Memorandum

Date SEP 19 2001

From Thomas D. Roslewicz
Deputy Inspector General for Audit Services

Subject Audit of Medicare Payments to PacifiCare of California for Beneficiaries Classified as Institutionalized in January 1998 (A-09-01-00056)

To Neil Donovan, Director
Audit Liaison Staff
Centers for Medicare and Medicaid Services

This memorandum is to alert you of the issuance on September 21, 2001, of our final report titled, "Audit of Medicare Payments to PacifiCare of California for Beneficiaries Classified as Institutionalized in January 1998" (A-09-01-00056). A copy of the report is attached. We suggest that you share this report with the Centers for Medicare and Medicaid Services (CMS)[1] components involved in the Medicare managed care organization (MCO) operations, particularly the Center for Health Plans and Policy. Our objective was to determine if enhanced Medicare payments made to PacifiCare of California (PacifiCare) were appropriate for beneficiaries classified as institutionalized in January 1998. We estimate that PacifiCare was overpaid at least $2 million for beneficiaries incorrectly classified.

During a previous audit entitled, "Audit of Medicare Payments to Pacificare of California for Beneficiaries Classified as Institutionalized During the Period October 1, 1996 through December 31, 1999" (A-09-00-00104), we determined that PacifiCare had not implemented Operational Policy Letter (OPL) #54 issued by CMS in a timely manner. This policy letter changed the definition of an institution for all institutional payments made for those months beginning after December 1997. This change reduced the amount of payment that a health maintenance organization would receive for its enrolled beneficiaries who were no longer classified as institutionalized. We found that PacifiCare implemented this policy change in February rather than January 1998.

We selected two statistical samples of 100 monthly payments each from a universe of 9,595 monthly Medicare payments to PacifiCare. These payments were for beneficiaries classified by PacifiCare as institutionalized in January 1998. We determined that 111 of these payments were for beneficiaries inappropriately classified as institutionalized. Based on our audit results, we estimate that PacifiCare received Medicare overpayments of at least $2,083,163 for beneficiaries incorrectly classified as institutionalized in January 1998.

PacifiCare informed us in December 2000 that adjustments would be submitted for those beneficiaries identified in our two samples as inappropriately classified as institutionalized.

[1] Formally known as the Health Care Financing Administration.

These adjustments would return the enhanced institutional payment that had been inappropriately paid to PacifiCare. However, as of the date of this report, PacifiCare had not provided any documentation to support that these overpayments had been reported to CMS.

In addition to notifying PacifiCare in December 2000 of the overpayments, we also notified CMS of the overpayments at PacifiCare in our January 19, 2001 Early Alert entitled "Review of Payments to Medicare Managed Care Risk Plans for Beneficiaries Classified in Institutional Status" (A-09-01-00062). This dual notification (to both PacifiCare and CMS) falls within the notification period for retroactive corrections to payment contained in OPLs #12 and #13. We provided PacifiCare the specific member information for these overpayments and will provide CMS this list under separate cover.

We recommended that PacifiCare: (1) refund the specific overpayments of $66,658 identified in the sample; (2) coordinate with CMS to ensure that adjustments already submitted, totaling $8,756, are processed; and (3) review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments (total overpayments are estimated to be $2,083,163).

In the response to our draft report, PacifiCare stated that it was verbally informed by a Director at CMS that its interpretation of the policy change was reasonable. PacifiCare interpreted the policy change to be effective January 1, 1998. This interpretation made the change effective for the February 1998 payment rather than the January 1998 payment. Based upon the conversation with CMS, PacifiCare does not believe a review of the institutionalized beneficiary universe is warranted.

Our determination that PacifiCare had incorrectly implemented the change in policy was based upon our interpretation of OPL #54. A CMS official in the Medicare Managed Care Group, Division of Program Policy, confirmed our position. We continue to believe that PacifiCare should have implemented this change to be effective for the January 1998 payment. The policy letter specifically states that the change is effective for all institutional payment rate adjustments made for months after December 1997.

Any questions or comments on any aspect of this memorandum are welcome. Please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104, or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, (415) 437-8360.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REGION IX

AUDIT OF MEDICARE PAYMENTS TO PACIFICARE OF CALIFORNIA FOR BENEFICIARIES CLASSIFIED AS INSTITUTIONALIZED IN JANUARY 1998

September 2001
A-09-01-00056

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-01-00056

Debra Logan, Corporate Director
PacifiCare Health Systems, Inc.
3120 Lake Center Drive
Santa Ana, California 92799-5186

Dear Ms. Logan:

This report provides you with the results of our audit of Medicare payments to PacifiCare of California (PacifiCare) for beneficiaries classified as institutionalized in January 1998.

