

**Memorandum**

MAY 26 1995

Date
From
Subject
To

June Gibbs Brown
Inspector General *June G. Brown*

Review of Medicare Payments for Institutionalized Beneficiaries Made to Medica Health Maintenance Organization in Minneapolis, Minnesota (A-05-94-00053)

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on May 30, 1995 of our final report. A copy is attached.

This report results from one of a series of reviews we are conducting under our "Strategic Plan for the Oversight of Managed Care." We have been doing extensive audit work in the area of enhanced payments to managed care plans, and have had discussions with your staff specifically about the enhanced payments for institutional beneficiaries. The problems we are finding in our reviews of institutional payments have again surfaced in this review.

In this review we are particularly concerned that the managed care plan incorrectly claimed enhanced institutional payments for some beneficiaries for over 5 years. We are discussing our findings with our Office of Investigations and our Office of Civil Fraud and Administrative Adjudications, and our findings may result in a special managed care fraud alert. We also plan to continue to work with your staff to assess the effectiveness of the Health Care Financing Administration's (HCFA) monitoring visits in verifying the appropriateness of payments to managed care plans.

As you know, there has been considerable congressional interest in managed care plans that contract with HCFA to provide services to Medicare beneficiaries. There is also escalating departmental and governmentwide interest in managed care plans. The Department of Justice recently hosted a multi-departmental conference on fraud in managed care. We will continue to keep you informed of our work in the managed care area.

This report discloses that Medica, a health maintenance organization (HMO) in Minnesota, received improper payments under its Medicare risk-based contract on behalf of beneficiaries who were improperly classified as institutionalized during the period January 1, 1989 through September 30, 1994. We identified improper

payments totaling \$93,252 for 15 out of 100 beneficiaries sampled. Projecting our statistical sample, we estimate Medica received improper payments during the period amounted to at least \$861,615.

The Medica HMO risk-based contract provides prospective per capita payments on behalf of Medicare eligible beneficiaries. The per capita payments are adjusted by a set of risk factors such as age, gender and whether the beneficiary is institutionalized. Institutionalized rates, which are higher than the basic capitation rates, are claimed each month for each beneficiary who has been a resident for 30 days or longer of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital or domiciliary home.

Medica maintains a file of its members who are institutionalized, and depends on its primary care providers (PCP) to notify it when the institutionalization ends. We found that 15 of the 100 beneficiaries shown on its files as institutionalized during the month of April 1994 were not, in fact, institutionalized.

A number of reasons appeared to have resulted in the erroneous institutionalized status entries, such as failure of PCPs to provide notification of noninstitutional status; failure of Medica staff to enter PCP notifications into their system; and a data processing system conversion. In addition, lists of the beneficiaries recorded as institutionalized which were sent to the PCPs for review and verification each month were not adequately reviewed by the PCPs. As a result, some beneficiaries were incorrectly classified and claimed as institutionalized for over 5 years.

We recommended that Medica refund the \$93,252 of improper payments identified during our audit and take appropriate action to quantify and refund additional overpayments which we estimate to total at least \$861,615 related to beneficiaries which we did not review. We also recommended that Medica establish more prescriptive policies and procedures for monitoring and reporting their beneficiaries' institutional status.

We provided a draft of this report to Medica for review and comment. Medica generally agreed with the findings and recommendations in our report, proposing to work with HCFA to arrive at an equitable settlement amount.

For further information, contact:

Paul Swanson
Regional Inspector General
for Audit Services, Region V
(312) 353-2621

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
FOR
INSTITUTIONALIZED BENEFICIARIES**

**MEDICA
HEALTH MAINTENANCE ORGANIZATION**

MINNEAPOLIS, MINNESOTA



**JUNE GIBBS BROWN
Inspector General**

**MAY 1995
A-05-94-00053**



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

OFFICE OF
INSPECTOR GENERAL

CIN: A-05-94-00053

Mr. David R. Strand, President
Medica
P. O. Box 1587
Minneapolis, Minnesota 55440-1587

Dear Mr. Strand:

This report provides you with the results of our review of Medicare payments to Medica on behalf of beneficiaries classified as institutionalized under your Medicare risk-based contract. The objective of our audit was to determine the appropriateness of Medicare payments to Medica for beneficiaries classified as institutionalized.

