Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

FALLON COMMUNITY HEALTH PLAN WORCESTER, MASSACHUSETTS

JANET REHNQUIST
Inspector General

MAY 2002
A-05-01-00100

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

REGION V
OFFICE OF
INSPECTOR GENERAL

May **14,** *2002*

Common Identification Number: A-05-01-00100

Eric H. Schultz, President & CEO
Fallon Community Health Plan
10 Chestnut Street
Worcester, Massachusetts 01608-2810

Dear Mr. Schultz:

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 he 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 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 are made available to the public to the extent information 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-05-01-00100 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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Eric H. Schultz, President & CEO
Fallon Community Health Plan
10 Chestnut Street
Worcester, Massachusetts 01608-2810

Dear Mr. Schultz:

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 Fallon Community Health Plan (Contract H9001) were appropriate for beneficiaries reported as institutionalized.

We determined that Fallon received Medicare overpayments totaling $18,842 for 44 beneficiaries incorrectly classified as institutionalized during the period January 1, 1998 through December 31, 2000. All of the beneficiaries were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. Fallon 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 was 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, which 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

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 MCOs are required to submit to CMS, 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 Worcester area received a monthly advance payment of $486 for each 75-years old beneficiary, residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to $995.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Fallon Community Health Plan (Contract H9001) were appropriate for beneficiaries reported as institutionalized during the period January 1, 1998 through December 31, 2000. This review was performed as survey work prior to 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 Fallon was complying with CMS's current definition of an institutional facility. We reviewed the plan's records documenting where 2,215 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 Fallon 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 January through April 2001 at Fallon's offices in Worcester, Massachusetts and our field office in Columbus, Ohio.

RESULTS OF AUDIT

Fallon received Medicare overpayments totaling $18,842 for 44 beneficiaries incorrectly classified as institutionalized. All of the beneficiaries were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. Fallon should not have received payment at the enhanced institutional rate.

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. The majority of the overpayments occurred because Fallon staff did not fully implement CMS's 1998 guidance concerning institutional facilities until February 1998. The only unallowable monthly

payment Fallon received for 37 of the 44 beneficiaries was for January 1998. The Medicare overpayments attributable to the remaining seven beneficiaries also occurred in 1998 though not solely in January.

Fallon's current internal control procedures for verifying the institutional residency of the Medicare beneficiaries enrolled in the MCO are adequate. Fallon staff contacts the institutional facilities monthly to verify each beneficiary's residency. Our review found that all beneficiaries reported as institutionalized by Fallon staff in 1999 and 2000 were residents of qualifying institutional facilities.

RECOMMENDATIONS

We recommend Fallon refund the identified overpayments totaling $18,842. We are making no recommendations related to internal controls because Fallon's current procedures resulted in no incorrectly reported beneficiaries in 1999 and 2000.

AUDITEE COMMENTS AND OIG RESONSE

AUDITEE COMMENTS

In their January 3, 2002 response to our draft report, Fallon officials state that they believe the Plan was permitted under OPL #54, to report residents of domiciliary facilities during December 1997 as institutionalized, in order to receive institutional payments for January 1998. Fallon officials also believe there is some inconsistency between the number of incorrectly reported beneficiaries identified in our report, and the number of beneficiaries identified in supplementary documentation provided to the Plan. Finally, Fallon officials state that per OPL #12, CMS will not process adjustments of payments more than three years old, thus Fallon is not required to return the overpayments identified in our review.

OIG RESPONSE

In OPL #54, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. OPL #54 clearly states that the revised definition of which Medicare enrollees are institutionalized will be effective for all institutional payments made for months after December 1997. As a result, we disagree with the Fallon officials' interpretation of OPL #54 and believe that the January 1998 institutional payments for beneficiaries residing in domiciliary facilities are unallowable.

There is no inconsistency between the questioned beneficiaries identified in our final report and the beneficiaries identified in supplementary documentation provided to Fallon officials. Both the report and the supplementary documentation discuss 44 questioned beneficiaries, 37 beneficiaries incorrectly reported in January 1998 only, and seven other questioned beneficiaries that were not incorrectly reported solely in January 1998.

beneficiaries incorrectly reported in January 1998 only, and seven other questioned beneficiaries that were not incorrectly reported solely in January 1998.

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 older than three years. As a result, we recommend Fallon refund the remaining institutional overpayments.

