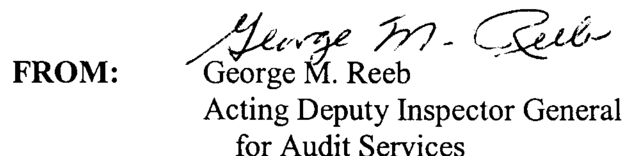
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR - 8 2003

TO: Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services



FROM: George M. Reeb
Acting Deputy Inspector General
for Audit Services

SUBJECT: Review of Medicare Payments for Beneficiaries With Institutional Status at Coventry Healthcare of Kansas, Inc. for the Period January 1, 2000 Through May 31, 2002 (A-07-02-00148)

As a part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance within 5 business days of our final audit related to our review of beneficiaries classified as institutional by Coventry Healthcare of Kansas, Inc. (Coventry), contract number H2672. The general issue of payments for institutional beneficiaries has been of interest to components of the Centers for Medicare & Medicaid Services (CMS) involved with program integrity and the Health Plan Benefits Group, Center for Beneficiary Choices. We suggest you share this report with them.

The objective of this review was to determine if capitation payments to Coventry were appropriate for beneficiaries reported as institutionalized during the audit period. We used Medicare policy and procedure manuals as well as operational policy letters issued by CMS as our primary criteria in making these determinations. Medicare generally pays a higher monthly capitation rate for enrolled beneficiaries who are residents of a Medicare or Medicaid certified institution (or the distinct part of the institution).

We determined that Coventry received Medicare overpayments totaling $132,000 for 61 beneficiaries incorrectly classified as institutionalized during the audit period. Of these, a total of 37 beneficiaries were incorrectly classified because they were residing in assisted living facilities (19); or were residing in non-approved facilities (7); or had not met the 30 consecutive day minimum time requirement to qualify as institutionalized (11). In addition, Coventry incorrectly classified 24 beneficiaries as institutional who were residing in the non-certified portion of the institution.

We recommend that Coventry refund overpayments of approximately $132,000, ensure adherence to policies and procedures for verifying institutional care, and develop more effective internal control procedures for verification of each beneficiary's institutional status.

Coventry did not agree that the 37 beneficiaries incorrectly classified resulted from lack of oversight over internal controls. We acknowledged the existence of substantial controls and recent improvements, but still found errors resulting from an insufficient application of Coventry's internal control procedures.

In addition, Coventry did not agree with our finding relating to the 24 beneficiaries who resided in non-certified portions of institutions. We disagree with Coventry's position since these beneficiaries do not meet the CMS criteria of institutional.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to David A. Dimler, Audit Director, at (410) 786-7102 or James P. Aasmundstad, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

APR 11 2003

Report Number: A-07-02-00148

Ms. Linda Tenute
Director of Compliance
Coventry Healthcare of Kansas, Inc.
1001 East 101st Terrace
Suite 300
Kansas City, Missouri 64131

Dear Ms. Tenute:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Medicare Payments for Beneficiaries With Institutional Status at Coventry Healthcare of Kansas, Inc. for the Period January 1, 2000 Through May 31, 2002." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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 (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

To facilitate identification, please refer to Report Number A-07-02-00148 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Director, Health Plan Benefits Group, Center for Beneficiary Choices
Centers for Medicare & Medicaid Services
Mail stop C4-23-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS AT COVENTRY HEALTHCARE OF KANSAS, INC. FOR THE PERIOD JANUARY 1, 2000 THROUGH MAY 31, 2002

JANET REHNQUIST
Inspector General

APRIL 2003
A-07-02-00148

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

APR 11 2003

Report Number: A-07-02-00148

Ms. Linda Tenute
Director of Compliance
Coventry Healthcare of Kansas, Inc.
1001 East 101st Street
Terrace Suite 300
Kansas City, Missouri 64131

Dear Ms. Tenute:

This final report provides the results of our audit entitled, "Review of Medicare Payments for Beneficiaries With Institutional Status at Coventry Healthcare of Kansas, Inc. for the Period January 1, 2000 Through May 31, 2002." Our objective was to determine if capitation payments to Coventry Healthcare of Kansas, Inc. (Coventry), contract number H2672, were appropriate for beneficiaries reported as institutionalized for the audit period.

