Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

HEALTHCAREPLAN BUFFALO, NEW YORK

JUNE GIBBS BROWN
Inspector General

JUNE 1998
A-05-97-00025

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V
105 W. ADAMS ST.
CHICAGO. ILLINOIS 60603-6201

OFFICE OF
INSPECTOR GENERAL

June 30, 1998

Common Identification Number: A-05-97-00025

Arthur R. Goshin, M.D.
President
HealthCarePlan
900 Guaranty Building
Buffalo, New York 14202

Dear Dr. Goshin:

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 HealthCarePlan (HCP) under Medicare risk contract H3351 were appropriate for beneficiaries reported as institutionalized.

We determined HCP received Medicare overpayments totaling $27,201 for 31 beneficiaries incorrectly classified as institutionalized. The 31 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 HCP received Medicare overpayments of at least $36,020 for beneficiaries incorrectly classified as institutionalized during the audit period.

INTRODUCTION

BACKGROUND

The HCP participates as a Medicare risk-based health maintenance organization (HMO) through contract H3351. 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 $236 for each non-Medicaid female beneficiary, age 65 to 69, residing in a non-institutional setting in Erie County, New York. The Medicare payment to HMOs for a similar beneficiary living in an institutional setting was $590. The monthly advance payment of $236 would have been adjusted to $590 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 HCP were appropriate for beneficiaries reported as institutionalized. We also conducted a review of the HMO's internal controls, focusing on procedures for verifying the institutional status of Medicare beneficiaries.

A simple random sample of 100 was selected from a universe of 219 Medicare beneficiaries reported as institutionalized by HCP during the period October 1994 through September 1996. From HCP, 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 HCP 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 HCP 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 HCP offices in Buffalo, New York and our field office in Columbus, Ohio.

RESULTS OF AUDIT

The HCP received Medicare overpayments totaling $27,201 for 31 beneficiaries incorrectly classified as institutionalized. The 31 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 HCP received Medicare overpayments of at least $36,020 for beneficiaries incorrectly classified as institutionalized during the audit period.

CAUSES OF MEDICARE OVERPAYMENTS

Our review indicated that Medicare overpayments resulted from a weakness involving internal control procedures implemented by HCP to verify the institutional status of enrolled members. During our audit period, HCP internal control procedures required that institutional status of Medicare beneficiaries be verified monthly. The procedures were inadequate because verification of institutional residency was made at various times during a month rather than at months end. As a result, institutionalized status was claimed for beneficiaries who had not met the regulatory requirement of residency for 30 consecutive days prior to the first day of the reporting month.

IMPROVEMENTS IN INTERNAL CONTROLS

In response to our audit results, HCP officials have made changes to their internal control procedures. The staff at HCP have begun verifying the institutional residency of Medicare beneficiaries at the end of each month by telephone. This change should improve the accuracy of HCP's reporting of beneficiaries with institutional status and help prevent future overpayments by Medicare. Because the procedural changes eliminated the cause of the Medicare overpayments identified during our audit, no additional adjustments to HCP's internal controls will be recommended.

RECOMMENDATIONS

We recommend that HCP:

- Refund the overpayments identified through our review totaling $27,201

- Review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments. We estimate the total overpayments to be at least $36,020.

AUDITEE COMMENTS AND OIG RESPONSE

In a letter dated May 15, 1998, HCP responded to our draft report. Below, we have summarized key aspects of the response and, where applicable, have provided our additional comments. The complete response is included with this report as Appendix B.

AUDITEE COMMENTS

Officials at HCP agree that they received Medicare overpayments totaling $27,201 for 31 beneficiaries incorrectly classified as institutionalized during our audit period. However, HCP officials disagree with our statistical projection which estimated total Medicare overpayments to be $36,020 because they believe our sample results do not represent a normal distribution and should not be used to generalize.

The HCP response also suggests that we are questioning the $27,201 in overpayments identified in our sample and an additional projected amount of $36,020. Officials at HCP also stated that they are unclear as to whether our statistical results were reported at the 90 or 95 percent confidence level.

In addition, staff at HCP believe they have identified a number of months where beneficiaries included in our sample were institutionalized, but not claimed at the enhanced rate. Officials at HCP believe that HCFA should take these underpayments into account when resolving our audit findings.

OIG RESPONSE

We disagree with HCP's contention that our statistical estimation of total Medicare overpayments cannot be used to generalize. We selected a simple random sample of 100 beneficiaries from a universe of 219 Medicare beneficiaries reported as institutionalized by HCP during the audit period. We estimate, with 90 percent confidence, that HCP received Medicare overpayments totaling between $36,020 and $83,122 during this period. To clear up confusion regarding confidence levels, it is also correct that we are 95 percent confident the overpayments are not less than the lower limit of this range nor higher than the upper limit.

