Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOLLOW-UP REVIEW OF MEDICARE PAYMENTS FOR INSTITUTIONALIZED BENEFICIARIES

MEDICA HEALTH MAINTENANCE ORGANIZATION

JUNE 2001
A-05-00-00060

Office of Inspector General

http://oig.hhs.gov/

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

June 22,2001
Common Identification No. A-05-00-00060

Mr. David R. Strand, Chief Operating Officer
Allina Health System
P.O. Box 9310
Mail Route 80003
Minneapolis, Minnesota 55440

Dear Mr. Strand:

Enclosed are two copies of the Office of Inspector General report entitled "Follow-up Review of Medicare Payments for Institutionalized Beneficiaries, Medica Health Maintenance Organization". A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determinations as to actions taken on all matters reported will be made by the action official. 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, 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.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification No. A-05-00-00060 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Director, Office of Managed Care
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
33-02-01
7500 Security Boulevard
Baltimore, Maryland 2 1244-1850

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OFFICE OF AUDIT SERVICES
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June 22,2001

CIN: A-05-00-00060

Mr. David R. Strand, Chief Operating Officer
Allina Health System
P.O. Box 9310
Mail Route 80003
Minneapolis, Minnesota 55440

Dear Mr. Strand,

This report provides you with the results of our follow-up review of the appropriateness of Medicare payments to Medica on behalf of beneficiaries classified as institutionalized under the Medicare risk-based and Medicare Plus Choice (M+C) contracts. The objective of our audit was to determine if Medica corrected the problem of improper institutional classifications that resulted in Medicare overpayments, as presented in our previous audit report, issued in May 1995 (A-05-94-00053).

Although Medica attempted corrective actions to address the problem, Medicare overpayments have continued. Based on a random sample of 100 beneficiaries, receiving institutional payments during the period of June 1, 1998 through May 31,2000, we determined that Medica was overpaid $17,514 for eight beneficiaries, who were incorrectly classified as institutionalized. Projecting our sample results, we estimate that during the aforementioned period, Medica received Medicare overpayments totaling at least $133,795. Medica conducted two separate reviews of payments made on behalf of institutionalized beneficiaries which identified institutional overpayments and resulted in a refund to Centers for Medicare and Medicaid Services (CMS) on December 23, 1999. These reviews were initiated four years after the issuance of our last audit report. Due to limitations in the scope and methodology of these reviews, Medica's refund underestimated the total liability of overpayments. We are recommending that Medica refund an additional $133,795 in estimated Medicare overpayments, including $17,514 of identified overpayments. Medica concurred with our finding, but suggested modifications to the tone and language of our draft report. The full text of Medica's response is presented in Appendix B.

INTRODUCTION

BACKGROUND

Medica is a nonprofit Health Maintenance Organization (HMO) licensed to provide prepaid comprehensive health maintenance services in the State of Minnesota under the provisions of

the Minnesota Health Maintenance Act of 1973. In accordance with Medicare regulations, Medica contracted with CMS to provide medical services to Medicare beneficiaries entitled to benefits under both Medicare Parts A and B, with the exception of individuals with end stage renal disease (ESRD) and those receiving hospice benefits. On January 1, 1999, Medica's risk-based contract converted to a Medicare Plus Choice (M+C) contract. Medica voluntarily decided to terminate their M+C contract with CMS on December 31, 2000 and will not renew it for calendar year 2001.

Under both the risk-based and the M+C contract, CMS made prospective monthly Medicare payments to Medica on a capitation basis. A higher capitation rate was paid for risk-based or M+C HMO enrollees who were institutionalized. To be considered institutionalized, an enrolled member must have been a resident of a certified skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospitallunit, rehabilitation hospital/unit, long-term care hospital or a swing-bed hospital for at least 30 consecutive days immediately prior to the current reporting month. The monthly advance payments were subsequently adjusted by CMS to reflect the increased reimbursement for institutional status. When a beneficiary is released from institutional care, the respective monthly payment to Medica should return to the basic premium amount. At Medica, depending on the individual patient demographics, the institutionalized rate could be over $300 higher per month than the basic rate.

In 1994, the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services, conducted a review of Medicare payments made to Medica on behalf of beneficiaries classified as institutionalized. (A-05-94-00053, issued May 1995). The review documented that Medica received overpayments for Medicare beneficiaries incorrectly classified as institutional due to inadequate procedures for monitoring the status of such beneficiaries. In response to the report, Medica refunded over $950,000 to CMS, relative to the actual and estimated overpayments, and agreed to take corrective action to accurately identify institutionalized beneficiaries.

Scope of Audit

Our audit was made in accordance with generally accepted government auditing standards. The objective of our audit was to conduct a follow-up assessment of whether Medica took appropriate corrective action to exclude beneficiaries inaccurately classified as institutionalized from Medicare claims for enhanced reimbursement.