During our previous audit (CIN: A-09-00-00104), we determined that PacifiCare had not implemented a policy letter issued by the Centers for Medicare and Medicaid Services (CMS) in a timely manner. This policy letter changed the definition of an institution for all institutional payments made for those months beginning after December 1997. This change reduced the amount of payment that a health maintenance organization (HMO) would receive for its enrolled beneficiaries who were no longer classified as institutionalized. We found that PacifiCare interpreted this policy change to be effective January 1, 1998. This interpretation made the change effective for the February 1998 payment rather than the January 1998 payment.

We selected two statistical samples of 100 monthly payments each from a universe of 9,595 monthly Medicare payments to PacifiCare. These payments were for beneficiaries classified by PacifiCare as institutionalized in January 1998. We determined that 111 of these payments were for beneficiaries inappropriately classified as institutionalized. Based on our audit results, we estimate that PacifiCare received Medicare overpayments of at least $2,083,163 for beneficiaries incorrectly classified as institutionalized in January 1998. Details of our sample appraisals are shown in APPENDIX A.

The first sample was taken from beneficiaries that were reported as institutionalized in January 1998 but were not reported as institutionalized in February 1998. From this sample, we identified 89 payments for beneficiaries that were inappropriately classified as institutionalized. We also identified one payment that had been inappropriately adjusted, resulting in a Medicare underpayment.

The second sample was taken from beneficiaries that were classified as institutionalized in both January and February 1998. From this sample, we identified 22 payments for beneficiaries that were inappropriately classified as institutionalized. We also identified additional Medicare overpayments for seven of these beneficiaries for months subsequent to our audit period.

PacifiCare informed us in December 2000, that adjustments would be submitted for those beneficiaries identified in our two samples as inappropriately classified as institutionalized. These adjustments would return the enhanced institutional payment that had been inappropriately paid to PacifiCare. However, as of the date of this report, PacifiCare had not provided any documentation to support that these overpayments had been reported to CMS.

We recommended that PacifiCare submit the appropriate adjustments in order to refund the Medicare overpayments identified and coordinate with CMS to ensure that adjustments already submitted were processed. PacifiCare should also review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments, which we estimate to be at least $2,083,163. In the response to our draft report, PacifiCare stated that it was verbally informed by a Director at CMS that its interpretation of the policy change was reasonable. Based upon this conversation, PacifiCare did not believe a review of the institutionalized beneficiary universe was warranted. PacifiCare's response has been included in its entirety in APPENDIX B.

INTRODUCTION

BACKGROUND

PacifiCare is an HMO which is part of PacifiCare Health Systems, Inc.; a health care services company that provides managed care for employer groups and Medicare beneficiaries in nine states and Guam serving more than 3.5 million members (972,800 Medicare members). Approximately 2.2 million members are served in California with almost 600,000 of those being Medicare members.

An HMO is a legal entity that provides or arranges health services for its enrollees. Under the Medicare program, HMOs contract with CMS to provide health care services to beneficiaries. CMS makes monthly advance payments to HMOs at the per capita rate set for each beneficiary. Enhanced payments are made each month on behalf of certain high-cost categories of beneficiaries, such as those residing in a nursing home or other qualifying institution. The HMOs identify and report to CMS, on a monthly basis, beneficiaries who meet the definition of institutionalized status.

In order to be eligible for this enhanced institutional payment, the beneficiary must have been a resident of a qualifying facility for a minimum of 30 consecutive days. This period includes, as the 30th day, the last day of the month prior to the month for which the higher institutional rate is paid. For example, for January, the 30 days would be December 2 through December 31. This qualifying period of residency must be satisfied each month in order for the HMO to be paid the higher institutional rate.

In a 1993 Region IX letter, CMS specified skilled nursing facilities, swing-bed facilities, intermediate care facilities, sanatoriums, rest homes, convalescent homes, long-term care hospitals, or domiciliary homes as the types of institutions that qualify for enhanced payment. Operational Policy Letter #54 (OPL #54), issued by CMS on July 24, 1997, revised the definition of institutionalized status to be effective for the months beginning after December 1997.