We are not duplicating amounts questioned. We are recommending that HCP immediately refund $27,201 in specific overpayments we identified when reviewing a sample. We also recommend that HCP review all other claims to determine the amount of total overpayments. Our estimate of $36,020 includes the $27, 201. However, because the estimate represents the lower limit of our statistical projection, a conservative number, a full review of all claims may identify a larger total amount pertaining to overpayments.

Regarding possible underpayments, if HCP has identified Medicare beneficiaries who should have been claimed at the institutional rate but were not, HCP should work with HCFA to determine if submitting retroactive claims is allowable.

- - - - -

Final determination as to the 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 the 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-05-97-00025 in all correspondence relating to this report.

Sincerely yours,

Stephen Glamar

for 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

HEALTH CARE PLAN

VARIABLE APPRAISAL OF STATISTICAL SAMPLE

Universe:	219
Sample Size:	100
Nonzero Items:	31
Value of Nonzero Items:	$27,201
Mean:	272.01
Standard Deviation:	878.63
Standard Error:	64.77
Skewness:	7.25
Kurtosis:	63.31
Point Estimate:	$59,571

Projection at the 90 Percent Confidence Level:

Lower Limit:	$36,020
Upper Limit:	$83,122
Precision Amount:	$23,551
Precision Percent:	39.53%

HCP HealthCarePlan

May 15, 1998

John Hagg
HHS/OIG Office of Audit Services
Two Nationwide Plaza, Suite 710
280 North High Street
Columbus, Ohio 43215

Re: Common Identification Number: A-05-97-00025

Dear Mr. Hagg:

I am writing in response to the letter HealthCarePlan received on March 20, from Paul Swanson to Arthur R. Goshin, M.D. It contained the draft report of the Inspector General's audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status." The OIG conducted this audit on a sample of 100 Medicare beneficiaries reported by Health Care Plan (HCP) to Health Care Financing Administration (HCFA) as institutionalized during the period October 1, 1994 through September 30, 1996.

The result of the above-mentioned study was the identification of 31 beneficiaries incorrectly classified as institutionalized during that period. This resulted in an overpayment from HCFA to HealthCarePlan of $27,201. We do not disagree with that conclusion. Based on that sample, you estimated that HealthCarePlan received an additional overpayment of at least $36,020 for additional beneficiaries incorrectly classified as institutionalized during the audit period. We do not agree with the use of this sample to determine an overpayment of $36,020, as described below.

Study
We worked with David Shaner of your office to verify the institutional status of the beneficiaries selected for the study. Of the 100 beneficiaries in the study, the preliminary audit identified 49 who did not appear to meet the criteria. After documentation by HealthCarePlan and confirmation from the facilities involved, this list was reduced to 31. As noted in the report, HealthCarePlan has made changes to the internal controls to more accurately verify the institutional residency of Medicare beneficiaries. We changed the process so that we monitor and coordinate changes in institutional status with the enrollment process.

Sampling

We believe that the sample used to project the additional overpayments is skewed. The skewness and kurtosis of the distribution show that this is not a normal distribution and therefore should not be used to generalize. It appears that most of the sample is compliant. However, a few outliers distort the distribution and affect the mean by pulling it in a higher direction. There are also two reported Confidence Levels included in the report. On page 2 of the letter, in the last paragraph, a 95 percent confidence level is estimated, but in the Appendix a 90 Percent Confidence Level is indicated. We estimate that the sample would have to be 139 based on a universe of 219, and a 95 Percent Confidence Level, with a maximum sampling error of 5%. These numbers represent a sampling error of +/- 7.22% with a Confidence Level of approximately 83%.

Underpayment

We reviewed the cases included in the sample and identified at least twelve members for whom we could have billed at the institutionalized rate, but did not. This produces an underpayment in the range of $14,000 from Health Care Financing Administration to HealthCarePlan. We did not look at the rest of the members institutionalized during the study period.

Recommendations

1. HealthCarePlan acknowledges the errors involving the 31 beneficiaries found in the sample.
2. We recommend that before using this sample you should normalize the distribution and recalculate the resulting projection.
3. Health Care Financing Administration should consider the underpayment to HealthCarePlan of the additional institutional payment for members who could have been paid as institutional but were not, as an offset to the money owed as a result of the recalculation of the sample.

We would appreciate your consideration of our recommendations as you finalize this report and look forward to seeing another draft. If you wish to discuss this further I can be reached at (716) 857-6156.

Sincerely,

Valerie J. Rosenhoch
Director, Government Affairs

cc: David Shaner