Based on a random sample of 100 beneficiaries classified by Medica as institutionalized during April 1994, we determined that institutionalized payments to Medica for 15 beneficiaries who were not institutionalized during the period January 1, 1989 through September 30, 1994, amounted to \$93,252. On the basis of the sample, we project that at least \$861,615 of overpayments were made to Medica on behalf of beneficiaries incorrectly classified as institutionalized during the aforementioned period.

INTRODUCTION

BACKGROUND

The Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) is a legal entity that provides or arranges for health services for enrolled members. In accordance with Medicare regulations, an HMO can contract with the Health Care Financing Administration (HCFA) to provide medical services to Medicare beneficiaries on a prepayment basis. With the exception of individuals with end stage renal disease (ESRD) and those receiving hospice benefits, all Medicare beneficiaries entitled to benefits under both Medicare Parts A and B or only Medicare Part B, may enroll in HMOs that have HCFA contracts. Beneficiaries must choose a physician or group of physicians, otherwise known as a primary care provider (PCP), affiliated with the HMO.

Medica is a nonprofit health maintenance corporation licensed to provide prepaid comprehensive health maintenance services in the State of Minnesota under the provisions of the Minnesota Health Maintenance Act of 1973. Medica was formed in 1991 through the merger of two existing HMOs, Share and Physicians Health Plan (PHP) of Minnesota. A third entity, PHP Limited, changed its name to Medica and became the parent of the two merged HMOs. Share and PHP, renamed Medica Primary and Medica Choice, continued to operate under two separate licenses until March, 1993, when they were relicensed as one HMO named Medica. Subsequently, on August 1, 1994, Medica joined another health services provider, HealthSpan, to operate as separate divisions under a new parent organization, Allina.

As part of the merger agreement, Medica assumed responsibility for Share's existing HMO contract with HCFA, which became effective in 1979. Under the risk-based contract, HCFA makes prospective monthly payments to Medica on behalf of each Medicare enrollee. The monthly payment rates are based on the demographic status of the individual enrollees. Thus, during the course of an individual's HMO enrollment, HCFA's monthly payments to the HMO will vary with the individual's age, geographic location and entitlement status. The amount of the prospective monthly payments for each enrollee are determined by HCFA in accordance with 42 CFR 417.584.

Regulations

According to Federal regulations found at 42 CFR 417.584(a), regarding payments to organizations with risk contracts:

HCFA makes monthly advance payments equivalent to the organization's per capita rate of payment for each beneficiary who is registered in HCFA records as a Medicare enrollee of the organization.

The monthly advance payments are adjusted after the end of each month for beneficiaries who were in special rate classifications, such as those who were institutionalized, during the prior month.

The HCFA HMO Manual, section 6008.1, requires HMOs to:

...identify all beneficiaries each month who meet the institutional definition and submit the coding work sheet...

This submission to HCFA is done through electronic media.

The HMO Manual also requires the HMO to review monthly status reports generated by HCFA and to inform HCFA of any changes in the beneficiaries' status.

Section 6008.A.1 of the HMO Manual defines "institutionalized" as:

...A Medicare beneficiary who has been a resident for 30 days or longer of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital or domiciliary home.

Further HCFA clarification specifies that the 30-day period of institutionalization must have been a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

Payments for Institutionalized Beneficiaries

To receive payment for an institutionalized Medicare beneficiary, the following events need to occur.

- An HMO must notify HCFA that an individual has enrolled in the HMO.
- The HCFA places the individual into the HMO payment data base.
- Prospective basic monthly payments for all beneficiaries enrolled in the HMO are calculated and paid by HCFA according to individual demographic and status factors, such as age, sex and entitlement status.
- The HMO provides HCFA with a monthly notice of all beneficiaries who were in an institutionalized status, entitling the HMO to receive a higher monthly payment. The PCPs are responsible for notifying the HMO when a beneficiary begins and ends institutionalization.
- HCFA provides the HMO with monthly reports of all beneficiaries for whom its records indicate the HMO is entitled to receive the institutional payment rate.
- The HMO reviews the monthly reports and informs HCFA of any further changes in beneficiary status.
- On the basis of the status shown on the monthly reports, HCFA adjusts the payments for the institutionalized beneficiaries to reflect the correct payment rates.