Beginning in 1998, CMS limited institutionalized status to enrolled beneficiaries who were residents of specific types of Medicare or Medicaid certified institutions including skilled nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric, rehabilitation, long-term care, or swing-bed hospitals. Both the independent and assisted living portions of facilities do not qualify for institutional status under this revised definition. The requirement for 30 consecutive days remained the same, only the types of qualifying facilities were changed.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit was performed in accordance with generally accepted government auditing standards. The objective was to determine if enhanced Medicare payments received by PacifiCare were appropriate for beneficiaries reported as institutionalized in January 1998.

Our review of PacifiCare's internal controls was limited to evaluating controls and procedures related to classifying and reporting enrolled institutionalized beneficiaries to CMS during our audit period.

We selected two statistical samples of 100 monthly payments each from a universe of 9,595 monthly Medicare payments to PacifiCare. These payments were for beneficiaries classified by PacifiCare as institutionalized in January 1998. The first sample of 100 payments was taken from 4,521 beneficiaries that were reported as institutionalized in January 1998 but were not reported as institutionalized in February 1998. The second sample of 100 payments was taken from the 5,074 beneficiaries reported as institutionalized in both January and February 1998. We selected two separate samples to confirm that PacifiCare had not implemented OPL #54 for January 1998, but instead, waited until February 1998 to apply the new requirements.

PacifiCare provided us with the names and addresses of the institutions where each of the selected beneficiaries resided during the 30-day period prior to January 1998. In December 2000, PacifiCare also provided us the results of its review of the 200 sample items. The institutional status for each beneficiary was determined either by reviewing the facility□s records or verifying admission and/or discharge dates by telephone. We discussed any differences between our findings and PacifiCare's findings with PacifiCare personnel to determine if additional information was available.

In determining the overpayments, we calculated the difference between (1) the actual amount paid to PacifiCare by Medicare for the month selected, and (2) the amount Medicare should have paid PacifiCare based on the results of our audit.

Our audit was conducted from October 2000 through March 2001 with fieldwork performed at the 73 institutions we visited throughout California.

FINDINGS AND RECOMMENDATIONS

We found that 111 of the 200 sample items were for beneficiaries inappropriately classified as institutionalized. Based on the results of our audit, we estimate PacifiCare received Medicare overpayments of at least $2,083,163 for the month of January 1998.

We selected two statistical samples of 100 monthly payments each from a universe of 9,595 monthly Medicare payments to PacifiCare. These payments were for beneficiaries classified by PacifiCare as institutionalized in January 1998. The first sample of 100 payments was taken from the 4,521 beneficiaries that were reported as institutionalized in January 1998 but were not reported as institutionalized in February 1998. Based on information provided by PacifiCare in December 2000, we identified 89 payments for beneficiaries that were inappropriately classified as institutionalized. These payments included Medicare overpayments totaling $41,935. We also identified one payment that had been inappropriately adjusted, resulting in a Medicare underpayment of $296.

The second sample of 100 payments was taken from the 5,074 beneficiaries that were classified as institutionalized in both January and February 1998. Based on information provided by PacifiCare in December 2000, we identified 22 payments for beneficiaries that were inappropriately classified as institutionalized. These payments included Medicare overpayments totaling $9,982.

We also identified additional Medicare overpayments for seven of these beneficiaries totaling $23,793 for months subsequent to our audit period. PacifiCare provided documentation indicating it had submitted adjustments to CMS for three of the seven beneficiaries returning $8,756 of the $23,793 in overpayments prior to our audit. No adjustments have been submitted for the remaining $15,037.

Based on our audit results, PacifiCare received net Medicare overpayments that have not been reported to CMS of $66,658 as follows:

First Sample:	
Error amounts in sample	$41,935
Underpayment	<296>
Second Sample:	
Error amounts in sample	9,982
Additional overpayments	15,037
Net overpayment not reported to CMS	**$66,658**[1]

QUALIFYING FACILITIES

The CMS revised the definition of a qualifying facility with the issuance of OPL #54. To be considered institutionalized, an enrolled member must have been a resident of one of the following title XVIII (Medicare), or title XIX (Medicaid) certified institutions for at least 30 consecutive days immediately prior to the month for which a monthly Medicare payment is being made:

- a skilled nursing facility, or
- a nursing facility, or
- an intermediate care facility for the mentally retarded, or
- a psychiatric hospital or unit, or
- a rehabilitation hospital or unit, or
- a long-term care hospital, or
- a swing-bed hospital[2].

