DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date JUN 18 1998

From June Gibbs Brown
Inspector General

Subject Review of Medicare Payments for Beneficiaries with Institutional Status, Group Health Plan, Inc. (A-05-97-00014)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance of our final report on Monday, June 22, 1998. A copy is attached.

Our objective was to determine if payments to Group Health Plan, Inc. (GHI), under Medicare risk contract H9005, were appropriate for beneficiaries reported as institutionalized.

We determined that GHI received Medicare overpayments totaling $167,630 for 41 beneficiaries incorrectly classified as institutionalized. The 41 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries reported as institutionalized during the period October 1, 1994 through September 30, 1996. Based on our sample results, we estimate that GHI received Medicare overpayments of at least $1,640,678 for beneficiaries incorrectly classified as institutionalized during the audit period.

Our review indicated that the majority of the Medicare overpayments occurred due to a breakdown in the transmission of information between computer systems. The GHI process for tracking and reporting institutionalized beneficiaries relies on two computer systems - the Authorization System and the Medicare System. We found that information from the Authorization System did not always flow into the Medicare System. This system flaw caused GHI to submit incorrect information to the Health Care Financing Administration (HCFA) regarding the institutional status of beneficiaries. The GHI had previously discovered the system flaw and reported the problem to HCFA in September 1995. According to GHI, this flaw has since been corrected.

We also found that GHI did not verify the institutional status of beneficiaries on a monthly basis. If a monthly verification process had been used by GHI, the errors caused by the system flaw would have been detected sooner. The GHI's policy now requires that all institutional facilities be contacted each month to verify beneficiary status.

We recommend that GHI: (1) continue to strengthen internal control procedures to ensure errors do not occur in the future, (2) refund the overpayments identified through our review

totaling $167,630, and (3) review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments. We estimate the total overpayments to be at least $1,640,678.

In a written response to our draft report, GHI officials did not dispute that they had received Medicare overpayments for 41 beneficiaries who were incorrectly classified as institutionalized during our audit period. However, they did state that the system limitations which caused the Medicare overpayments also caused instances of underreporting (i.e., GHI could have claimed institutional reimbursement for beneficiaries, but did not do so).

We did not verify the accuracy of the underreporting instances that GHI had identified because our audit focused on claims that GHI had submitted to HCFA. However, if GHI has identified Medicare beneficiaries that should have been claimed at the institutional rate but were not, GHI should work with HCFA to determine if submitting retroactive claims is allowable.

After the Recommendation section of our report, we have paraphrased GHI's response and have added some additional comments. The full text of GHI's response is included with our report as Appendix B.

For further information, contact:

Paul Swanson
Regional Inspector General
for Audit Services, Region V
(312) 353-2618

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, GROUP HEALTH PLAN, INC.

JUNE GIBBS BROWN
Inspector General

JUNE1998
A-05-97-00014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION V
105 W. ADAMS ST.
CHICAGO, ILLINOIS 60603-6201

OFFICE OF
INSPECTOR GENERAL

Common Identification Number: A-05-97-0001 4

Mr. George Halvorson
President and Chief Executive Officer
Group Health Plan, Inc.
8100 34th Avenue South
Minneapolis, Minnesota 55440- 1309

Dear Mr. Halvorson:

This final report provides the results of our audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status, Group Health Plan, Inc." Our objective was to determine if payments to Group Health Plan, Inc. (GHI), under Medicare risk contract H9005, were appropriate for beneficiaries reported as institutionalized.

We determined that GHI received Medicare overpayments totaling $167,630 for 41 beneficiaries incorrectly classified as institutionalized. The 4 1 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries reported as institutionalized during the period October 1, 1994 through September 30, 1996. Based on our sample results, we estimate that GHI received Medicare overpayments of at least $1,640,678 for beneficiaries incorrectly classified as institutionalized during the audit period.