We performed a limited evaluation of Medica's internal controls for classifying and reporting institutionalized Medicare beneficiaries to CMS. We reviewed the changes Medica has made to their procedures and internal controls, relative to this matter, since our previous audit. However, we did not conduct a review of Medica's internal control systems as a whole, nor did we place reliance on those controls. We selected the period June 1, 1998 through May 31, 2000

to perform compliance testing as to the appropriateness of the institutional payments made to Medica, for enrollees who were reported as being in an institutional setting.

Based on CMS data, we determined that during the period June 1, 1998 through May 31,2000, Medica was paid higher capitation rates for 2,802 Medicare enrollees reported as institutionalized. We statistically selected a random sample of 100 beneficiaries for detailed testing. With the assistance of Medica staff, we sent confirmation letters to the facilities where Medica's listings showed the 100 beneficiaries were institutionalized. We also reviewed beneficiary and facility records applicable to our audit period. Details of our statistical sample and projections are shown in the attached Appendix **A.**

Our field work was performed during July through November, 2000, at the offices of Medica in Minneapolis, Minnesota.

FINDINGS AND RECOMMENDATIONS

Our follow-up review disclosed that Medica has continued to receive Medicare overpayments on behalf of beneficiaries inaccurately classified as institutionalized. We attribute the improper classifications and resulting overpayments to Medica's inadequate attempts to implement effective procedures for'monitoringthe status of its institutionalized beneficiaries

Eight of the 100 beneficiaries (eight percent), that we sampled, for whom Medica received institutional payments during the period June 1, 1998 through May 31,2000, were not eligible for institutional status. Our determinations were based on the responses to confirmation letters sent to each facility that serviced the sampled beneficiaries. The responses provided evidence that the eight beneficiaries did not reside in eligible institutions during the audit period. However, Medica's monthly claims to CMS for institutionalized beneficiaries included these eight beneficiaries. Consequently, we determined that CMS incorrectly paid institutionalized rates to Medica for the eight beneficiaries for periods ranging from 1 to 14 months.

Based on CMS payment data applicable to the individual demographics of the eight beneficiaries, we calculated that Medica received overpayments totaling $17,514. Using statistical projection techniques, we estimate with 90 percent confidence that total overpayments to Medica for enrollees improperly classified as institutionalized amounted to at least $133,795. (Details of the statistical projections are shown in Appendix A).

Although Medica made some improvements to their institutional residency monitoring procedures since our prior audit, the revisions prior to July 1999 were inadequate in ensuring that enrollees were properly classified as institutional. Medica began internal quarterly monitoring of beneficiary institutional status in September of 1995 and changed to monthly monitoring as of May 1998. Beginning in June 1999, Medica conducted two reviews of payments made on behalf of institutionalized beneficiaries. While these two efforts identified

$83,029 of institutional overpayments, which were refbnded to CMS on December 23, 1999, they were initiated four years after our last audit report. Medica's first review was limited in scope, while the second review had limitations in it's methodology. As a result, the reviews did not adequately estimate Medica's total liability of unrefbnded overpayments. Medica's first review effort verified the institutional status of 100 percent of their institutional members. However, the review focused on only one month, May 1999, and if an overpayment situation was discovered in that month, the overpayment calculation was not extended to any months prior to or beyond May 1999. Subsequently, Medica sampled from a universe of institutionalized beneficiaries covering the period August 1997 through April 1999. In this review, Medica only quantified the overpayments disclosed in their sample cases and did not project the sample results to the universe. Our review quantified the overpayments in our sample cases, projected the sample results to our universe and accounted for Medica's aforementioned refbnd through adjustments to our sample projection. Accordingly, we estimate that Medica owes CMS an additional $133,795 of unrefbnded Medicare overpayments.

In July 1999, Medica assigned the monthly responsibility for verifying the institutional status of its members to the United Health Group (UHG). Further, Medica indicated they perform monthly audits of UHG's institutional verification process by selecting a random sample of institutional members and calling the applicable nursing homes for certification of UHG results. Based on our review, only one of the eight errors in our sample occurred after July 1999. Therefore, these actions seem to provide more effective measures regarding institutional overpayments.

RECOMMENDATION

We recommend that Medica review the balance of the institutional beneficiary universe and refbnd the additional overpayments, which we estimate to be at least $133,795.

Since Medica discontinued its Medicare contract effective January 1,2001, we have no procedural recommendations.

Auditee's Response

Medica concurred with our finding and agreed to repay the recommended amount of $133,795. However, they objected to the tone of the report because they felt it did not properly acknowledge that Medica has made repeated attempts, since our last report, to address the problems of institutional payments. They suggested modifications to the language of the draft report. Medica's response is presented in Appendix B.

OIG Response

We have modified some of the language in our draft report in consideration of Medica's comments.

If you have any questions regarding this report, please contact Stephen Slamar at (312) 353-7905. Please refer to the Common Identification Number (CIN) A-05-00-00060 in any correspondence regarding this report.

