Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

KAISER FOUNDATION HEALTH PLAN CLEVELAND, OHIO

JUNE GIBBS BROWN
Inspector General

MAY 2000
A-05-99-00045

Office of Inspector General

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

REGION V
OFFICE OF
INSPECTOR GENERAL

May 19,2000

Common Identification Number: A-05-99-00045

Chris dulaney, CEO
Kaiser Permanente
North Point Tower, Suite 1200
1001 Lakeside Avenue
Cleveland, Ohio 44114-1153

Dear Mr. dulaney:

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 capitation payments to Kaiser Foundation Health Plan (Contract H3607) were appropriate for beneficiaries reported as institutionalized.

We determined that Kaiser received Medicare overpayments totaling $11,214 for 15 beneficiaries incorrectly classified as institutionalized. The 15 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries reported as institutionalized during the period January 1, 1996 through December 31, 1998. Based on our sample results, we estimate that Kaiser received Medicare overpayments of at least $49,963 for beneficiaries incorrectly classified as institutionalized. The majority of the overpayments occurred because, prior to 1997, Kaiser staff did not consistently verify the institutional residency of beneficiaries.

INTRODUCTION

BACKGROUND

A health maintenance organization (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.

The HCFA makes monthly advance payments to HMOs at the per capita rate set for each enrolled beneficiary. A higher capitation rate is paid for HMO enrollees who are institutionalized. Prior to 1998, requirements for institutional status were met if a Medicare beneficiary had 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. Beginning in 1998, HCFA changed the requirements for institutional status. Under the new rules beneficiaries had to be residents of one of the following Medicare or

Medicaid certified institutions: 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.

The HMOs are required to submit to HCFA, a monthly list of enrollees meeting institutional status requirements. The advance payments received by HMOs each month are subsequently adjusted by HCFA to reflect the enhanced reimbursement for institutional status. For example, during 1999, HMOs in Summit County, Ohio received a monthly advance payment of $499 for a Medicare-eligible female beneficiary, age 75 through 79, living at home. If this beneficiary was institutionalized, the monthly advance payment of $499 would rise to $1,066.

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 limited review of Kaiser's internal controls focusing on procedures for verifying the institutional status of Medicare beneficiaries. The audit covered the period January 1, 1996 through December 31, 1998.

A simple random sample of 100 was selected from a universe of 834 Medicare beneficiaries reported as institutionalized by Kaiser during the audit period. We obtained from Kaiser 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 the facilities, we identified Medicare beneficiaries who were incorrectly reported as institutionalized. The Medicare overpayment for each incorrectly reported beneficiary was calculated 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 August through November 1999 at Kaiser offices in Cleveland, Ohio and our field office in Columbus, Ohio.

RESULTS OF AUDIT

Kaiser received Medicare overpayments, totaling $11,214, for 15 beneficiaries incorrectly classified as institutionalized. The 15 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries reported as institutionalized during the period January 1, 1996 through December 31, 1998. Based on our sample results, we estimate, with 95 percent confidence, that Kaiser received Medicare overpayments of at least $49,963 for beneficiaries incorrectly classified as institutionalized.

Kaiser's current internal control procedures for verifying the institutional residency of the Medicare beneficiaries enrolled in the HMO are adequate. The internal control procedures require that institutional facilities be contacted each month by telephone to verify each beneficiary's residency prior to Kaiser submitting the monthly list of institutionalized members to HCFA.

Eleven beneficiaries in our sample were incorrectly reported as institutionalized during 1996 and early 1997, because Kaiser did not consistently follow established verification procedures. Kaiser officials agree that, in the past, the institutional residency of each beneficiary may not have been verified monthly, but that the problem was corrected in 1997. Our audit results provide evidence that Kaiser did correct the problem.

Payments for three beneficiaries were questioned because they were hospitalized during the first month that they were claimed at the higher institutional payment rate. The higher payment rate cannot be claimed for the first 30 day period if the beneficiary is hospitalized during that period. Kaiser staff misinterpreted language in HCFA's Operational Policy Letter #54 and believed that hospital stays during the first month of institutional status were allowable.