We determined that Coventry received Medicare overpayments totaling $132,000 for 61 beneficiaries incorrectly classified as institutionalized during the audit period. Of these, a total of 37 beneficiaries were incorrectly classified because they were residing in assisted living facilities (19); or were residing in non-approved facilities (7); or had not met the 30 consecutive day minimum time requirement to qualify as institutionalized (11). In addition, Coventry incorrectly classified the remaining 24 beneficiaries as institutional who were residing in the non-certified portion of the institution.

The overpayments occurred because of lack of oversight of internal control procedures. Some of the overpayments also occurred due to the lack of procedures requiring managed care organizations (MCO) to determine if the beneficiary resides in a certified distinct part of the institution. We are recommending that Coventry refund the overpayments, ensure adherence to policies and procedures for verifying institutional care, and develop more effective internal control procedures.

In its response to the draft report, Coventry did not agree with our findings regarding (1) oversight of internal controls and (2) beneficiaries not residing in certified, distinct parts of the institution. Coventry's response, in its entirety, is presented as Appendix A.

Notwithstanding the fact that Coventry does have substantial internal controls, we found several errors in reporting institutional care that should have been identified. We found that facilities generally provided more detailed information to us than to Coventry. It should be noted that Coventry enhanced its internal controls twice during our audit period and communicated

overpayments to the Centers for Medicare & Medicaid Services (CMS) on five occasions. Also, we disagree with Coventry's position concerning beneficiaries who reside in the non-certified portion of facilities. Specifically, we do not believe these beneficiaries meet the CMS criteria of institutional.

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 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 CMS, including MCOs. Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations.

The CMS makes monthly advance payments to MCOs at the per capita rate set for each enrolled beneficiary. Medicare generally pays a higher monthly rate to MCOs for institutionalized beneficiaries. The MCOs receive the enhanced rate for enrollees who are residents of Medicare or Medicaid certified institutions (or the distinct part of an institution), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care, and swing-bed hospitals. Institutional status requirements contained in CMS's Operational Policy Letter (OPL) number 54 specify that the beneficiary must be a resident of a qualifying facility for at least 30 consecutive days immediately prior to the month for which an institutional payment is being made.

Each month, the MCOs are required to submit a list of enrollees meeting institutional status requirements to CMS. The advance payments paid to MCOs each month are adjusted by CMS to reflect the enhanced reimbursement for institutional status. For example, during 2001, the monthly advance payment for an 87 year old female residing in a non-institutional setting (with no other special status indicator) in the Kansas City area was $584. If the MCO reported the beneficiary as institutionalized, CMS would have increased the payment to $959[1].

The MCOs have the autonomy to transmit corrections, or retroactive adjustments, for their enrollees' institutional statuses to CMS. These adjustments are equivalent to a Medicare claim request. In the fee-for-service arena, CMS allows providers up to 3 years to submit corrections to claims. To ensure consistency in the managed care program, Chapter 7 of the Medicare Managed Care Manual requires all retroactive payment adjustments "…to a three-year period

[1] This calculation does not include the risk adjustment method implemented January 1, 2000 that accounts for variation in per capita cost that is based on health status and demographic factors. The inclusion of risk adjustment would not have a material impact on the overpayments.

preceding the month in which CMS receives any data indicating a change is needed to a Medicare enrollee's record."

Coventry began operations as a Medicare+Choice plan (contract number H2672) in May 1999 and enrolled its first member in August 1999. In April 2001, Coventry took over the Medicare contract for Kaiser Permanente and received payments under contract number H1751 through December 31, 2001. Since January 2002, Coventry has received payments only under contract number H2672.

While enrollment at Coventry increased considerably during the audit period, the number of institutional beneficiaries also escalated. In January 2000, CMS's Group Health Plan (GHP) System indicated only one beneficiary classified as institutional. When Coventry began receiving payments under both contract numbers H1751 and H2672 in April 2001, the number of institutional beneficiaries had climbed to 78. In May 2002, the GHP showed 132 institutional beneficiaries for contract number H2672. Between January 2000 and May 2002, Coventry classified 278 of its Medicare enrollees as institutionalized.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if capitation payments to Coventry were appropriate for beneficiaries reported as institutionalized during the period January 1, 2000 through May 31, 2002.

