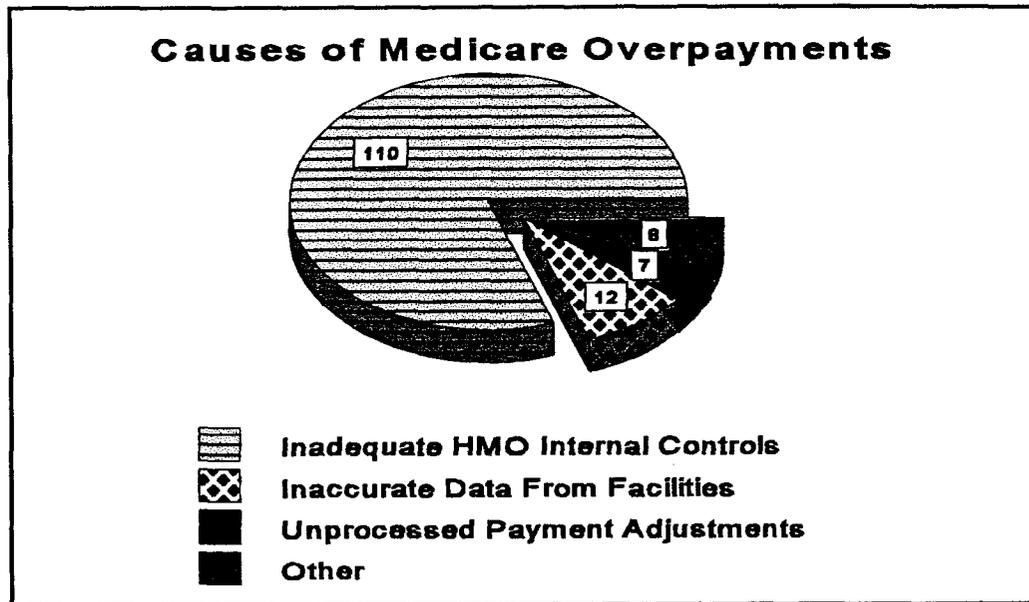
CAUSES OF OVERPAYMENTS

The majority of the Medicare overpayments that we identified resulted from inadequate internal controls at the audited HMOs. The internal control difficulties were primarily in two areas:

- Verification of beneficiaries' institutional status.
- Reporting of institutional beneficiaries to HCFA.

These problems caused 110 beneficiaries in our sample to be incorrectly claimed as institutionalized. The HMO Provider Manual required that risk-based HMOs identify, on a monthly basis, the beneficiaries who meet institutional status requirements and submit a list of the beneficiaries to HCFA.

The audited HMOs received unallowable institutional payments for 27 other beneficiaries as the result of institutional facilities providing inaccurate residency data to the HMOs, HCFA not processing submitted payment adjustments, and other miscellaneous errors.



In addition to the causes of unallowable institutional payments identified at the individual HMOs, we found that HCFA's on-site review procedures need to be strengthened to better identify HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries.

Internal Controls at HMOs

We determined that internal control procedures used by some HMOs to verify the institutional status of beneficiaries were inadequate. The HMOs attempted to track institutional residency using information obtained in the normal course of business, rather than contacting institutional facilities at the end of each month. Data from operational areas such as admissions, billing, or medical care would be used to identify which beneficiaries were residents of institutional facilities. We found that HMOs that tracked institutional residency in this way could not consistently identify the dates beneficiaries were discharged from nursing homes or other institutional facilities. As a result, beneficiaries were reported to HCFA as institutionalized after being discharged from institutional facilities causing unallowable payments by Medicare. At the close of our audit, all eight HMOs included in our review had implemented procedures requiring that institutional facilities be contacted each month to verify the continued residency of Medicare beneficiaries.

We also found that HMOs did not always accurately report to HCFA the institutional residency data which had been compiled. We identified significant data processing errors involving the computer systems at two HMOs which caused beneficiaries to be inaccurately reported to HCFA as institutionalized. At one HMO, data was not being accurately transferred from the computer system maintaining beneficiary residency information to the computer system used to report institutional beneficiaries to HCFA. At another HMO, programming logic errors caused the computer to report beneficiaries to HCFA as institutionalized when the 30-day residency requirement was not met or after beneficiaries had been discharged from facilities.

Inaccurate Residency Data

The HMOs in our review that had effective procedures for verifying institutional status, contacted institutional facilities each month to verify the continued residency of beneficiaries before reporting them to HCFA. However, we found that the residency data provided by the institutional facilities to the HMOs was not always accurate, which caused the beneficiaries to be incorrectly reported to HCFA as institutionalized. Even though this is occurring, HMOs still have the responsibility to report accurate information to HCFA.