INTRODUCTION

BACKGROUND

The GHI has participated as a Medicare risk-based health maintenance organization (HMO) through contract H9005 since 1984. An HMO is a legal entity that provides or arranges for basic health services for its enrolled members. An HMO can contract with the Health Care Financing Administration (HCFA) to provide medical services to Medicare beneficiaries. Medicare beneficiaries enrolled in risk-based HMOs receive all services covered by Parts A and B of the program.

Under risk-based contracts, HCFA makes monthly advance payments to HMOs at the per capita rate set for each enrolled beneficiary. The rates are set at 95 percent of the expected fee-for-service costs that would have been incurred by Medicare had beneficiaries not enrolled in HMOs.

A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. Requirements for institutional status are met if a Medicare beneficiary has been a resident of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital or

domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month. Risk contract HMOs are required to submit to HCFA each month a list of enrollees meeting the institutional status requirements. The advance payments received by HMOs each month are subsequently adjusted to reflect the enhanced reimbursement for institutional status. For example, during 1996 HMOs received a monthly advance payment of $457 for each non-Medicaid male beneficiary, 80 to 84 years of age, residing in a non-institutional setting in Hennepin County, Minnesota. The Medicare payment to HMOs for a similar beneficiary living in an institutional setting was $842. The monthly advance payment of $457 would have been adjusted to $842 after the beneficiary was reported to HCFA as having institutional status.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. The objective was to determine if capitation payments to GHI were appropriate for beneficiaries reported as institutionalized. We also conducted a review of GHI's internal controls, focusing on procedures for verifying the institutional status of Medicare beneficiaries.

The audit covered the period October 1, 1994 through September 30, 1996. A simple random sample of 100 was selected from a universe of 1,334 Medicare beneficiaries reported as institutionalized by GHI during the audit period. From GHI, we obtained the names and addresses of the institutions in which the beneficiaries in the sample resided. Confirmation letters were sent to institutional facilities to verify that the sample beneficiaries were institutionalized for the periods GHI reported to HCFA. Based on responses received from institutional facilities, we identified Medicare beneficiaries who were incorrectly reported as having institutional status. For each incorrectly reported beneficiary, we calculated the Medicare overpayment by subtracting the non-institutional payment that GHI should have received from the institutional payment actually received.

Using the overpayments identified in our sample, we projected the probable value of Medicare overpayments in the universe of beneficiaries. Details of our statistical sample and projection are shown on Appendix A.

Our field work was performed April through November 1997 at GHI offices in Minneapolis, Minnesota; HCFA offices in Chicago, Illinois; and our field office in Columbus, Ohio.

RESULTS OF AUDIT

The GHI received Medicare overpayments totaling $167,630 for 41 beneficiaries incorrectly classified as institutionalized. The 41 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries reported as institutionalized during the period October 1, 1994 through September 30, 1996. Based on our sample results, we estimate that GHI received Medicare overpayments of at least $1,640,678 for beneficiaries incorrectly classified as institutionalized during the audit period.

MEDICARE OVERPAYMENTS

Our review indicated the majority of the Medicare overpayments occurred due to a breakdown in the transmission of information between computer systems. The GHI process for tracking and reporting institutionalized beneficiaries relies on two computer systems - the Authorization System and the Medicare System.

The Authorization System maintains beneficiary records that include long-term care admission and discharge dates. On a weekly basis, the admission and discharge dates are reported to Membership Accounting staff who enter the dates into the Medicare System. The Medicare System uses the admission and discharge dates to determine which beneficiaries qualify for the institutional classification. A list of beneficiaries classified as institutionalized is then transmitted to HCFA.

We found that information from the Authorization System did not always flow into the Medicare System. This system flaw caused GHI to submit incorrect information to HCFA regarding the institutional status of beneficiaries. The GHI had previously discovered the system flaw and reported the problem to HCFA in September 1995. Since then, GHI has worked to improve internal controls used for tracking and reporting institutionalized beneficiaries.

We also found that GHI did not verify the institutional status of beneficiaries on a monthly basis. If a monthly verification process had been used by GHI, the errors caused by the system flaw would have been detected sooner. Currently, GHI uses a monthly verification process to help ensure the accuracy of beneficiary status prior to submitting the list of institutionalized beneficiaries to HCFA.

