Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

INTER VALLEY HEATLH PLAN POMONA, CALIFORNIA

JANET REHNQUIST
Inspector General

MAY 2002
A-05-01-00096

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

REGION V
OFFICE OF
INSPECTOR GENERAL

May 23, 2002

Common Identification Number: A-05-01-00096

Michael Nelson
President & CEO
Inter Valley Health Plan
300 South Park Avenue
Pomona, California 91769

Dear Mr. Nelson:

Enclosed arc two copies of the U.SDepartment 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 the 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 Jnformation Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports are made available to the public to the extent infonnation contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05.01 -00096 in all correspondence relating to this report.

Sincerely yours,

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

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Michael Nelson
President & CEO
Inter Valley Health Plan
300 South Park Avenue
Pomona, California 91769

Dear Mr. Nelson:

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 Inter Valley Health Plan (Contract H0545) were appropriate for beneficiaries reported as institutionalized.

Inter Valley received Medicare overpayments totaling $319,355 for 27 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. Twenty-six of the identified beneficiaries were residents of domiciliary facilities that do not qualify a beneficiary for institutional status. Inter Valley 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 contained in Operational Policy Letter #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 2000, MCOs in the Pomona, California area received a monthly advance payment of $656 for each 84 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 $1,190.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Inter Valley Health Plan (Contract H0545) 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 Inter Valley was complying with CMS's current definition of an institutional facility. We reviewed the plan's records documenting where 486 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 Inter Valley 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 at Inter Valley's offices in Pomona, California and through December in our field office in Columbus, Ohio.

RESULTS OF AUDIT

Inter Valley Health Plan received Medicare overpayments totaling $319,355 for 27 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. We identified 26 beneficiaries who were residents of domiciliary facilities that do not qualify a beneficiary for institutional status and one beneficiary who was discharged prior to meeting the 30-residency requirement in an institutional facility.

Twenty-five of the unallowable beneficiaries resided in a facility that provided both skilled nursing and assisted living care. The skilled nursing section was certified for Medicare and beneficiaries in those beds were eligible for institutional status. The 25 identified beneficiaries

were residents of the assisted living section that does not meet the current CMS definition of an institutional facility.

Inter Valley staff contacts nursing facilities monthly to verify the continued institutional residency of all beneficiaries reported to CMS. The 25 beneficiaries were incorrectly reported because the nursing facility's staff did not fully understand which beneficiaries should be included in the monthly residency information provided to Inter Valley. Staff at the Health Plan discovered this problem during a self-audit in preparation for our site visit. In response, Inter Valley officials clarified with the nursing facility that only beneficiaries in the skilled nursing section should be included on the monthly form used to verify institutional residency. At the time of our site visit officials at Inter Valley were also in the process of submitting adjustments to CMS to reverse the unallowable institutional payments.

RECOMMENDATIONS

We recommend that Inter Valley Health Plan refund the identified overpayments totaling $319,355. We are making no recommendations related to internal controls because Inter Valley has corrected the miscommunication that resulted in the Medicare overpayments.

AUDITEE COMMENTS AND OIG RESONSE

In their March 8,2002 response to our draft report, Inter Valley Health Plan officials agreed with our audit results, and have submitted adjustments to CMS reversing the unallowable institutional payments. Citing CMS Operational Policy Letters 94.012 and 95.013 that only allow Plans to make retroactive adjustments up or down for the previous 36 months, the response further states that the adjustments sent to CMS did not cover the entire audit period. We agree that the CMS Policy Letters limit the retroactive adjustment period to 36 months, but other mechanisms do exist for collection of unallowable payments which are older tban three years. We recommend that Inter Valley refund any remaining overpayments. Inter Valley's complete response is included with this report as Appendix A.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

APPENDIX

Inter Valley Health Plan

Real People. Real Service.

March 8, 2002

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

Re: Inter Valley Health Plan - - OIG Audit
Review of Medicare Payments for beneficiaries with Institutional Status
Common ID# A-05-01-00096

Dear Mr. Shaner:

This letter is in response to the Office of Inspector General's (OIG) report dated February 11, 2002 regarding Medicare payments for institutionalized enrollees. Below, are Inter Valley Health Plan's comments regarding the OIG's findings.

The report notes that the Centers for Medicare & Medicaid Services (CMS) has overpaid the Plan $319,355 for henry-seven (27) members the Plan incorrectly classified as institutionalized. Twenty-five (25) of these members reside at the facility, Royal Oaks Manor. This facility inaccurately informed Inter Valley Health Plan that all its members were institutionalized rather than just those who reside in the medical unit of the facility. This issue has since been rectified. In July of 2001, Inter Valley Health Plan began conducting self-audits of those members classified as institutional. The Plan's Case Manager Field Auditor has been surveying, and continues to survey, Royal *Oaks* Manor on a monthly basis to ensure that we submit to CMS only those members in the medical unit and who meet the criteria defined by CMS for institutional classification.

The 25 members from Royal *Oaks* Manor were submitted to CMS for retroactive adjustments. Ninteen (19) of the 25 were submitted in July 2001 prior to The Office of Inspector General's visit. In Ocrobcr 2001, while working with David Shaner from the Office of Inspector General, six (6) additional members were submitted to CMS for adjustments. In October *2001*, retroactive adjustments were processed *for* 11 of the members submitted in July 2001 by CMS. The Plan will bc submitting a request lo the CMS Regional Office to adjust the overpayments for the remaining **two** members noted in the report.

In the repon, the Office of Inspector General is recommending that retroactive adjustments be made to January 1998. The timeframe of the audit included examining

Plan members from January 1998 through November 2000. This timeframe appears inconsistent with the thirty-six (36) month retroactivity rule cited in CMS' Operational Policy Letters 94.012 and 95.013, which states that Plans may make retroactive adjustments up or down for the previous 36 months. The submission of retroactive adjustments in July 2001 includes 36 months, retroactive to July 1998. This being the case, current **adjustments** are **less than** the $319,355 noted by the OIG.

Inter Valley Health Plan believes **we** have satisfactorily addressed all areas noted by *the* OIG in its report and looks forward ***to*** working with the agency in providing closure to the findings noted.

Please contact Susan Stein, Director of Compliance at (909) 623-6333, extension 428 if you have *any* questions and/or comments.

Sincerely

Michael Nelson

Michael Nelson
President & CEO

cc: Chuck Nickel. VP, Service & Sales
Susan Stein, Director, Compliance