The monthly payment that an HMO receives during the period that a Medicare enrollee is institutionalized is generally higher than the monthly payment it receives for the enrollee's basic Medicare

coverage. For example, in Minnesota, an HMO will receive a monthly Medicare payment of \$615.92 for an institutionalized female enrollee, between the ages of 70 and 74, residing in Hennepin County. The corresponding basic Medicare coverage premium for the same individual is only \$264.34. Once a beneficiary is released from institutional care, the respective monthly payment to the HMO should return to the basic premium amount.

Based on HCFA's *Transaction Replies/Monthly Activity Report ID 10* (HCFA Report ID 10; May run), we determined that Medica reported 1,941 Medicare enrollees as institutionalized during the month of April 1994.

SCOPE OF AUDIT

Our audit was made in accordance with generally accepted government auditing standards. The objective of our audit was to determine the appropriateness of the Medicare payments made to Medica for Medicare beneficiaries classified as institutionalized. We selected the month of April 1994 to determine whether the beneficiaries reported by Medica as institutionalized, were actually in an institutional setting.

We performed a limited evaluation of Medica's internal controls for classifying and reporting institutionalized Medicare beneficiaries to HCFA. We also reviewed computerized reports, beneficiary files and medical records maintained by selected provider institutions and PCP offices, as well as reports and records maintained by HCFA and the HMO. We did not conduct a review of Medica's internal control systems as a whole, nor did we place reliance on those controls. Our review was limited to compliance testing of payments made for the beneficiaries reported to be institutionalized as of April 1994.

Of the 1,941 beneficiaries reported as institutionalized in the May 1994 run of the HCFA Report ID 10, we selected a random sample of 100 for detailed testing. With the assistance of Medica staff, we sent confirmation letters to the facilities where the 100 institutionalized beneficiaries were housed during April 1994, according to Medica's records. Based on the responses to those confirmation letters, we computed overpayments applicable to the 15 beneficiaries improperly classified as institutionalized for periods prior to and subsequent to the month of April 1994 and projected the probable value of overpayments to the universe of beneficiaries classified as institutionalized. Details of our statistical sample and projections are shown in the attached Appendix A.

At the time we selected our sample, we understood that the beneficiaries listed in the May run of HCFA Report ID 10 represented persons reported by Medica as institutionalized during the month of April 1994. We later became aware that the May run actually reflected the beneficiaries reported as institutionalized during March 1994. However, our subsequent review verified that all of the 15 beneficiaries found to be improperly classified as institutionalized during April 1994 were also improperly classified as institutionalized during March 1994.

Our field work was performed during May through October, 1994, at the offices of Medica and United HealthCare (UHC) in Minnetonka, Minnesota; HCFA in Chicago, Illinois and Baltimore, Maryland; and 16 nursing facilities and 2 clinics (PCPs) which provided services for sampled beneficiaries.

FINDINGS AND RECOMMENDATIONS

IMPROPER PAYMENTS FOR INSTITUTIONALIZED BENEFICIARIES

Medica received overpayments totalling \$93,252 for 15 Medicare beneficiaries who were incorrectly classified as institutionalized. Although Medica received the institutional premiums for the 15 beneficiaries, none were institutionalized during the month of April 1994. Documentation pertaining to periods before and after April 1994 disclosed that while these beneficiaries were not institutionalized, Medica improperly received institutional premiums for periods ranging from 5 months to over 5 years.

We attribute the misclassifications and resulting overpayments to inadequate procedures at Medica for monitoring the status of its institutionalized beneficiaries. Although Medica functioned as the HMO under the HCFA contract, many of its activities, such as claims processing, billing and beneficiary enrollment, were subcontracted to UHC. The duties of UHC included maintaining proper beneficiary registration and status information with HCFA. We believe that the high percentage of misclassifications (15 percent) relate to Medica's inadequate monitoring of the subcontractor's beneficiary registration and status reporting activities. This allowed misclassified beneficiaries to go undetected.