As mentioned in the background, MCOs are required to submit a list of enrollees meeting institutional status requirements to CMS each month. While we verified existence of internal controls designed by Coventry to ensure the correct classification of beneficiaries, we did not validate that these procedures were followed each month.

To determine if payments had been made, we started by accessing the GHP and identified 261 beneficiaries classified as institutional during our audit period. Based on data from Coventry systems and 7 retroactive adjustment letters Coventry submitted to CMS, we added 17 beneficiaries to our review for a total of 278 individuals. We then used the beneficiary history information from the Managed Care Option Information System, as of June 2002, to identify the months in which the institutional status had been claimed during the audit period.

The aforementioned retroactive adjustments related to Coventry requests to CMS on both positive and negative adjustments for 142 beneficiaries out of the 278 institutionalized beneficiaries. We did not validate these claims requests, instead, we reviewed the appropriateness of all enhanced payments made as of June 2002, regardless of whether CMS made the adjustments or not.

From Coventry, we obtained the names and addresses of the facilities in which the beneficiaries resided. We contacted the facilities to verify that the beneficiaries qualified for institutional status for the months that Coventry reported to CMS. Based on residency information obtained

from the nursing facilities, we identified Medicare beneficiaries who were incorrectly reported as institutionalized. The Medicare overpayment, for each incorrectly reported beneficiary, was calculated (without regard to the risk factors) by subtracting the non-institutional payment that Coventry should have received from the institutional payment actually received.

Our field work was performed during June and July 2002 in Harrisburg, Pennsylvania where Coventry maintains all its records pertaining to institutional status and in our field office in Kansas City, Missouri.

FINDINGS AND RECOMMENDATIONS

Coventry received Medicare overpayments of $132,000 for 61 beneficiaries incorrectly classified as institutionalized. Of these, a total of 37 beneficiaries were incorrectly classified because they (1) resided in a residential or assisted living portion of the facility, (2) resided in a non-approved facility, or (3) were not institutionalized for at least 30 consecutive days immediately prior to the month for which enhanced payments were made. Additionally, we identified 24 beneficiaries claimed as institutional status who were not residing in a Medicaid or Medicare certified distinct part of the institution.

With regard to the 37 beneficiaries mentioned above, we specifically noted the following:

- 19 beneficiaries (overpayments totaling $36,000) were in a residential or assisted living portion of the facility, which does not qualify as institutional as defined by CMS.

- 7 beneficiaries (overpayments totaling $28,000) were admitted into a facility that did not qualify as institutional.

- 11 beneficiaries (overpayments totaling $10,000) did not reside in a certified facility or certified part of the facility for 30 consecutive days immediately prior to the month for which an institutional payment was made.

The overpayments generally occurred because of lack of oversight of internal control procedures. The data we collected from the institutions did not always agree with data originally submitted to Coventry by the institutions. Additionally, an oversight of Coventry's re-verification of eligible facilities resulted in enhanced payments occurring on behalf of the seven beneficiaries residing in a non-approved facility.

Coventry officials generally agreed with our conclusions for these findings and demonstrated their attempts to make corrections. Coventry revised its policies and procedures twice during the audit period in an attempt to enhance its controls over classifying beneficiaries as institutional. In fact, five of the seven previously mentioned retroactive letters showed Coventry's attempts to correct overpayments. These overpayments, which totaled $18,000, had not been adjusted by CMS at the time of our audit.