Of the 200 payments reviewed, we found that 111 were for beneficiaries residing in an institution not meeting the requirements for institutional status. These beneficiaries were found to have resided in either independent or assisted living facilities that do not qualify for the enhanced institutional payment. Medicare overpayments related to these 111 beneficiaries total $51,917.

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1. Only $51,621 ($66,658 – $15,037) was used to project the overpayment amount. Additional details of our sample appraisals are shown in APPENDIX A.
2. Section 1883 of the Social Security Act permits certain small rural hospitals and critical access hospitals to enter into a swing-bed agreement, under which the hospital can use its beds to provide either acute or skilled nursing facility care, as needed.

PAYMENTS PREVIOUSLY ADJUSTED

We also identified 11 payments that had been originally paid in error. PacifiCare determined that these payments had been made for beneficiaries not meeting the requirements for institutional status and submitted adjustments to CMS. These adjustments, returning the enhanced institutional payment, had already been processed by CMS prior to our audit. These 11 sample items were not considered errors and were not included in the projected overpayment amount.

PAYMENT INCORRECTLY ADJUSTED

We identified one payment that had been previously adjusted in error. The beneficiary had been admitted to the hospital from a skilled nursing facility in the middle of the month and was then released after 2 days to a different skilled nursing facility. During the hospital stay, a bed was being held and paid for on behalf of the beneficiary.

CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave if a bed is being held and paid for on behalf of the member. The institutional payment for this beneficiary had been adjusted prior to our audit returning the enhanced payment to Medicare. This was determined to be incorrect. A CMS Region IX official stated that this beneficiary qualified for institutional status and PacifiCare should have received the enhanced institutional payment for January 1998 resulting in a Medicare underpayment of $296.

RECOMMENDATIONS

We recommended that PacifiCare:

1. Refund the $66,658 Medicare overpayments identified.
2. Coordinate with CMS to ensure that adjustments already submitted, totaling $8,756, are processed.
3. Review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments, which we estimate to be at least $2,083,163.

PACIFICARE'S COMMENTS AND OIG RESPONSES

PacifiCare disagreed with our recommendations, stating that its interpretation of the policy change was justifiable. Specific responses to each recommendation and OIG responses are shown below. PacifiCare's response has been included in its entirety in APPENDIX B.

PACIFICARE'S COMMENTS – RECOMMENDATION #1

PacifiCare responded to our draft indicating that it had received clarification from CMS on the interpretation of OPL #54. PacifiCare stated, "A Director at [CMS] in Baltimore with responsibility over the payment function, verbally informed PacifiCare that the OPL #54 is "clearly ambiguous" and that PacifiCare's interpretation is reasonable." PacifiCare then stated

that the Director "indicated that the interpretation provided to the OIG has been "reversed" upon reconsideration."

OIG'S RESPONSE – RECOMMENDATION #1

Our determination that PacifiCare had incorrectly implemented the change in policy was based upon our interpretation of OPL #54. Our position was then confirmed by a CMS official in the Medicare Managed Care Group, Division of Program Policy. We continue to believe that PacifiCare should have implemented this change to be effective for the January 1998 payment. The policy letter specifically states that the change is effective for all institutional payment rate adjustments made for months after December 1997. Final determination on this matter will be made by the appropriate CMS action official.

As noted on page 4 of the report, $51,621 of the $66,658 in Medicare overpayments identified was for payments received for January 1998. We identified additional overpayments in the amount of $15,037 for months subsequent to our audit period. PacifiCare was provided with the specific member information for these payments and should make the necessary adjustments. PacifiCare's contention that it implemented the policy appropriately has no impact on these additional overpayments.

PACIFICARE'S COMMENTS – RECOMMENDATION #2

PacifiCare noted in its response that they have a system in place to report institutionalized overpayments. PacifiCare then stated, "Without the specific member information, we are unable to adequately respond to this finding."

OIG'S RESPONSE – RECOMMENDATION #2

In correspondence to PacifiCare dated March 29, 2001, we provided the details of our findings for each of our sample items. Also included in that correspondence was a listing of the additional overpayments by month for each of the sample items. This listing provided the specific member information related to the $8,756 in adjustments already submitted. This information can be provided again if necessary.