Projecting our sample results, we estimate, with 95 percent confidence, that Medica received overpayments from Medicare of at least \$861,615 for beneficiaries misclassified as institutionalized during the audit period.

The Problem: Beneficiaries Inappropriately Classified as Institutionalized Resulting in Overpayments

Medica provided monthly listings of institutionalized beneficiaries to HCFA which included beneficiaries who were not institutionalized. Consequently, Medica was overpaid when it received the higher institutional rate rather than the basic Medicare rate for these beneficiaries.

Our tests of Medica's 1,941 Medicare enrollees classified as institutionalized during April 1994 disclosed that 15 of 100 beneficiaries were not in an institution during that month. We used statistical sampling techniques to randomly select 100 beneficiaries for review. From Medica's records, providers for the 100 institutionalized beneficiaries were identified and mailed confirmation letters to confirm the beneficiaries' institutionalized status. We conducted site visits of selected facilities, including those that did not return the confirmation letters. We determined that 15 of the 100 tested beneficiaries did not reside in institutions during April 1994 as reported by Medica. Further, of the 15 beneficiaries, we found 3 who were never institutionalized during the course of their Medica enrollment.

We subsequently reviewed HCFA's regional and central office records, as well as various HMO, beneficiary and facility records for periods before and after April 1994. We found that HCFA incorrectly paid institutionalized rates to Medica for the 15 beneficiaries for periods ranging from 5 months to over 5 years. Based on payment data furnished by HCFA for the 15 beneficiaries, we calculated that HCFA overpaid Medica a total of \$93,252. Using statistical projection techniques, we estimate with 95 percent confidence that total overpayments to Medica for enrollees misclassified as institutionalized amounted to at least \$861,615. Additional details pertaining to our statistical projections are shown in Appendix A to this report.

The Cause: Medica's Monitoring of Beneficiary Status

Medica's monitoring procedures were not adequate to ensure that enrollees in institutional status were properly classified. Medica relied on PCPs for updates on the beneficiaries' institutionalized status but did not have controls in place to ensure that the PCPs' efforts were effective and efficient. Furthermore, because Medica did not consistently administer beneficiary status notifications received from the PCPs, appropriate changes in beneficiary status were not made on Medica's records.

Medica policies and procedures required that the PCPs notify Medica when their patients entered institutionalized status and again when they left the institutional setting or otherwise changed their status. In addition, Medica sent listings of beneficiaries and their recorded status to the PCPs on a monthly basis. The PCPs were supposed to review the listings and notify Medica if any of their patients were wrongly classified.

Our review disclosed that the PCPs did not always detect discrepancies between their documentation and the Medica listings. We interviewed staff members at 2 of the PCPs whose patients were among the 15 inappropriately classified as institutionalized. We noted that the PCPs generally maintained documentation indicating when the patients were no longer institutionalized but we could not verify if the documentation was sent to Medica. We found that the PCPs either did not review or only gave a cursory review to the beneficiary status listings received from Medica. Consequently, misclassifications that should have been readily identified through a comparative analysis remained undetected for extended periods.

Medica officials stated they were unaware that the PCPs did not always review the monthly listings to identify inappropriately classified beneficiaries. The three misclassified beneficiaries in our sample who were never institutionalized demonstrate the effect of Medica's lack of controls over the PCP review process. Medica personnel attributed these erroneous institutionalized classifications to data entry errors and a major data processing system conversion in 1991. However, since the respective PCPs had no documentation indicating that the three beneficiaries entered an institution, they should have quickly detected the misclassifications if they had followed the prescribed monitoring procedures.

Medica officials acknowledged that they apparently received notifications terminating beneficiaries from institutional status but were unable to show that they took appropriate action to correct their files. Thus, the respective beneficiaries continued to be identified as institutionalized on the beneficiary status listings sent to the PCPs. Since the PCPs did not adequately review these listings, they did not detect the Medica failure to act on prior notifications.

Medica has taken action to terminate the institutional status of the individuals we identified as inappropriately classified for April 1994. Medica officials also informed us that they are in the process of revising the policies and procedures for monitoring the status of special rate beneficiaries.