The remaining 24 beneficiaries (overpayments totaling $58,000) incorrectly claimed as institutional status did not reside in a certified bed, in the certified distinct part of the institution, as required by OPL number 54. The OPL number 54 stated that the enrolled member must reside in one of seven types of Medicare or Medicaid certified institutions. To further simplify the institution descriptions, definitions included in the OPL denoted skilled nursing facilities (SNF) or nursing facilities (NF) as being institutions or the distinct part of an institution. The definitions parallel those in the Medicare fee-for-service sector. For example, section 201.1 of the SNF Manual provides guidance for institutions containing distinct parts that are certified to provide SNF and/or NF services: "The beds in the certified distinct part must be physically separate from (that is, not commingled with) the beds of the institution or the institutional complex in which it is located." Based on the rules and regulations promulgated by CMS, beneficiaries not in certified beds do not reside in the certified distinct part of the institutions. By definition, MCO enrollees not residing in the distinct part of the institutions do not qualify for the enhanced payments.

Coventry officials disagreed with this finding. They expressed concerns that CMS requires MCOs to verify that a beneficiary resides in a certified facility (with the exception of the residential care and assisted living). Coventry does not believe the MCOs should look at the specific bed in which the beneficiaries reside. We disagree with Coventry's interpretation.

Coventry officials stated that, to the best of their knowledge, they were following the rules and regulations imposed by CMS in a proper manner.

RECOMMENDATIONS

We recommend that Coventry:

- Refund the overpayments identified in our review totaling $132,000 through a letter written to CMS delineating the beneficiaries to adjust.
- Ensure policies and procedures regarding the verification of institutionalized beneficiaries are followed.
- Develop internal control procedures requiring verification of each beneficiary's residency, including whether the beneficiary's bed is in a Medicare or Medicaid certified facility or certified distinct part of the facility.

COVENTRY'S COMMENTS AND OIG'S RESPONSE

Internal Controls

Coventry disagreed that the reporting errors we found during this audit resulted because of internal control oversight. Coventry stated facilities, for reasons unknown, submitted information to them that differed from what they submitted to the Office of Inspector

General (OIG). The response also stated that Coventry personnel "...actively oversee the implementation of specific policies and procedures regarding institutional status, as well as the revisions of such policies and procedures as necessary. Additionally, upon discovering issues, CHC takes corrective action to remedy identified issues and prevent recurrences."

We discussed on at least two occasions with the facilities, which presented differing information, to ensure the accuracy of our data and to determine the details of the beneficiary's classification. Also, we found several instances of facilities presenting to OIG more detailed information than they had presented to Coventry. For example, the information submitted to OIG--and not Coventry--presented an exact indication of when beneficiaries were admitted into assisted living facilities. After Coventry responded to our draft report and further analysis, we (1) eliminated two beneficiaries previously reported as overpayments and (2) added two beneficiaries as overpayments.

Notwithstanding the fact that Coventry does have substantial internal controls, we found several errors in reporting institutional care that should have been identified and then corrected, which is a function of internal controls. We recognize that Coventry revised its internal controls twice during our audit period and communicated overpayments to CMS on five occasions.

Certified Beds

Coventry also disagreed with our finding regarding beneficiaries not residing in certified distinct parts of the institution. Their response disagreed with our interpretation of OPL number 54 and other various program manuals, including paralleling the fee-for-service and managed care environments. Coventry also stated that facilities may have been confused by our question of beneficiaries residing in certified "beds."

We continue to believe MCOs should not categorize beneficiaries residing in non-distinct parts of certified facilities as institutional. We believe that the original provisions contained in OPL number 54 distinguished non-certified distinct parts from the remainder of the facility. Because CMS mandates facilities clearly separating institutional care patients using distinct parts in the fee-for-service arena, we believe the same logic should be consistently applied in the managed care arena.

Coventry's response, in its entirety, is presented as Appendix A.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
for Audit Services

COVENTRY
Health Care of Kansas, Inc.

December 20, 2002

Mr. James P. Aasmundstad
Department of Health and Human Services
Office of the Inspector General
Office of Audit Services, Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

RE: CIN: A-07-02-00148 Review of Medicare Payments for Beneficiaries with Institutional Status for Coventry Health Care of Kansas, Inc.

