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

REGION V
OFFICE OF
INSPECTOR GENERAL

October 17, 2002

Common Identification Number: A-05-01-00094

Daniel Barzman
Director, Medicare Compliance
Health Plan Regulatory Services
Kaiser Foundation Health Plan, Inc.
1800 Harrison Street, 8th Floor
Oakland, California 94612

Dear Mr. Barzman:

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and 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-05-01-00094 in all correspondence relating to this report.

Sincerely,

Paul Swanson

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

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

KAISER FOUNDATION HEALTH PLAN, INC. OAKLAND, CALIFORNIA

JANET REHNQUIST
Inspector General

OCTOBER 2002
A-05-01-00094

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1800 Harrison Street, 8th Floor
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Dear Mr. Barzman:

This 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 Kaiser (Contract H0583) were appropriate for beneficiaries reported as institutionalized.

We determined that Kaiser received Medicare overpayments totaling $229,656 for 315 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. Institutional status requirements specify that a beneficiary must be a resident of a qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month. The 315 beneficiaries included 266 that had admittance or discharge dates during the 30-day residency period. The remainder consisted of: 16 beneficiaries residing in facilities not certified for Medicare or Medicaid; 28 beneficiaries for whom institutional residency could not be documented; and 5 beneficiaries with hospitals stays greater than 15 days.

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 outlined in CMS's Operational Policy Letter #54 (OPL #54) specify that a beneficiary must be a resident of a 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. During 1999, MCOs in the Oakland, California area received a monthly advance payment of $587 for each 82 years old female beneficiary, residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to $1,111.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Kaiser (Contract H0583) 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 Kaiser was complying with CMS's current definition of an institutional facility. We reviewed the Plan's records documenting where 5,571 beneficiaries with institutional status resided to determine if beneficiaries were in qualifying Medicare or Medicaid certified facilities. The Medicare overpayment for each incorrectly reported beneficiary was calculated by subtracting the non-institutional payment that Kaiser 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 July 2001 and April 2002 at Kaiser's offices in Oakland, California and through May 2002 in our field office in Columbus, Ohio.

RESULTS OF AUDIT

We determined that Kaiser received Medicare overpayments totaling $229,656 for 315 beneficiaries incorrectly reported as institutionalized. Institutional status requirements in OPL #54 specify that a 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 315 beneficiaries included 266 that had admittance or discharge dates during the 30-day residency period. We found that 206 of the beneficiaries were claimed as the result of clerical errors by Kaiser staff or incorrect residency information provided by the nursing facilities. Patients leaving nursing facilities late in the month, after Kaiser verified residency caused the remaining 60 to be incorrectly claimed.

Institutional status requirements in OPL #54 require beneficiaries to be residents of qualifying facilities that are certified for Medicare or Medicaid. We identified 16 beneficiaries who were residents of either non-qualifying domiciliary facilities or nursing facilities that were not certified for Medicare or Medicaid.

We identified 28 beneficiaries for whom Kaiser could provide no institutional residency documentation. Kaiser officials believe that 28 beneficiaries were incorrectly reported do to difficulties with the MCO's computer system for tracking membership.

Medicare continues to pay the institutional rate while an enrolled member is temporarily absent from the institutional facility for hospital stays of less than 15 days. During our review we identified five beneficiaries with hospital stays greater than 15 days who were incorrectly claimed as institutionalized.

INTERNAL CONTROLS

Kaiser staff contacts nursing facilities, towards the end of each month, to verify the institutional residency of beneficiaries enrolled in the Plan. Beneficiaries identified as residents of qualifying facilities, will be reported to CMS as institutionalized at the beginning of the coming month. Kaiser incorrectly reported as institutionalized 60 beneficiaries who were discharged, late in the month, after Kaiser staff had already verified that the beneficiaries were still residents of the institutions.

Kaiser should establish procedures to identify beneficiaries incorrectly reported as institutionalized because of discharges occurring in the period between the Plan's monthly verification of institutional residency and the end of the month. This could be accomplished by reconciling the list of beneficiaries reported as institutionalized at the beginning of each month, with the residency information gathered at the end of the same month. The discharges previously missed, will appear in the residency data provided by the nursing facilities in the subsequent month. If incorrectly reported beneficiaries are identified, adjustments reversing the institutional payments should be sent to CMS.

RECOMMENDATIONS

We recommend that Kaiser:

1. Refund the identified overpayments totaling $229,656.

2. Improve procedures for verifying institutional residency to decrease the number of beneficiaries incorrectly reported as institutionalized to CMS.

3. Establish reconciliation procedures that identify beneficiaries incorrectly reported as institutionalized, because of discharges occurring in the period between the Plan's monthly verification of institutional residency and the end of the month.