Unprocessed Payment Adjustments

During our audit, we were provided documentation by officials from one HMO indicating that adjustments had been submitted to HCFA to return payments for beneficiaries incorrectly reported as institutionalized. When we reviewed payment data for those beneficiaries, we found that the adjustments submitted by the HMO had not been processed. During discussions with HCFA staff, we were told that the regional office had been receiving 400 adjustments a month which had to be manually entered into HCFA's computerized payment system. Officials at the HCFA regional office agreed that because of the large volume of adjustments and the possibility of keying errors, it was probable that some adjustments submitted by HMOs had not been processed.

HCFA Oversight

The periodic reviews conducted by HCFA at risk-based HMOs include steps to determine if HMOs are properly reporting to HCFA only those beneficiaries who meet institutional status requirements. Based on the results of our audit we concluded that HCFA's review procedures have not always been effective. Eighty percent of the Medicare overpayments identified in the course of this review resulted from inadequate internal controls at HMOs. We found that HMOs were either unable to accurately verify the institutional status of Medicare beneficiaries or unable to accurately report the results after verification procedures were completed. We believe that HCFA's on-site review procedures need to be strengthened to better identify HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries.

In order to test the effectiveness of an HMO's procedures for verifying and reporting the institutional status of beneficiaries, HCFA selects for review a sample of 30 beneficiaries who were enrolled in the HMO and reported as institutionalized during a 6-month review period. The HCFA reviewer examines the HMO's documentation supporting an institutional month for each of the 30 beneficiaries to determine if the beneficiaries were in a qualifying facility and that dates of residency meet the 30-day requirement. As a final step, the institutional facilities where 10 of the beneficiaries resided are contacted to verify the dates of residency. Based on our audit results, we concluded that by reviewing single month periods for each beneficiary, and verifying the residency of only 10 beneficiaries, HCFA is not always able to identify which HMOs have inadequate procedures.

To improve the on-site reviews, HCFA staff should examine entire periods of institutional residency for each beneficiary selected, rather than single months. This is significant because we found that beneficiaries were often incorrectly claimed as institutionalized in the first or last month of multi-month periods of institutional residency. The errors occurred because HMOs had difficulty accurately determining the dates beneficiaries were admitted to, and discharged from, institutional facilities. When HCFA staff review HMO documents supporting institutional status or contact institutional facilities to verify dates of residency, they should examine all months of a continuous period of institutional status, not just one month.

Current review procedures require that HCFA staff contact the institutional facilities for 10 beneficiaries to verify dates of residency. We believe that 10 verifications are not sufficient to be sure that HMO steps for confirming institutional status are effective. The HCFA monitoring procedures should be strengthened by having reviewers verify the dates of residency of more than 10 beneficiaries. During our audits, we were successful in identifying beneficiaries who were incorrectly reported as institutionalized because we reviewed all months of an institutional status period and because we verified the dates of residency of 100 beneficiaries. The HCFA reviewed a single month and only 10 beneficiaries. We believe that if HCFA strengthens its monitoring visits as suggested, HCFA reviewers will be better able to identify HMOs that do not accurately verify and report institutional status and to prevent future Medicare overpayments.

Another area of concern is HCFA's handling of HMOs identified as having inadequate procedures for verifying and reporting the institutional status of enrolled beneficiaries. During our audit, we found that HCFA knew that an HMO was incorrectly reporting beneficiaries as

institutionalized due to computer system problems, yet HCFA continued to pay the HMO's institutional claims. We believe HCFA should have discontinued making institutional payments to the HMO until it had some assurance that the institutional claims were correct. Further, HCFA should have conducted a detailed audit to identify and recover the overpayments received by the HMO.

RECOMMENDATIONS

We have issued individual reports for the eight audited HMOs which included recommendations, where necessary, to correct areas of concern at the individual HMOs and to refund overpayments to HCFA. In this report, we are making the following recommendations to HCFA concerning all risk-based HMOs. We recommend that HCFA:

- Strengthen its on-site review procedures in order to identify HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries.
- Use the strengthened review procedures, on the next round of site visits, to identify those HMOs which have been incorrectly reporting beneficiaries as institutionalized and conduct detailed audits to identify and recover Medicare overpayments which we estimate to be \$22.2 million.
- Establish procedures to suspend institutional payments to HMOs identified as unable to accurately verify and report the institutional status of enrolled beneficiaries, until the HMO has improved internal controls.
- Develop procedures to ensure that HCFA regional offices process all institutional payment adjustments submitted by HMOs.

We believe that HCFA's narrowing of the definition of an institutional facility to include only Medicare and Medicaid certified facilities should improve the accuracy of residency data received by risk-based HMOs when verifying institutional status. As a result, we are currently making no recommendations in this area.

HCFA'S COMMENTS

In a written response, HCFA officials generally concurred with the recommendations included in our report and are taking action to address the concerns identified through our audit work. The full text of HCFA's response is included with this report as Appendix B.