Dear Mr. Aasmundstad:

Thank you for allowing Coventry Health Care of Kansas, Inc. ("**CHC**") the opportunity to respond to (A-07-02-00148) (the "**Draft Report**") dated November 2002 and issued by the Office of Inspector General for the Department of Health and Human Services ("**OIG**"). CHC-Kansas appreciates the extension of the time period in which to respond to the Draft Report until today December 20, 2002, as approved pursuant to a December 17 conversation with Chris Breshette. The report is being sent via overnight mail. The Draft Report is based on the OIG's review of Medicare payments for beneficiaries reported by CHC as institutionalized between January 1, 2000 and May 31, 2002. The appropriate management staff of CHC has reviewed the Draft Report and offers the following comments in response to the review and resulting recommendations.

The OIG selected 278 beneficiaries reported as institutionalized during the audit period and identified several alleged overpayments. CHC has responded to certain of the OIG's findings and recommendations below.

I. INTERNAL CONTROLS

A. OIG Finding

"The overpayments generally occurred because of lack of oversight of internal control procedures"

B. OIG Recommendation

"We are recommending that Coventry:... Ensure policies and procedures regarding the verification of institutionalized beneficiaries are followed correctly."

C. CHC Response

CHC disagrees with the OIG's findings and recommendations regarding oversight of internal controls. As part of its corporate compliance program, CHC has formal written policies and procedures regarding institutional status for Medicare beneficiaries, which policies and procedures have been effective since January 2000, the beginning of the audit period. Although CHC believes that the OIG already has copies of these policies and procedures, CHC would be happy to provide additional copies to the OIG upon request. These procedures specifically address CHC's processes for verifying and re-verifying institutional status on a monthly basis.

CHC-Kansas and Coventry Health Care, Inc. Government Programs personnel at both the local and national levels monitor compliance with these policies and procedures on an ongoing basis. Such monitoring is achieved via a variety of mechanisms, including, but not limited to, internal audits of compliance with plan institutional beneficiary policies and procedures performed at least annually since November 2000. In addition to formal internal audits, CHC performs informal data validations quarterly. CHC also provides appropriate staff members with copies of the plan policies and procedures, and provides training to such staff on those policies and procedures as well as training specific to OPL 54 and the software package used in connection with the plan policies and procedures. CHC revises and updates its policies and procedures, as well as its relevant forms, as appropriate, in response to identified issues. Importantly, CHC makes every effort to identify discrepancies and institute give-backs to the Centers for Medicare and Medicaid Services (**CMS**) as appropriate

In addition to the oversight described above, CHC maintains a comprehensive corporate compliance program which includes an anonymous compliance hotline for CHC employees to report concerns or violations, which is monitored 24/7, and through which any identified issues are redressed expediently.

With respect to particular issues the OIG identified in the Draft Report, CHC took the following corrective actions:

- The OIG cited CHC for overpayments relating to nineteen beneficiaries in a residential or assisted living portion of a facility that did not qualify. Prior to the audit, in November 2001, CHC changed its fax form used to confirm eligibility with facilities to specifically ask whether a member is in residential or assisted living care, and CHC ensures that if the answer is "yes" such members are not submitted for enhanced institutional payments. Any discrepancies are investigated and any required give-backs are submitted to Interiguard.
    - Eight of the members identified by the OIG were submitted to CMS as discrepancies prior to the audit commencing, and are currently awaiting processing by CMS for payment corrections.
    - Nine of the members identified by the OIG had been previously reported to CHC by their facilities via fax or telephone as in intermediate or higher care (and thus properly submitted). For reasons that remain unclear to CHC, the facilities reported differently to the OIG.

- The OIG cited CHC for overpayments relating to eleven beneficiaries not admitted in a facility for thirty consecutive days of institutional residency. CHC relies on its monthly verification with facilities to determine a members' status.
    - Nine of the members identified by the OIG had been previously reported to CHC by their facilities via fax or telephone as admitted in a facility for thirty consecutive days of institutional residency (and thus properly submitted). For reasons that remain unclear to CHC, the facilities reported differently to the OIG.

- The OIG cited CHC for overpayments relating to seven beneficiaries admitted to a non-approved facility. With respect to this facility, during the relevant period, CHC requested written validation of certification from the facility, and the facility continued to validate its certification to CHC for more than a year under its revoked certification number. Upon learning of this discrepancy in July 2002, CHC changed its policies to ensure that its enrollment personnel would no longer rely on the facility to validate its certification number. CHC now requires quarterly downloading of the current CMS institutional listing and uses this data to compare to its submission certification numbers. Any discrepancies are investigated and any required give-backs are submitted to Interiguard.
    - Discrepancies were already submitted to CMS on August 8, 2002, and most of the money relating to these discrepancies was collected as of a December 2002 payment.