RECOMMENDATIONS

We recommend that Medica:

- establish more prescriptive policies and procedures for monitoring the status of all beneficiaries classified as institutionalized and promptly notifying HCFA when their institutionalized status ceases;
- refund the identified overpayment of \$93,252;
- review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments, which we estimate to total at least \$861,615.

AUDITEE COMMENTS AND OIG RESPONSES

Medica responded to our draft report in a letter dated March 10, 1995. The response is attached to this report as Appendix B. In addition to addressing our three recommendations, Medica's response included general comments which we have summarized with our response as presented below.

HCFA'S INSTITUTIONAL REPORTING REQUIREMENTS

Auditee Comments

Medica's response contained a detailed description of the process it has used to identify and report the monthly status of its institutionalized members to HCFA and attempted to show that certain inherent characteristics of HCFA's reporting system can result in inaccuracies in reported institutionalizations. Medica specifically cited:

- The 30-day waiting period, before a clinic may report an institutional admission, creates an issue as to whether the clinic reports accurately, or the health plan is able to measure, the time the member has been institutionalized before submitting information to HCFA.
- Lagged reports from HCFA, reflecting institutional membership 2 months earlier, can result in confusion for clinics and the health plan and makes follow-up with clinics extremely difficult.

OIG Response

Based on our review, we acknowledge that the methodology required by HCFA for monitoring and reporting beneficiary institutionalized status is complex. However, the difficulties and complexities do not alter Medica's responsibility for diligently monitoring and accurately reporting beneficiary status under the HCFA contract.

Medica and/or its predecessor entities have operated under the risk based contract since 1979. We believe that Medica's experience should have been sufficient to enable it to develop quality assurance procedures and refine its systems for monitoring and reporting beneficiary status. These procedures should consider the waiting period for reporting institutionalizations. As far as the lag time in HCFA's reports of institutional status, these are merely informational reports to be used to verify the accuracy of Medica's determinations. They allow Medica a second chance to clarify an omission or adjust for an inclusion error.

MEDICA'S POLICIES AND PROCEDURES

Auditee Comments

Medica indicated that, because it capitates its primary care clinics at approximately 85 percent to 90 percent of HCFA's monthly capitation to the plan, Medica does not financially benefit as a result of inaccurate institutionalized reports.

OIG Response

We disagree with Medica's statement that it does not financially benefit as a result of inaccurate institutionalized reporting. Based on Medica's capitation rates to primary care clinics, they retain 10 percent to 15 percent of the monthly capitation from HCFA. Since the capitation rate for institutionalized beneficiaries is generally significantly higher than the basic beneficiary rate, we believe Medica does receive a financial benefit from improperly reported institutionalizations.

CONCLUSION

Auditee Comments

The Medica letter reiterated our three report recommendations and responded as follows:

1. Medica enclosed their modified policy and procedures for monitoring the status of beneficiaries classified as institutionalized, effective February 1, 1995 and requested that HCFA determine whether the revised policy and procedure is sufficient to accomplish HCFA's reporting needs.
2. Medica agreed to repay \$93,252 related to the 15 beneficiaries who were improperly reimbursed as institutionalized.
3. Medica stated they are unclear how the OIG projected an overpayment amount of \$861,615 across Medica's entire institutionalized membership. Medica stated that they are willing to negotiate an overpayment amount with HCFA, but they request that HCFA work with Medica to project an overpayment amount that all parties feel accurately reflects overpayments.

OIG Response

Medica's responses to the first two recommendations appear reasonable and reflect concurrence with our findings.

Regarding our projected overpayment amount of \$861,615, our sample selection and projection were developed with the assistance of computerized statistical software which is capable of generating random numbers and uses standard statistical formulas for computing variable sample projections. The software is titled RAT-STATS, May 1993 revision, and is available commercially. We will provide additional assistance in understanding and interpreting our statistical projections if requested.

We disagree that an additional projection of an overpayment amount is necessary. Our statistical sample projections, shown in Appendix A, should be the basis for the overpayment estimate. As shown in Appendix A, we are 90 percent confident that improper institutionalized payments totalled between \$861,615 and \$2,758,428, with a point estimate of \$1,810,021. The lower limit of our statistical projection was the \$861,615 identified as the estimated overpayment in our report. We believe this information is sufficient for Medica to negotiate an estimated overpayment amount with HCFA.