4. Correct problems with membership tracking system to eliminate errors in reporting institutionalized beneficiaries.

AUDITEE COMMENTS AND OIG RESPONSE

In their August 22, 2002 response to our draft report, Kaiser officials:

- Disagreed with our audit results for four of the 269 beneficiaries we questioned because of admit or discharge dates during the required 30-day residency period.

- Did not contest the beneficiaries we questioned because of: residency in non-qualifying nursing facilities; a systems error; or hospital stays exceeding 15 days.

Other comments by Kaiser officials have been omitted because they concern issues no longer included in our report.

In addition to their comments about our audit findings, Kaiser officials stated that they have contacted CMS regarding the overpayments and will be submitting adjustment documentation per CMS's instructions. Kaiser has also developed a corrective action plan to prevent future misreporting of beneficiaries as institutionalized.

We reviewed the additional documentation provided by Kaiser for the four beneficiaries they believe are allowable and concluded the institutional payments were appropriate.

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Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

APPENDIX

August 22, 2002

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

RE: Common Identification Number: A-05-01-00094

Dear Mr. Shaner:

This letter is in response to your draft audit report, "Review of Medicare Payments for Beneficiaries with Institutional Status", dated June 25, 2002, and received by Kaiser Foundation Health Plan, Inc. on July 2, 2002. Thank you for extending the response date deadline to August 25, 2002.

We have completed our review of the draft audit report and recommendations and respond as follows:

Regarding the 269 members who you have identified as having admit or discharge dates during the 30-day residency period and are thus ineligible for institutional status, we disagree with your finding in four cases. Enclosed is a spreadsheet listing the name and HIC number of these members. Documentation attached to the spreadsheet provides additional information regarding two of these members to verify their qualification for institutional status. The spreadsheet also notes two other members who you identify as being ineligible for institutional status. Our research indicates a recision of the institutional status adjustment. We do not contest the finding regarding the remaining 265 members.

Regarding the 16 members who were residents of either non-qualifying domiciliary facilities or nursing facilities that were not certified for Medicare or Medicaid, we do not contest the finding. Apparently, our staff member misunderstood the nature of private pay facilities and thought they qualified for institutional status, which we know they do not. The staff member was educated regarding this issue, and the criteria for qualifying facilities were reviewed with all of the staff who verify institutional status.

Regarding the 28 members identified as possibly incorrectly reported due to a system error by an outside contractor, we have ascertained that the submissions were not made by an outside contractor, but by our own in-house membership system, Foundation Systems. We

Program Offices
One Kaiser Plaza
Oakland, California 94612
(510) 271-5910

are working with Foundation Systems IT to address the issues identified. We do not contest the finding.

Regarding the 28 members who were hospitalized during their initial 30 days of institutional residency, we understand CMS has clarified with you that institutional status is permissible in these instances, as long as the hospital stay does not exceed 15 days. We request the final audit report delete the finding with respect to these 28 members, given CMS' clarification of this issue.

Regarding the five members who we incorrectly claimed had institutional status despite hospital stays of more than 15 days, we do not contest the finding.

We have already contacted CMS Regional Office IX regarding the overpayments, and will be submitting adjustment documentation in accord with their instructions.

Because the majority of the institutional status overpayments stemmed from clerical error, incorrect residency information provided by the nursing facilities or members leaving nursing facilities late in the month after we had verified residency, our corrective action plan is as follows:

1. Due to a large volume of calls, we had been granted permission to begin calling nursing facilities on the 25th of the qualifying month. CMS Region IX recently notified us that instead, we should begin calling on the 1st day of the month immediately after the qualifying month. We plan to implement this transition by the end of 2002. We believe this change will significantly reduce the possibility of overpayments.

2. We plan to automate our reconciliation system to identify and track both underpayments and overpayments by comparing facility admit and discharge dates against institutional status criteria and payments received. This process is currently a manual one. This enhancement is scheduled for implementation November, 2002.

3. To identify any additional overpayments that may have occurred from January, 2001 to the present, we will develop a program to identify members for whom Medicare paid at the institutional status rate but who may not have qualified. We will submit adjustments to CMS based on verification of any overpayments. We expect to be able to begin identifying any such overpayments by October, 2002.

We appreciate your assistance in working with us during this audit. If you have any questions, or need any additional information, please contact Janice Gronhovd at (510) 987-3012.

Sincerely,

Judith Mears

Judith Mears
Vice President and Assistant General Counsel
Kaiser Foundation Health Plan, Inc.

cc: Diane Morissette
Tammi Keating
Gib Sims
Jim Taul
Bob Wellsted
Daniel Barzman
Kevin R. Smith
Elaine Schweitzer, Kaiser Permanente