D. CONCLUSIONS

As indicated above, CHC personnel actively oversee the implementation of specific policies and procedures regarding institutional status, as well as the revisions of such policies and procedures as necessary. Additionally, upon discovering issues, CHC takes corrective action to remedy identified issues and prevent recurrences. Therefore, CHC objects to the OIG's bare statement that CHC has a "lack of oversight of internal control procedures" as it is CHC's position that this is not a fair and accurate statement. For the reasons set forth above, CHC respectfully requests that the OIG reconsider its findings and recommendations on this issue, and adjust the estimated overpayments accordingly.

II. "CERTIFIED BEDS"

A. OIG Finding

"We also identified 24 beneficiaries ... claimed as institutional status that did not reside in a certified bed in the certified distinct part of the institution, as required by OPL number 54. Coventry officials disagreed with this finding. They expressed concerns that CMS required MCOs to verify that a beneficiary resides in a certified facility (with the exception of the residential care and assisted living). Coventry does not believe the MCOs should look at the specific bed in which the beneficiaries reside."

"We disagree with Coventry's interpretation. The OPL number 54 stated that the enrolled member must reside in one of several types of Medicare or Medicaid certified

institutions. To further simplify the institution descriptions, definitions included in the OPL denoted skilled nursing facilities (SNF) or nursing facilities (NF) as being institutions or the distinct part of an institution. The definitions parallel those in the Medicare fee-for-service sector. For example, section 201.1 of the SNF Manual provides guidance for institutions containing distinct parts that are certified to provide SNF and/or nursing facility services: "*The beds in the certified distinct part must be physically separate from (that is, not commingled with) the beds of the institution or the institutional complex in which it is located.*" Based on the rules and regulations promulgated by CMS, beneficiaries not in certified beds do not reside in the certified distinct part of the institutions. By definition, MCO enrollees not residing in the distinct part of the institutions do not qualify for enhanced payments. Coventry officials stated that, to the best of their knowledge, they were following the rules and regulations imposed by CMS in a proper manner."

B. OIG Recommendation

"We are recommending that Coventry:... Develop internal control procedures requiring verification of each beneficiary's residency, including whether the beneficiary's beds are in the Medicare or Medicaid certified facility or certified distinct part of the facility."

C. CHC Response

CHC disagrees with the OIG's findings and recommendations regarding "certified beds." As described more fully below, there is no such concept as a "certified bed" applicable to Medicare+Choice payments. OPL 54 and Section 170 of chapter 7 the Medicare Managed Care Manual require that a member reside in a "certified institution" for thirty consecutive days immediately prior to the month for which the Medicare+Choice organization begins to report a member as institutionalized. However, in conducting its audit, the OIG did not ask CHC whether a member resided in a "certified institution". Rather, the OIG asked whether the member was in a "certified bed". CHC believes that it is in full compliance with OPL 54, as well as all other relevant guidance, in ensuring that institutionalized members are in "certified institutions", without investigating to the certification level of the actual "bed".

OPL 54 and Section 170.1 of chapter 7 the Medicare Managed Care Manual identify the following types of "certified institutions": a SNF as defined in 42 U.S.C. § 1395i-3; a NF as defined in 42 U.S.C. § 1396r; an intermediate care facility for the mentally retarded (ICF/MR) as defined in 42 U.S.C. § 1396d; a psychiatric hospital or unit as defined in 42 U.S.C. § 1395ww(d)(1)(B); rehabilitation hospital or unit as defined in 42 U.S.C. § 1395ww(d)(1)(B); a long-term care hospital as defined in 42 U.S.C. § 1395ww(d)(1)(B); or a swing-bed hospital as defined in 42 U.S.C. § 1395ww(d)(1)(B). OPL 54 provides "brief explanations" of the terms above, indicating that such terms would respectively include "distinct part[s]" of SNFs, NFs, and Psychiatric Hospitals. For example, a distinct part of a SNF could qualify as a "certified institution". Therefore, CHC's verification that a member is in a "certified institution" necessarily includes verification that the member is in the certified distinct part of the institution, if applicable. However, there is no clear basis for requiring further certification that a member is in a "certified bed."