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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 CFR Part 5.)

If you have any questions regarding this report, please contact Stephen Slamar at (312) 353-7905. Please refer to the Common Identification Number (CIN) in any correspondence regarding this report.

Sincerely yours,



Paul Swanson
Regional Inspector General
for Audit Services

Attachments:

- Appendix A - Variable Appraisal
of Statistical Sample
- Appendix B - Medica's Response

APPENDIX A

**MEDICA
HEALTH MAINTENANCE ORGANIZATION**

MINNEAPOLIS, MINNESOTA

**VARIABLE APPRAISAL OF
STATISTICAL SAMPLE**

Universe:	1941
Sample Size:	100
Nonzero Items:	15
Value of Nonzero Items:	\$93,252

Mean:	932.52
Standard Deviation:	3,021.66
Standard Error:	294.28
Skewness:	3.99
Kurtosis	19.78
Point Estimate:	\$1,810,021

Projections:

	At 90 Percent Confidence	At 95 Percent Confidence
Lower Limit	\$861,615	\$676,648
Upper Limit	\$2,758,428	\$2,943,395
Precision Amount	\$948,406	\$1,133,373
Precision Percent	52.40%	62.62%

5001 Amerin Circle
P.O. Box 4310
Minneapolis, MN 55440-4310
612-992-1900

APPENDIX B
Page 1 of 17

March 10, 1995



Mr. Paul Swanson
Acting Regional Inspector General
for Audit Services
Department of Health and Human Services
Region V
105 West Adams Street
Chicago, Illinois 60603-6201

Re: **CIN: A-05-94-00053** (Risk Contract H9006): Medica's Reporting of Institutionalized Members

Dear Mr. Swanson:

I am writing on behalf of Medica in response to a report issued by the Office of Inspector General (OIG) regarding Medica's reporting of institutional status of membership under its risk contract H9006. We received this report on March 1, 1995. After reviewing the report, I felt it was important to respond to various issues outlined therein. Notwithstanding our attempts, Medica has not always been able to ensure accurate institutional reporting. Although we recognize the need to improve our policies and procedures regarding reporting of institutionalized members, we feel that the complexity of HCFA's institutionalized reporting process, Medica's previous good-faith attempts at compliance, and its corrective action plan, which has already been implemented, should be taken into account when resolving this issue.

BACKGROUND

OIG Note -- Comments have been deleted at this point because they pertain to material that has been incorporated in the report.

OIG Note -- Comments have been deleted at this point because they pertain to material that has been incorporated in the report.

HCFA'S INSTITUTIONAL REPORTING REQUIREMENTS

Institutionalized reporting is a complex process further complicated by lags in verification reports received from HCFA. When a member is admitted to an institution, the admission must be reported by the admitting clinic to the health plan, which then reports such information to HCFA through electronic monthly accretion records. A member cannot be reported as institutionalized, however, until the reporting month after the member has been in an institution for at least 30 days. An institution could include a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, domiciliary home, assisted living if a minimal level of medically necessary care is provided, and for disabled beneficiaries, a halfway home and state schools. See HCFA HMO Manual §6008.

Once a member is institutionalized and a report is made by the plan, HCFA electronically sends a reply listing to the reporting health plan that includes a list of all member accretions, deletions, changes, and special status, including members that have been reported as institutionalized. The report, however, only reflects members who were reported as institutionalized two months earlier. Thus, there is a significant reporting lag between actual reporting of new institutionalized members and HCFA's verification. HCFA's payments for institutionalization are also lagged.

Due to HCFA's policy and reporting procedures for institutionalized members, verification and ongoing accuracy of institutional status is difficult to achieve. Misreporting can occur without knowledge or intent at several points in the reporting process. Two of the most difficult reporting aspects to monitor are described below.

- **The 30-day waiting period can result in inaccuracies.** Clinics may report the institutional admission upon admission, which is the easiest time to report the institutionalization. However, this can lead to premature reporting to HCFA and the report may be inaccurate if the member is discharged before 30 days has passed. The 30-day waiting period creates an issue as to whether the clinic reports accurately or the health plan is able to measure the time the member has been institutionalized before submitting information to HCFA.