PACIFICARE'S COMMENTS – RECOMMENDATION #3

Based upon its response to the first recommendation, PacifiCare stated, "our interpretation of OPL #54 is justifiable" and that a review of the entire universe is not warranted.

OIG'S RESPONSE – RECOMMENDATION #3

As discussed above, we continue to recommend that PacifiCare review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments, which we estimate to be at least $2,083,163.

Final determinations as to actions taken on all matters reported will be made by the HHS office named below. We request that you respond to that office 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.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Director, Office of Managed Care
Centers for Medicare and Medicaid Services, HHS
7500 Security Boulevard, Room 33-02-01
Baltimore, Maryland 21244-1850

APPENDICES

APPENDIX A

AUDIT OF MEDICARE PAYMENTS
TO PACIFICARE OF CALIFORNIA FOR BENEFICIARIES
CLASSIFIED AS INSTITUTIONALIZED IN JANUARY 1998

STATISTICAL SAMPLE INFORMATION
Single Stage Variable Samples

	FIRST SAMPLE (Beneficiaries reported as institutionalized in January but not in February 1998)	SECOND SAMPLE (Beneficiaries reported as institutionalized in both January and February 1998)
POPULATION	4,521	5,074
SAMPLE SIZE	100	100
ERRORS	90	22

PROJECTION OF SAMPLE RESULTS
Precision at the 90 percent Confidence Level

	FIRST SAMPLE (Beneficiaries reported as institutionalized in January but not in February 1998)	SECOND SAMPLE (Beneficiaries reported as institutionalized in both January and February 1998)
UPPER LIMIT	$2,027,012	$667,883
POINT ESTIMATE	$1,882,543	$506,486
LOWER LIMIT*	$1,738,073	$345,090

*COMBINED LOWER LIMIT AT
THE 90% CONFIDENCE LEVEL: $2,083,163

PacifiCare®
Health Systems

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June 29, 2001

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Region IX Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-01-00056
"Draft Audit of Medicare Payments to PacifiCare of California for Beneficiaries Classified as Institutionalized in January 1998"

Dear Ms. Ahlstrand:

This is in response to the May 23, 2001 request from the Office of Inspector General for the Department of Health and Human Services (the OIG) to provide comments on the Draft Audit Report on Medicare Payments to PacifiCare of California for Beneficiaries Classified as Institutionalized in January 1998, (CIN: A-09-01-00056) (the Draft Report).

The Draft Report identifies three recommendations, which are stated below along with PacifiCare's responses:

1. *Refund the $ 66,658 Medicare overpayments identified.*

In previous correspondence with the OIG, PacifiCare requested clarification from HCFA on the interpretation of OPL #54 and had suggested that the OIG re-contact HCFA since the OIG based the "institutional overpayment findings for January 1998 on earlier discussions with HCFA officials. A Director at HCFA in Baltimore with responsibility over the payment function, verbally informed PacifiCare that the OPL#54 is "clearly ambiguous" and that PacifiCare's interpretation is reasonable. Moreover, she is willing to talk with the OIG and indicated that the interpretation provided to the OIG has been "reversed" upon reconsideration.

2. *Coordinate with HCFA to ensure that adjustments already submitted, totaling $8,756 are processed.*

PacifiCare has a process in place for reporting to HCFA any institutionalized overpayments. As noted in the findings of the Draft Report, some overpayments had already been reported. Without the specific member information, we are unable to adequately respond to this finding.

3. *Review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments, which we estimate to be at least $2,083,163.*

As noted in our response to recommendation #1 above, PacifiCare believes that our interpretation of OPL #54 is justifiable based on our conversation with HCFA personnel in Baltimore and does not warrant further review of the entire universe.

PacifiCare appreciates having the opportunity to review the Draft Report. If you have any questions regarding the above, please do not hesitate to contact me at (714) 825-5464 or at the address on this stationery.

Sincerely,

Debra Logan
Corporate Director
Membership Accounting Services

Cc: Mary McLean, HCFA Central Office
Robert Donnelly, HCFA Central Office
Susan Herman, HCFA Region IX
Judith D'Ambrosio, PacifiCare Health Systems
Nancy Monk, PacifiCare Health Systems
Katrina Pelto, PacifiCare Health Systems
Rebecca de la Torre, PacifiCare Health Systems
Lisa Jansen, PacifiCare Health Systems