INTERNAL CONTROLS

During our audit period, GI-II did not have adequate controls for verifying and reporting the institutional residency of the Medicare beneficiaries enrolled in the HMO. Since reporting the internal control weakness to HCFA in September 1995, GHI now reports that it has corrected the system flaw and implemented new controls to help ensure the accurate reporting of institutionalized beneficiaries to HCFA.

The GHI now requires that all institutional facilities be contacted each month to verify beneficiary status. A report is mailed to each facility listing all HMO members believed to be residents of that institutional facility. The facility is asked if beneficiaries on the list are residents, have gone home or to the hospital, transferred to another facility, or expired. If a facility fails to respond, GHI staff follow up by faxing the request or contacting the facility by telephone.

The GHI also conducts a monthly comparison of data in the Authorization System with information from the Medicare System. All discrepancies discovered are investigated and corrected.

RECOMMENDATIONS

We recommend that GHI:

- Continue to strengthen internal control procedures to ensure errors do not occur in the future.
- Refund the specific overpayments identified through our review totaling $167,630.
- Review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments which we estimate to be at least $1,640,678.

AUDITEE COMMENTS AND OIG RESPONSES

In a letter dated March 19, 1998, GHI responded to our draft report. The response is included with this report as Appendix B.

AUDITEE COMMENT

The GHI did not dispute that they had received Medicare overpayments for 41 beneficiaries who were incorrectly classified as institutionalized during our audit period. However, they did state that the system limitations that caused the Medicare overpayments also caused instances of underreporting (i.e., GHI could have claimed institutional reimbursement for beneficiaries, but did not do so). The GHI requested that we change the Scope of Audit section of the report to state that our sample was not designed to examine whether there were beneficiaries or additional months for which institutional reimbursement could have been claimed.

OIG RESPONSE

We believe that the Scope of Audit section in the report clearly states the sampling methodology used during our review. In addition, we did not verify the accuracy of the underreporting instances that GHI had identified because our audit focused on claims that GHI had submitted to HCFA. However, if GHI has identified Medicare beneficiaries that should have been claimed at the institutional rate, but were not, GHI should work with HCFA to determine if submitting retroactive claims is allowable.

AUDITEE COMMENT

The GHI requested clarification regarding the confidence level used in projecting our audit results.

OIG RESPONSE

We used the 90 percent confidence level to project our audit results to the universe of beneficiaries with institutional status. At this level, we are 90 percent confident that GHI received Medicare overpayments between $1,640,678 and $2,83 1,695 during the period October 1994 through September 1996. We are 95 percent confident that the Medicare overpayments are at least the lower limit, which is $1,640,678. We are also 95 percent confident that the Medicare overpayments are not greater than the upper limit, which is $2,831,695.

AUDITEE COMMENT

The GHI agreed with our recommendation to strengthen internal control procedures to ensure errors do not occur in the future. They stated that they have instituted a number of new internal controls and have developed a process to notify HCFA should a discrepancy be discovered. However, GHI believes that our recommendations regarding the refunding of overpayments results in double counting the 100 members sampled. In addition, GHI requests that we recommend that HCFA consider all cases of underreporting in reconciliation of overpayments identified through our review.

OIG RESPONSE

We are encouraged that GHI agrees with our recommendation to strengthen internal control procedures. We believe this positive step will help to ensure that improper payments do not occur in the future.

Our recommendations involving refunding overpayments are not intended to double count the 100 beneficiaries included in our sample. We continue to recommend that GHI refund the overpayments identified through our review totaling $167,630. We also recommend that GHI review the remaining institutional beneficiaries included in the universe (excluding the 100 beneficiaries from our sample) and refund all additional overpayments that are identified. We estimate total overpayments during the period October 1, 1994 through September 30, 1996 to be between $1,640,678 and $2,831,695.