**VARIABLE APPRAISAL OF STATISTICAL SAMPLE
(TWO STAGE)**

Primary Units Sampled:	8
Primary Units Not Sampled:	66
Primary Units in Population:	74

Projection at 90 Percent Confidence Level

Point Estimate of Population Total:	\$22,181,783
Standard Error:	\$14,156,642
Lower Limit:	(\$1,103,769) ¹
Upper Limit:	\$45,467,334
Precision Amount:	\$23,285,552
Precision Percent:	104.98%

¹The range between the upper and lower limit occurred due to variability among the Medicare overpayments identified at the eight HMOs included in our sample. As noted on page five of the report, the overpayments ranged from a low of \$4,037 to a high of \$167,630. Three of the eight HMOs reviewed had 20 percent or more errors in institutional payments while an additional three HMOs had under 10 percent in errors. The net effect of all this variability is a large standard error causing a wide confidence interval.



DATE: FEB 26 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *NMD*
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Review of Medicare Managed Care Payments for Beneficiaries with Institutional Status,"
A-05-98-00046

The objective of this OIG review was to determine if HCFA is making accurate capitation payments to risk-based health maintenance organizations (HMOs) for beneficiaries in institutional status. The conclusions are based on the combined results of audits completed in eight HMOs, located throughout the country, and work performed at HCFA regional offices. The OIG issued individual reports for the eight audited HMOs which included recommendations, where necessary, to correct areas of concern at the individual HMOs and to refund overpayments to HCFA.

We appreciate the opportunity to comment on the issues raised in this report. Our detailed comments are as follows:

OIG Recommendation 1

OIG recommends that HCFA strengthen its on-site review procedures in order to identify HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries.

HCFA Response

We agree with this recommendation. The report focused on HCFA overpayments to Medicare HMOs based on the incorrect reporting of institutional status of enrolled beneficiaries. We believe the overpayments are a symptom of the more basic problem of a lack of accuracy in HCFA's institutional status records. This inaccuracy results in both overpayments and underpayments to Medicare HMOs. While the OIG, with its responsibility for protecting the interests of the Federal taxpayers, has rightly focused on overpayments, HCFA is committed to the proper administration of the Medicare managed care program, which includes ensuring that contracting HMOs are paid accurately for the services they provide Medicare beneficiaries. Success in HCFA's effort to improve the

accuracy of the institutional status data would necessarily address the OIG's concerns about overpayments to Medicare HMOs.

HCFA plans to take the following actions:

- ▶ Improve oversight of special status rate cells. HCFA is currently developing a statement of work (SOW) for a managed care program safeguard contractor. This SOW will include the task of developing comprehensive procedures for validating the institutional status rate cell submissions by M-C organizations. HCFA intends to use the information provided by OIG in its audits of institutionalized beneficiaries to assist in the development of both the SOW and the comprehensive procedures for validating special status rate cells.
- ▶ HCFA will develop and issue instructions to Regional Office staff regarding recovery of overpayments when they are identified during a routine monitoring visit.

OIG Recommendation 2

The OIG recommends that HCFA use the strengthened review procedures, on the next round of site visits, to identify those HMOs which have been incorrectly reporting beneficiaries as institutionalized and conduct detailed audits to identify and recover Medicare overpayments which we estimate to be \$22.2 million.

HCFA Response:

We concur. As indicated in the above response, HCFA is developing a SOW for a managed care program safeguard contractor to assist our agency with the development of comprehensive procedures for validating all special status beneficiaries. HCFA is also beginning the development of a revised Medicare HMO monitoring tool which will incorporate the new requirements promulgated under the Balanced Budget Act of 1997 (BBA). In developing this monitoring tool, HCFA will review the procedures used by OIG in this series of audits. HCFA anticipates revising the monitoring tool within approximately four to six months.

HCFA will also work to further develop procedures for recovery of overpayments when evidence of this is found through on-site monitoring reviews.

Finally, HCFA will begin the development of regulations which allow the agency to pay such plans (i.e., HMOs identified as unable to accurately verify and report institutional status of enrolled beneficiaries) only the base payment (i.e., aged or disabled) and not the marginal increase for institutional status until such time the HMO has improved its internal controls.

OIG Recommendation 3

The OIG recommends that HCFA establish procedures to suspend institutional payments to HMOs identified as unable to accurately verify and report the institutional status of enrolled beneficiaries, until the HMO has improved internal controls.

HCFA Response:

HCFA concurs with this recommendation and will begin the development of appropriate regulations, as discussed above.

OIG Recommendation 4

The OIG recommends that HCFA develop procedures to ensure that HCFA regional offices process all institutional payment adjustments submitted by HMOs.

HCFA Response:

HCFA concurs with this recommendation. HCFA will work with the Regional Offices' staffs to develop appropriate procedures. This work will take place during the revision of the new monitoring tool.