Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

BLUE CARE NETWORK SOUTHFIELD, MICHIGAN

JANET REHNQUIST
Inspector General

JUNE 2002
A-05-01-00079

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

REGION V
OFFICE OF
INSPECTOR GENERAL

June 10, 2002

Common Identification Number: A-05-01-00079

Kevin Seitz
President & CEO
Blue Care Network
25925 Telegraph Road
Southfield, Michigan 48034

Dear Mr. Seitz:

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

Final detemiination 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 hearing 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 contactors 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.)

To facilitate identification, please refer to Common Identification Number A-05-01-00079 in all correspondence relating to this report.

Sincerely yours,

for Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Director of Health Plan Benefits Group
C4-23-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Kevin Seitz
President & CEO
Blue Care Network
25925 Telegraph Road
Southfield, Michigan 48034

Dear Mr. Seitz:

This final report provides the results of our audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status." Our objective was to determine if payments to Blue Care Network (Contract H9009) were appropriate for beneficiaries reported as institutionalized.

We determined that Blue Care received Medicare overpayments totaling $100,692 for 54 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31,2000. The majority of the beneficiaries did not meet the 30-day residency requirement in a qualifying institutional facility. Blue Care Network should not have received payment at the enhanced institutional rate.

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 (M+C) Program. Its primary goal is 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 that has been approved by the Centers for Medicare and Medicaid Services (CMS). Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. Beneficiaries eligible to enroll in the new M+C Plans must be entitled to Part **A** and enrolled in Part B.

The CMS makes monthly advance payments to managed care organizations (MCOs) at the per capita rate set for each enrolled beneficiary. Medicare pays a higher monthly rate to MCOs for beneficiaries who are institutionalized. The MCOs receive the enhanced institutional rate for enrollees who are residents of Medicare or Medicaid certified institutions such as: 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 status requirements specify that the beneficiary must be a

resident of the qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The CMS requires MCOs to submit a monthly list of enrollees meeting institutional status requirements. The advance payments received by MCOs each month are subsequently adjusted by CMS to reflect the enhanced reimbursement for institutional status. For example, during 2000, MCOs in the Lansing, Michigan area received a monthly advance payment of $601 for each 82 years old male residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to $1,081.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Blue Care Network (Contract H9009) were appropriate for beneficiaries reported as institutionalized during the period January 1, 1998 through December 31,2000. This review was performed as part of our national review of institutional status issues.

In 1998, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. Our audit verified that Blue Care was complying with CMS's current definition of an institutional facility. We reviewed the plan's records documenting where 293 beneficiaries with institutional status resided to determine if beneficiaries were in qualifymg Medicare or Medicaid certified facilities. The Medicare overpayment for each incorrectly reported beneficiary was calculated by subtracting the non-institutional payment that Blue Care should have received from the institutional payment actually received. We reviewed the institutional residency documentation for all beneficiaries reported as institutionalized during our audit period, placing no reliance on the Plan's internal controls. Our limited review of internal controls focused on procedures for verifying institutional residency.

Our field work was performed during May 2001 at Blue Care's offices in Lansing, Michigan and through August in our field office in Columbus, Ohio.

RESULTS OF AUDIT

We determined that Blue Care received Medicare overpayments totaling $100,692 for 54 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31,2000. The majority of the beneficiaries did not meet the 30-day residency requirement in a qualifying institutional facility. Blue Care Network should not have received payment at the enhanced institutional rate.

Institutional status requirements specify that the beneficiary must be a resident of the qualifymg facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month, We found 36 beneficiaries, reported as institutionalized, that did not meet this standard. An identified weakness in the computerized process for reporting institutionalized status caused the beneficiaries to be incorrectly reported to CMS.

In 1998, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. Blue Care incorrectly reported as institutionalized nine beneficiaries who were residents of domiciliary facilities or occupying nursing facility beds that were not certified for Medicare or Medicaid. These beneficiaries were incorrectly reported because Blue Care staff did not, in January 1998, fully implement CMS's new guidance concerning institutional facilities. Blue Care officials were unable to provide any documentation of institutional residency for nine additional beneficiaries.

Staff at Blue Care conducted a self audit in 1999 to determine if any beneficiaries were incorrectly reported as institutionalized based on the stricter standards implemented by CMS in 1998. The majority ($70,758) of the unallowable institutional payments identified during our review were also identified in Blue Care's self audit. Blue Care officials reported the overpayments to CMS, and they are in the process of submitting adjustments through the CMS payment system.

RECOMMENDATIONS

We recommend that Blue Care Network refund the identified overpayments totaling $100,692 to CMS for the related beneficiaries. We are making no recommendations related to internal controls because Blue Care Network (Contract H9009) will not be participating in the Medicare Program after December 2001.

AUDITEE COMMENTS AND OIG RESPONSE

In their April 15, 2002 response to our draft report, Blue Care Network officials did not contest the results of our audit. Blue Care submitted adjustments to CMS for 26 of the questioned beneficiaries in January 2002, and is in agreement with our findings for the remaining 28 beneficiaries. Blue Care's complete response is included with this report as Appendix A.

Sincerely yours,

for Paul Swanson
Regional Inspector General
for Audit Services

APPENDIX

Blue Care Network

April 15, 2002

Mr. David Shaner
HHS/OIG Office of Audit Services
277 West Nationwide Boulevard
Suitc 225
Columbus, Ohio 43215

RE: REPORT No. A-05-01-00079

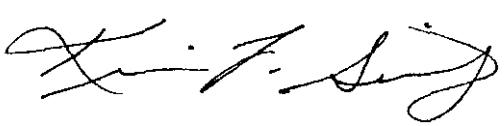
Dear Mr. Shaner:

We have reviewed your draft report entitled, "Review of Medicare Pavments for Beneficiaries with Institutional Status. Blue Care Network. Southfield. Michigan". We do not contest the findings that $100,692 in payments For 54 beneficiaries should be submitted for adjustment. Of the total 54 beneficiary adjustments, Blue Care Network had submitted (or re-submitted) 26 of them in January 2002 with additional adjustments For the other two contract regions and additional time periods. Blue Care Network is in agreement with the remaining 28 beneficiary adjustments identified within this OIG draft report.

Blue Care Network requests that the report be modified to add a statement at the summary or outset of the final report *to* clearly acknowledge the fact that Blue Care Network had conducted a self-audit in 1999 and had previously submitted a majority of these adjustments to CMS.

We would like to thank you and your auditors on site for conducting a professional and fair review of the reporting by Blue Care Network. Please contact Mary Finnan at 248-799-6347 with any questions or further requests.

Sincerely,



Kevin Seitz
President and CEO
Blue Care Network of Michigan

Enclosure
SK:lrs