Because we have not verified the accuracy of the underreporting instances identified by GHI, we do not believe it is proper for us to recommend that HCFA consider all cases of underreporting in the reconciliation of overpayments identified through our review. As stated previously, however, if GHI failed to submit claims in prior months for beneficiaries with institutional status, GHI should contact HCFA to determine if submitting the claims is allowable.

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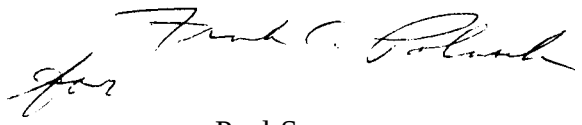
Final determination as to actions taken on all matters reported will be made by the U. S. Department of Health and Human Services (HHS) action official named below. . We

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 (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act that the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-97-000 14 in all correspondence relating to this report.

Sincerely yours,



Paul Swanson
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Director, Office of Managed Care
S3-02-01
7500 Security Boulevard
Baltimore, Maryland 21244-1850

APPENDIX A

GROUP HEALTH PLAN, INC.

VARIABLE APPRAISAL OF STATISTICAL SAMPLE

Universe:	1,334
Sample Size:	100
Nonzero Items:	41
Value of Nonzero Items:	$167,630
Mean:	1,676.30
Standard Deviation:	2,795.40
Standard Error:	268.86
Skewness:	1.76
Kurtosis:	5.24
Point Estimate:	$2,236,187

Projection at the 90 Percent Confidence Level:

Lower Limit:	$1,640,678
Upper Limit:	$2,83 1,695
Precision Amount:	$595,509
Precision Percent:	26.63%

HealthPartners

8100 34th Avenue South
PO Box 1309
Minneapolis, MN 55440-1309

March 19, 1998

Paul Swanson
Regional Inspector General for Audit Services
HHS/OIG Office of Audit Services
Two Nationwide Plaza, Suite 710
280 North High Street
Columbus, OH 43215

Transmitted via Facsimile and U.S. Mail

RE: Response to Office of Inspector General (O.I.G.) Draft Report, "Review of Medicare Payments for "Beneficiaries with Institutional Status" (A-05-97-00014)

Dear Mr. Swanson:

Thank you for the opportunity to review and comment on the February 1998 report of institutional status titled Review of Medicare Payments for Beneficiaries with Institutional Status. The report includes detail regarding a sample of 100 Medicare beneficiaries reported by Group Health Plan, Inc. (GHI) as institutionalized during the period October 1, 1994 through September 30, 1996. Our comments on this report include both technical corrections and substantive issues we would like to see addressed in the report's final version.

Document
All references throughout the document to "HealthPartners" should be changed to "Group Health Plan, Inc." Although HealthPartners performs administrative services for GHI, the Medicare risk contract is between the Health Care Financing Administration (HCFA) and GHI. Payments were actually made to GHI.

Page 1, First Paragraph, "Background"
Change the reference of "St. Paul-Ramsey Medical Center" to "Regions Hospital."

Page 2, "Scope of Audit"
We understand the sampling methodology included only those records for which we reported institutional stays during the study period, and therefore was designed specifically to identify and capture over-reporting. GHI also had under-reporting of institutional status to HCFA during this same time period. O.I.G. includes a statement on Page 3, first paragraph, under "Medicare Overpayments" which states, "the majority of the Medicare over-payments occurred due to a breakdown in the transmission of information between computer systems." The same systems limitations caused all information, new accretions as well as deletions to institutional status, not to flow consistently between computer systems. Therefore, under-reporting existed on the same magnitude as over-reporting during the review period of October 1994-September 1996.

GHI conducted its own, independent claims analysis which demonstrates the existence of both over and under-reporting.

1) GHI took the same sample of records selected by O.I.G. as described in this report, and investigated them for under-reporting of institutional status. Thirty four of the 100 members had institutional stays that were under-reported to HCFA. Thus, while we received some institutional payment for these members, we did not claim institutional status for all of the months a particular member was actually in the nursing home. We also obtained primary verification by nursing homes for this information. Again, this sample did not include an examination of members who may have been institutionalized but were never accreted for institutional status during the study period. Results of this study was provided to O.I.G. following the on-site review. Please refer to the attachment to this letter for additional detail on the financial impact of the findings.

