Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

KAISER FOUNDATION HEALTH PLAN PORTLAND, OREGON

JUNE GIBBS BROWN
Inspector General

APRIL 1998
A-05-97-00023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V
105 W. AOAMS ST.
CHICAGO. ILLINOIS 60603.6201

April 27, 1998

OFFICE OF
INSPECTOR GENERAL

Common Identification Number: A-05-97-00023

Michael H. Katcher, President
Kaiser Foundation Health Plan of the Northwest
Kaiser Permanente Building - Suite 100
500 N.E. Multnomah Street
Portland, Oregon 97232-2099

Dear Mr. Katcher:

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 Kaiser Foundation Health Plan, under Medicare risk contract H9003, were appropriate for beneficiaries reported as institutionalized.

We determined Kaiser received Medicare overpayments totaling $10,472 for 20 beneficiaries incorrectly classified as institutionalized. The 20 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 Kaiser received Medicare overpayments of at least $105,624 for beneficiaries incorrectly classified as institutionalized during the audit period.

INTRODUCTION

BACKGROUND

Kaiser participates as a Medicare risk-based health maintenance organization (HMO) through contract H9003. 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 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 $435 for each non-Medicaid male beneficiary, 80 to 84 years of age, residing in a non-institutional setting in Clackamas County, Oregon. The Medicare payment to HMOs for a similar beneficiary living in an institutional setting was $802. The monthly advance payment of $435 would have been adjusted to $802 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 Kaiser were appropriate for beneficiaries reported as institutionalized. We also conducted a review of Kaiser'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 2,391 Medicare beneficiaries reported as institutionalized by Kaiser during the audit period. From Kaiser, 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 Kaiser 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 Kaiser 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 December 1997 at Kaiser offices in Portland, Oregon; HCFA offices in Seattle, Washington; and our field office in Columbus, Ohio.

RESULTS OF AUDIT

Kaiser received Medicare overpayments totaling $10,472 for 20 beneficiaries incorrectly classified as institutionalized. The 20 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 Kaiser received Medicare overpayments of at least $105,624 for beneficiaries incorrectly classified as institutionalized during the audit period.

MEDICARE OVERPAYMENTS

Our review indicated the majority of the Medicare overpayments occurred due to flaws in Kaiser's Admitting Discharge and Transfer (ADT) system. The ADT system is designed to track beneficiaries in hospitals, skilled nursing facilities and other institutional settings. Information regarding beneficiaries in institutional settings is gathered from a variety of sources and entered into the ADT system.

Kaiser is paid an enhanced capitation rate for each beneficiary reported to HCFA as having institutional status. To qualify for the institutional classification, a beneficiary must be a resident of an institution for a minimum of 30 consecutive days immediately prior to the first day of the reporting month.

Prior to February 1994, Membership Accounting staff would receive patient information from the ADT system and manually determine which beneficiaries met the institutional status requirements based on admit and discharge dates. In February 1994, Kaiser modified the ADT system so that Membership Accounting staff would be provided with a report detailing beneficiaries who should be added to or subtracted from the institutional status listing submitted to HCFA, thus eliminating the manual task. The system modification, however, included several flaws.

(1) The ADT system fails to confirm that beneficiaries are in institutional settings for the 30 day qualifying period immediately prior to the first day of the current reporting month.

(2) The system adds 30 days to a beneficiary discharge date before notifying Membership Accounting staff that the beneficiary should be removed from the institutional status listing provided to HCFA. This program logic is incorrect.

(3) In situations where the ADT system is retroactively advised of a changed admit or discharge date, the system does not notify Membership Accounting of the changes.

We also found that errors caused by the system flaws were compounded because, in some cases, Membership Accounting staff did not report changes in beneficiary status to HCFA in a timely manner. For example, if a beneficiary was discharged from an institutional setting on June 20th, the ADT system would incorrectly inform Membership Accounting staff of an , effective deletion date of July 20th. Membership Accounting staff would then report the change in beneficiary status to HCFA in September rather than August.

In addition to the system flaws noted above, we found that overpayments for several beneficiaries occurred because Kaiser had incorrect admission and discharge dates in the ADT system. We also identified an overpayment that occurred because Kaiser did not properly account for a beneficiary hospital stay that was greater than 15 days.

INTERNAL CONTROLS

During our audit period, Kaiser did not have adequate controls for verifying and reporting the institutional residency of the Medicare beneficiaries enrolled in the HMO. Kaiser informed us that they verify the institutional status of beneficiaries on a monthly basis. However, Kaiser was unable to provide adequate supporting documentation to show that monthly verification had been conducted for several beneficiaries we selected to test the control system. If an adequate monthly process had been used by Kaiser to verify the status of all beneficiaries, the errors caused by the ADT system flaws may have been detected sooner.

Kaiser has indicated that the ADT system flaws have been corrected and the system has been tested to ensure it is working properly. In addition, Kaiser now requires that all institutional facilities be contacted each month to verify beneficiary status. Kaiser has contracted with an independent organization to conduct the monthly verification process.

RECOMMENDATIONS

We recommend that Kaiser:

- Continue to strengthen internal control procedures to ensure that errors do not occur in the future.

- Refund the specific overpayments identified through our review totaling $10,472.

- Review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments. We estimate the total overpayments to be at least $105,624.

AUDITEE COMMENTS

In a letter dated April 8, 1998, Kaiser responded to our draft report. They did not dispute the results of our review and had no additional information to supply. Their response is included with this report as Appendix B.

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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-05-97-00023 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
33-02-01
7500 Security Boulevard
Baltimore, Maryland 21244-1850

APPENDIX A

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

VARIABLE APPRAISAL OF STATISTICAL SAMPLE

Universe:	2,391
Sample Size:	100
Nonzero Items:	20
Value of Nonzero Items:	$10,472
Mean:	104.72
Standard Deviation:	372.52
Standard Error:	36.47
Skewness:	5.89
Kurtosis:	41.96
Point Estimate:	$250,389

Projection at the 90 Percent Confidence Level:

Lower Limit:	$105,624
Upper Limit:	$395,155
Precision Amount:	$144,766
Precision Percent:	57.82%

KAISER PERMANENTE

April 8, 1998

Paul Swanson
Regional Inspector General
105 W. Adams St.
Chicago, IL 60603

Dear Mr. Swanson:

We received your draft audit report March 20th. We understand it was unduly delayed in your offices and we are permitted to start the 30 day clock March 1 7th.

We were given adequate opportunity along the way to review and correct data associated with the sample. We have no further information to supply. We are anxious to proceed with making the appropriate adjustments to the HCFA master data file and understand HCFA won't allow us to initiate that until the final report is out. So, we request the final report be published as soon as possible. Thank you in advance.

Sincerely yours,

Thomas R. Hussey
Medicare Director

TRH:ls

c: John Hagg
Mike Katcher