Section VI of the CMS "M+C Contractor Performance Monitoring System", standard MB-06 and corresponding Worksheet MB-01, guide CMS personnel in reviewing institutionalized status issues in connection with site reviews of Medicare+Choice organizations. Although recently revised, both the November 1999 and May 2001 versions of this guide provide the following guidance for determining whether a facility meets the definition of "institution": "Ensure that the institution is a Medicare/Medicaid certified skilled nursing facility (SNF), nursing facility (NF), intermediate care facility for the mentally retarded (ICF/MR), psychiatric hospital, rehabilitation hospital, long term care hospital, or swing-bed hospital." There is no reference in this CMS guidance to "beds". In fact, the September 2002 CMS site review of CHC reviewed three of the same beneficiaries that the OIG has concluded under this audit there were overpayments for because of the certified bed issue. Although CMS and OIG reviewed these members for some of the same payment months, CMS did not cite CHC with respect to these members. Moreover, the September 2002 CMS site review of CHC-Kansas did not cite CHC-Kansas for *any* discrepancies relating to the institutionalized status issue.

Among other things, CHC relies on the spreadsheets provided by CMS at: http://www.cms.hhs.gov/healthplans/statistics/inst/, formerly provided at: http://www.hcfa.gov/stats/inst.htm, to verify what is a "certified institution" for payment purposes. Notably, although these files do not distinguish between certified "beds" and certified "institutions", CMS claims in the current "readme.txt" document that such files contain "a full national listing of *all* certified institutions *which meet the criteria of OPL 54*." [Emphasis added.]

Additionally, CHC is in receipt of a series of e-mails from the CMS central office to Julie Billman of CHC stating in relevant part that the OIG should not focus on the concept of "certified bed" in connection with its institutionalized status audit, as there is no such concept as a "certified bed" applicable to Medicare+Choice. Although CHC believes that the OIG already has copies of these e-mails, CHC would be happy to provide additional copies to the OIG upon request.

Nowhere do the relevant statutes, regulations, or CMS guidance documents require a Medicare+Choice organization to verify that a "bed" is certified. In fact, to the extent there previously were such references in CMS guidance, they have since been deleted. Provided that a facility or part thereof is a "certified institution", and the length of stay requirements are met, payment at the enhanced rate for institutionalized beneficiaries is proper under OPL 54. The OIG's reliance on the fee-for-service guidance is misplaced, as it does not, in fact, "parallel" the guidance applicable to Medicare+Choice regulations. Because the term "certified bed" is not applicable in a Medicare+Choice context, the OIG's audit questionnaire asking whether a beneficiary is "in a Medicare or Medicaid certified bed" was confusing to facilities, and may have affected their responses.

D. CONCLUSIONS

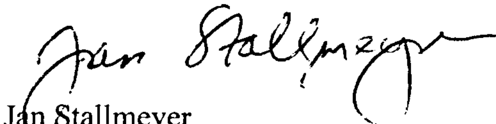
CHC strongly disagrees with OIG's application of a "certified bed" standard, as our position is that it is not the appropriate issue under the relevant guidance. The OIG's "certified

bed" requirement is in apparent contravention of the relevant CMS guidance on this issue. To the extent the OIG disagrees with CMS, that disagreement would be better addressed in another forum, and not in the context of this audit. Rather, the proper focus of this audit should be on whether the beneficiaries at issue were in "certified institutions" (which would include cases where the certified institution is a distinct part of a larger facility). For the reasons set forth above, CHC respectfully requests that the OIG reconsider its findings and recommendations on this issue, and adjust the estimated overpayments accordingly.

* * *

If you should have any questions regarding the above, please feel free to contact Linda Tenute at (866) 795-3995 extension 2145.

Sincerely,



Jan Stallmeyer
President and CEO

cc: Darin Wipperman, CMS