Fallon's complete response is included with this report as Appendix A.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

APPENDIX

FALLON COMMUNITY HEALTH PLAN

January 3,2002

Eric H. Schultz
***President** and CEO*

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

RE: Comments/Response to Draft OKG Report for Fallon Community Health Plan Entitled *"Review of Medicare Payments for Beneficiaries with Institutional Status"*

Dear Mr. Shaner:

This letter is written in response to the above-titled report ("OIG Draft Report") received by Fallon Community Health Plan ("Fallon") with regard to the audited period January 1, 1998 through December 31, 2000. We appreciate your sending us the report in draft so that we could have [he opportunity to review it before it is issued in final form. We are proud to learn that Fallon's performance results from this audit place it **among** the best of those plans that were audited for compliance with institutional status reporting requirements. Nonetheless, the **OJG** Draft Report cites forty-four (44) cases of beneficiaries being incorrectly reported as institutionalized during the audit period - thirty-seven (37) of which involved payments made in January 1998 for beneficiaries in institutions during December 1997 and eight (8) of which involved institutional residency and other payment months during 1998.[1] However, Fallon disagrees that most of these cases were reported in error. In any event, Fallon is not obligated to repay any amounts to Medicare because the time period for recoupment of payments is expired. Fallon's conclusions are supported **by** the following grounds.

First, the bulk of the cases cited as errors by OIG involve payments made by CMS to Fallon for January 1998. However, these payments relate to Fallon Medicare members who resided in institutions in December of 1997. **OPL** #54, which affected the definition of "institution" for institution status reporting, **we** interpreted as going into effect as of January 1, 1998. We, in good faith, removed these members from our institutional census as of January 1, 1998 and did not report those members. There **was** confusion regarding the interpretation of this OPL from all sectors.

The effective date of OPL #54 was for "all institutionalized payment **rate** adjustments made far those months beginning after December [1997]" ***(see* OPL** #54). Based on chis provision, Fallon read OPL ***#54*** to govern its listings ***of*** institutionalized beneficiaries submitted to HCFA beginning after the December 1997 census listing (*i.e.*, starting with the **January** 1998 census). Fallon's extremely high compliance rare for listings starting in January 1998 reflects this position. In contrast, the OIG Draft Report suggests that the govemmenr's position is that

[1] We note that the 37 members **plus** the 8 other members cited in the OIG Draft Report **add up** to more **than** the **44** total beneficiaries referenced in the Repon. **Also.** the listing of members attached to the OIG Draft Repon total 40 beneficiaries for payment month January 1998 and 9 other beneficiaries for which payment **was** made in other months during 1998. Thus. there **is** some inconsistency in the references to the exact number of beneficiaries at **issue.**

Mr. David Shaner
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institutionalized beneficiary listings for December 1997 should have complied with OPL #54. Such an interpretation is inconsistent with statements made by the auditors during their site visit at Fallon, and is nor clearly dictated by the language of the OPL.

Second, except for a handful of cases, all beneficiaries in institutions listed on submissions made by Fallon to CMS each month scarring in January 1998 and continuing through December 31, 2000 were in compliance with OPL #54. The OIG Draft Report reflects this finding. The handful of cases noted as errors certainly constitute minor errors when compared to the overall number of beneficiaries reported during the audit period.[2] Thus, we disagree with the statement in the OIG Draft Report that "[the majority of the overpayments occurred because Fallon staff did not fully implement CMS's 1998 guidance concerning institutional facilities until February 1998." To the contrary, the listing furnished by Fallon to CMS of beneficiaries in institutions during January 1998 also was compliant with OPL #54, but for no more than 2 minor errors?[3]

Finally, the time period for retroactivity of paymenr adjustments for the cases ar issue has expired. Pursuant to OPL #12, retroactive paymenr adjustments (both up and down) for Medicare risk contractors is limited to 3 years preceding :he month in which the government receives data that would indicate a change in beneficiary status, including institutional status (see also OPL #13). OPL #12 gives the example of a payment adjustment proposed in February 1995, which would cover a period of 3 years and (assuming all documenrary requirements were met) be made for all months starting in February 1992. On this basis, because the OIG Draft Report is dated October 4, 2001, it would apply, if at all, only to institutional status payments made for months starring in October 1998. All of the cases cited in the OIG Draft Report involved dares prior to October 1998.

On these grounds, Fallon disagrees with the OIG Draft Report findings that amounts are owed for incorrect reporting of institutional status for the forty-four (44) members discussed in the Report.

Please call if you have any questions.

Very truly yours,

Eric H. Schultz

Eric H. Schultz
President and CEO

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[2] As reflected in the OIG Draft Report, eight member months out of a total of approx 11,000 member months for institutionalized in 1998 equals 0.0008% error rate. The OIG Draft Report also states that 100% of beneficiaries reported by us as institutionalized during 1999 and 2000 were found during OIG's audit w be residents of qualifying institutions.

[3] This is supponed by the attachment to the OIG Draft Report which shows only 2 cases in error for payment month 3/98.