The institutional status of one beneficiary was questioned because the individual was a resident of a assisted living facility, which did not meet HCFA's definition of a qualifying institutional facility after 1997.

CONCLUSIONS AND RECOMMENDATIONS

As a result of not consistently verifyng the institutional residency of beneficiaries reported to HCFA, Kaiser staff, prior to 1997, incorrectly reported 15 of the 100 beneficiaries in our sample as institutionalized. Kaiser has since corrected this internal control weakness. As a result, we are making no recommendations related to Kaiser's procedures for verifying institutional status.

We recommend that Kaiser:

- refund the overpayments identified through our review totaling $11,214.

- review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments. We estimate total overpayments to be at least $49,963.

AUDITEE COMMENTS AND OIG RESPONSES

In a letter dated April 20,2000, Kaiser responded to our draft audit 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

Kaiser officials, responding to the draft audit report, raised concerns about the audit design, one of our conclusions and the wording of the recommendations. The officials believe that the audit is fkndamentally flawed because we did not attempt to identify instances in which Kaiser could have, but did not, submit claims for institutional payment. Kaiser officials also believe that hospital stays during the first month of institutional status are allowable. Finally, the officials, responding to our report, asked that we clarify the interrelation of the different amounts contained in our recommendations. The Kaiser staff is concerned that we are attempting to recover the same unallowable amounts twice.

OIG RESPONSE

We disagree with Kaiser's comments that there is a flaw with our audit design because we did not target Medicare underpayments as part of our review. Kaiser presented no evidence that underpayments occurred. We believe that, if Kaiser officials have knowledge of unclaimed institutional payments, the appropriate claims should be submitted to HCFA.

We also disagree with Kaiser's view that hospital stays during the first month of institutional residency are allowable. The HCFA Operational Policy Letter #54 states that Medicare will **continue** to make payments at the institutional rate for beneficiaries who temporarily leave an institutional facility to go to a hospital for 15 days or less. If a beneficiary has not qualified for institutional status prior to a hospital stay, Medicare cannot **continue** to make institutional payments that have not yet started. Beneficiaries must have an initial full month of institutional residency, prior to a hospital stay, for the temporary absence not to void institutional status.

Kaiser's response to our draft report requested the we clarify our recommendations. We are recommending that Kaiser immediately refund $11,214 for the specific overpayments identified in our sample. We also recommend that Kaiser review all other claims to determine the amount of total overpayments. Our estimate of $49,963 includes the $11,214. We are recommending a full review of all claims, because our estimate is conservatively based on the lower limit of our statistical projection, and actual total overpayments may be significantly higher.

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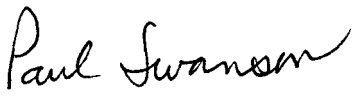
Final determination as to the actions taken on all matters reported will be made by the U.S. Department of Health and Human Services (HHS) action official named below. We request that you respond to the action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the

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 the 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 CAR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-99-00045 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

CLEVELAND, OHIO

VARIABLE APPRAISAL OF STATISTICAL SAMPLE

Universe:	834
Sample Size:	100
Nonzero Items:	15
Value of Nonzero Items:	$11,214
Mean:	112.14
Standard Deviation:	335.33
Standard Error:	31.46
Skewness:	3.80
Kurtosis:	18.04
Point Estimate:	$93,526

Projection at the 90 Percent Confidence Level:

Lower Limit:	$49,963
Upper Limit:	$137,089
Precision Amount:	$43,563
Precision Percent:	46.58%

APPENDIX B

KAISER PERMANENTE

Executive Offices, Ordway Building

April 20, 2000

David Shaner, Auditor
HHS/OIG Office of Audit Services
Two Nationwide Plaza, Room 710
280 North High Street
Columbus, Ohio 43215

Re: Common Identification Number A-05-99-00045

Dear Mr. Shaner,

The purpose of this letter is to respond to the February 23, 2000 letter sent to Chris DuLaney, CEO of Kaiser Foundation Health Plan of Ohio ("Kaiser-Ohio") by Paul Swanson, Regional Inspector General for Audit Services.