Sincerely yours,

Paul Swanson
Regional Inspector General
for Audit Services

Attachments:
Appendix A
Appendix B

APPENDM A

MEDICA
HEALTH MAINTENANCE ORGANIZATION

MINNEAPOLIS, MINNESOTA

VARIABLE APPRAISAL OF STATISTICAL SAMPLE

Universe:	2,802
Sample Size:	100
Nonzero Items:	8
Value of Nonzero Items:	$17,514
Mean:	175.14
Standard Deviation:	781.29
Standard Error:	76.72
Skewness:	4.98
Kurtosis:	27.01
Point Estimate:	$490,737

Projection at the 90 Percent Confidence Level:

Lower Limit:	**$133,795**
Upper Limit:	**$847,680**
Precision Amount:	**$356,942**
Precision Percent:	**72.74%**

MEDICA.
HEALTH PLANS
ALLINA HEALTH SYSTEM

May 30, 2001

Stephen Slamar, Audit Manager
U.S. Department of Health and Human Services
Office of Inspector General/Office of Audit Services
Suite 1360
233 North Michigan Avenue
Chicago, Illinois 60601

TRANSMITTED VIA FACSIMILE
AND UNITED STATES MAIL

Re: CIN: A-05-00-00060

Dear Mr. Slamar,

I am writing in response to Paul Swanson's letter of April 30, 2001 and the Office of Inspector General's draft report entitled "Follow-up Review of Medicare Payments for Institutionalized Beneficiaries, Medica[1] Health Maintenance Organization."

We appreciate having the opportunity to review the report prior to it being finalized. We don't dispute the basic substantive findings of the report, however, we do object to the tone of the report and the lack of context for the findings. We have taken the liberty of modifying the language in the report (see attached redlined version) and respectfully request that the OIG consider adopting the proposed changes.

Medica has taken the matter of tracking institutional status seriously and has made repeated attempts since the 1994 OIG audit to develop and implement system changes to accurately capture and report institutional status. Despite Medica's efforts, discrepancies in reporting institutional status continued as evidenced by the periodic internal audits conducted by Medica to determine the effectiveness of these system changes. Each audit resulted in Medica refunding overpayments to the federal government. While these audits admittedly indicate that the system changes weren't adequate, they demonstrate that Medica attempted to correct the problem. Accordingly, we believe it's unfair to characterize Medica as being "untimely," or having "delayed taking effective corrective action," or "delay[ed] in establishing effective procedures for monitoring the status of its institutionalized beneficiaries" or its reviews "were not timely." These characterizations are not consistent with Medica's repeated attempts to correct discrepancies in its institutional reporting and should therefore be deleted from the report.

As the OIG is well aware, tracking institutional status of Medicare beneficiaries is labor

[1] Please note that while we frequently refer to "Medica," the corporate name is "Medica Health Plans." We recommend that the cover page and the report refer to the corporate name "Medica Health Plans."

intensive and inherently challenging even with the best of systems because of a health plan's reliance on the accuracy of data provided by institutions and the timeframe of collecting and reporting the data to HCFA. Medica is by no means unique in its struggle to design an effective tracking system. Even the OIG auditors who conducted the follow-up audit found some of their verification data inaccurate because of incorrect information supplied by an institution. Some mention of these inherent limitations should be made in the report.

Page 3 of the report states that Medica made some improvements to its institutional residency monitoring procedures. In fact, the revised residency verification process implemented by Medica in 1999 resulted in extremely accurate residency reporting as evidenced by the marked decrease in residency reporting errors post mid-1999 in the OIG auditors' findings. The one discrepancy for 2000 in the OIG auditors' findings involved a Medicare beneficiary who was institutionalized at the beginning of the month and at the end of the month with a sixteen day, rather than the fifteen day allowable hospitalization in between. Again, even with the best of systems, such human reporting error is difficult to eliminate completely.

In its letter of December 23, 1999 to Ms. Sandy Wychyrst of the Health Care Financing Administration, in which Medica returned overpayments in the amount of $83,028.88, Medica also indicated that it had found $108,365.91 of underpayments which have yet to be repaid by the government. This amounts to a ratio of approximately two-to-three, overpayments to underpayments. In other words, for every two dollars of overpayments, there were three dollars of underpayments for the same sample population. Again, while we don't dispute the findings of the OIG follow-up audit report, it should be noted that the audit was focused exclusively on overpayments and did not address the issue of underpayments.

Medica agrees to accept the OIG's recommendation to refund to HCFA one hundred thirty three thousand seven hundred and ninety-five dollars ($133,795.00). We have initiated a check request in that amount and will remit it to HCFA within the next week.

I hope these comments are helpful. If you need any additional information or have questions regarding the above, please contact Jeff Reed at (952) 992-8565.

Sincerely,

Jane E. Rollinson
President
Medica Health Plans

cc: Mark Owen
Mamie Segall
Jeff Reed

Attachment