2) An internal study done in 1996 was conducted by GHI as an element of a corrective action plan to HCFA. In this study, GHI examined both over and under-reporting in a random sample of 100 beneficiaries, drawn from both the membership and authorization systems. The study confirmed both over and under-reporting. Under-reporting in this sample occurred in two situations; 1) members who were never accreted as institutional, and 2) those who were accreted fewer months than they were actually institutionalized. This information was also presented to O.I.G. during the course of the review.

Based on the strong evidence regarding under-reporting, we request that the following statement be included in the Scope of Audit section:

Our audit sample included only those records for which Group Health Plan, Inc. claimed institutional reimbursement. The sample was not designed to examine whether there were beneficiaries or additional months for which Group Health Plan, Inc. could have claimed institutional reimbursement, but did not do so.

Page 3, First Paragraph, "Results of Audit"
We would like clarification as to which level of confidence O.I.G. has used in reporting the results. The first paragraph on page three states 95 percent, while the appendix states a 90 percent level of confidence.

Page 3, Paragraph 3 of "Medicare Overpayments" and Page 4, Paragraph 1 of "Internal Controls"
GHI takes seriously its commitment to report institutional status accurately to HCFA. Following our self-report of these discrepancies in September 1995, we began concerted efforts to identify the reasons for discrepancies and to take corrective action. In addition, we completed the internal audit in 1996 described under "Scope of Audit". We appreciate the acknowledgement and recognition of these successful actions in the draft report.

Page 4, Recommendations
We agree with the first recommendation to: "Continue to strengthen internal control procedures to ensure errors do not occur in the future." We have instituted a number of new effective internal controls, and have a process to notify HCFA should a discrepancy be discovered. Our audits demonstrate significant improvement and consistency. We plan to maintain these controls to ensure the tracking process is accurate.

The third bullet under the recommendations in the report as written results in double counting the 100 members sampled. We urge you to either 1) recommend the estimated amount (net of estimated under-payments), or 2) recommend the estimated amount (net of the actual amount and estimated under-payments) in addition to the actual amount.

We request the second and third points under the recommendations be modified to recognize the potential of offsetting the overpayments to HCFA due to the under-reporting of institutional status. We specifically request modification to include the following language:

- *Although not captured in O.I.G.'s audit, HCFA should consider additional data regarding under-payments in the reconciliation of over-payments identified in our reviewed sample.*

We intend to work with HCFA to resolve the under/over-payment issue, considering all of the data collected. We appreciate the reviewer's suggestions on our overall institutional tracking process improvements.

Thank you again for the opportunity to comment on this report. Please let us know any next steps. If there are any questions, or if you need additional information, please feel free to contact me at (612) 883-5119.

Sincerely,

Donna Zimmerman

Donna Zimmerman
Director, Government Programs

cc: Gwen McKenzie-Sampson, HCFA Region V Office
David Kornisar, HCFA Region V Office
David Chambers, HCFA Central Office

Group Health Plan, Inc.

	OIG Findings	GHP, Inc.'s Findings
Universe	1,334	1,334
Sample Size	100	100
Nonzero Items	41	75
Value of Nonzero Items	$167,630	$86,148
Mean	1,676.30	861.48
Standard Deviation	2,795.40	3,691.02
Standard Error	268.86	369.10
Skewness	1.78	.55
Kurtosis	5.24	.95
Point Estimate	$2,236,187	$1,149,213
Projection at the 90 Percent Confidence Level		
Lower Limit	$1,840,678	$363,917
Upper Limit	$2,831,695	$1,934,509
Precision Amount	$595,509	$785,298
Precision Percent	26.63%	68.33%

Findings listed above vary due to the inclusion of both over and under-reporting in the analysis by Group Health Plan, Inc.