Mr. Swanson's letter enclosed a draft report providing the results of the OIG's audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status." Although Mr. Swanson states that the objective of the audit "was to determine if capitation payments to Kaiser-Ohio were appropriate for beneficiaries reported as institutionalized, you have confirmed, in your discussions with Eric Tabor, Kaiser-Ohio's Director of Medicare, that the OIG's sole aim was to determine if there were any Medicare overpayments for institutionalized members. No efforts were made during the audit to determine if there had been any Medicare underpayments during the audit period of January 1, 1996 through December 31, 1998. We continue to believe that a balanced and fair audit methodology would and should have looked for both overpayments and underpayments, and that any audit design that does not do so is fundamentally flawed.

The draft report states that the OIG determined that Kaiser-Ohio "received Medicare overpayments totaling $11,214 for 15 beneficiaries incorrectly classified as institutionalized. These 15 beneficiaries were part of a statistical sample of 100 beneficiaries reported as institutionalized during the audit period. Based on the sample results, the OIG estimates that Kaiser-Ohio "received Medicare overpayments of at least $49,963 for beneficiaries incorrectly classified as institutionalized".

The draft report states that of the 15 beneficiaries who were allegedly incorrectly classified as institutionalized, three beneficiaries were considered incorrectly classified "because they were hospitalized during the first month that they were claimed at the higher institutional payment rate." The report states that the higher payment rate "cannot be claimed for the first 30 day period if the beneficiary is hospitalized during that period", but it does not provide any authority or citation for this statement. The report goes on to note that Kaiser-Ohio staff misinterpreted OPL 54 when they believed that "hospital stays during the first month of institutional status were allowable."

We continue to believe that we are entitled to classify our Medicare+Choice members as institutionalized even if they are hospitalized during the first month they are claimed as having

institutional status. OPL 54 states clearly that temporary absences of fewer than 15 days for hospitalization will not destroy institutional status, if all other qualifying factors are met. Such temporary absences count toward the 30-day requirement. There is no exception in OPL 54 for a temporary absence during the first month. Indeed, OPL 54 provides the following example of an absence during the first month, which meets the requirements for claiming institutional status:

> 1. "A member of a risk contracting organization enters an institution identified above on March 2. On March 20, the individual is hospitalized for a surgical procedure. On April 2, the individual is discharged from the hospital, re-enters the institution, and remains there continuously through April 15. The individual does meet the residence requirement. The HMO/CMP will be paid the institutional rate for the month of April."

In sum, Kaiser-Ohio contends that the OIG should either (1) provide authority from a statute, regulation, written HCFA policy or manual for its position that temporary absences during the first month disqualify institutional status, or (2) revise the draft report by removing all references to the three beneficiaries who had temporary absences during the first month they were claimed as institutional, reduce the number of allegedly incorrectly classified beneficiaries from 15 to 12, and reduce the alleged overpayments correspondingly.

Whether or not the final report cites 15 members or 12 members as having been incorrectly classified as institutionalized, the OIG needs to clarify its recommendations as to amount of the refund(s) that Kaiser-Ohio should pay HCFA. The first recommendation in the draft report is that Kaiser-Ohio refund $11,214 in overpayments for the 15 beneficiaries found to be incorrectly classified in the sample of 100. The second recommendation is that Kaiser-Ohio "review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments", which the OIG estimates "to be at least $49,963." Shouldn't the total amount to be refunded to HCFA be $49,963, not $49,963 plus $11,214, since the OIG arrived at the $9,963 amount by *extrapolating* from the sample of 15 beneficiaries? Please confirm that $49,963 (or some lesser amount based on 12, not 15, beneficiaries incorrectly classified) is the total refund Kaiser-Ohio should make to HCFA, or clarify the interrelation of the two recommendations.

Thank you for your consideration of these comments. If you have questions, or need any further information, please call me at 510 271-5964 or Eric Tabor at 216 479-5694.

Very Truly Yours,
KAISER FOUNDATION HEALTH PLAN OF OHIO

Judith M. Mears RS
Vice President and Assistant General Counsel

cc: Eric Tabor