- **Lagged reports can lead to inaccuracies.** Lagged reports from HCFA reflecting institutional membership two months earlier, can result in confusion for clinics and the health plan. It is difficult to use the reports for current membership or to identify whether HCFA has recognized a recent institutional report. This makes follow-up with clinics extremely difficult.

OIG Note -- Comments have been deleted at this point because they pertain to material that has been incorporated in the report.

MEDICA'S POLICIES AND PROCEDURES

Medica currently has approximately 2,000 institutionalized members in nearly 150 nursing homes. Due to the large number and broad dispersion of institutionalized members, Medica must rely on its primary care clinics to report institutionalized status and changes in status. We are continually refining this process to achieve greater accuracy. Please note that Medica capitates its primary care clinics at approximately 85% to 90% of HCFA's monthly capitation to the plan. Therefore, the health plan does not financially benefit as a result of inaccurate institutionalized reports.

Medica contractually obligates clinics to report institutionalizations and any subsequent changes, because clinics have access to information regarding changes in institutional status to which Medica does not, such as medical records, patient charts, and treating physicians. To assist clinics in fulfilling this reporting obligation, Medica currently distributes a United HealthCare generated report, COSMOS PB4120, which sets forth information regarding what Medica has reported to HCFA regarding the institutional status of members. When Medica first began this type of reporting system, it notified primary clinics and instructed them to use the reports to verify member status, including institutional status. The clinics had previously been using other Medica reports to fulfill reporting obligations. The PB4120 report provides clinics with a check against their own records and the ability to notify Medica

of any reporting discrepancies. In addition, the PB4120 report is discussed and distributed during training sessions and Medica communicates that use of the report is necessary for clinics to ensure that their institutional reporting is accurate.

Medica has implemented policies and procedures under which the plan generates clinic-specific HCFA reply reports for each primary care clinic, trains clinics on the need to notify the plan of institutional admits, discharges and transfers, and develops written policies and procedures for clinic reference. Copies of previous policies and procedures are enclosed as Attachment A. Despite Medica's previous efforts, the OIG audit clarified that additional oversight and accuracy checks needs to be incorporated into the plan's policies and procedures to increase institutional reporting accuracy.

CORRECTIVE ACTION

In November 1994, Medica convened a task force of health plan and clinic representatives to identify problem reporting areas and modify existing policies and procedures. Policy modifications were developed and implemented. Under the revised policy clinics are required to affirmatively verify each institutionalized member each month, based on HCFA's previously reply listing. Medica has developed a new report to convey this information that is easier for clinics to use than the HCFA reply listing. If a signed verification and new institutionalized listing is not received from a clinic each month, any members assigned to the clinic who were previously reported as institutionalized will be removed from the health plan's next report to HCFA. Medica will also conduct quarterly sample audits to help identify any reporting problems. This policy was implemented beginning February 1, 1995 and is enclosed as Attachment B.

CONCLUSION

In its draft report, the OIG proposed three recommendations as a result of its audit.

1. Establish more prescriptive policies and procedures for monitoring the status of all beneficiaries classified as institutionalized and promptly notify HCFA when their institutionalized status ceases;
2. Refund the identified overpayment of \$93,252;

3. Review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments which are estimated to total at least \$861,615.

In response to the above recommendations, Medica proposes the following:

1. HCFA reviews the enclosed modified policy and procedures for monitoring the status of beneficiaries classified as institutionalized and determine whether this revised policy and procedure is sufficient to accomplish HCFA's reporting needs. Although the policy has been in effect since February 1, 1995, Medica will be happy to work with HCFA to identify any other necessary modifications to ensure institutional reporting accuracy.
2. HCFA notifies Medica regarding to whom the health plan should direct a check in the amount of \$93,252. Upon notice by HCFA, Medica will make payment of the recommended amount.
3. It is unclear based on the information provided to date how the OIG projected an overpayment amount of \$861,615 across Medica's entire institutionalized membership. While Medica is willing to negotiate a projected overpayment amount with HCFA, we request a more specific explanation of the OIG's projection methods. Additionally, due to the difficulty and the extensive resources and time needed to survey Medica's entire institutionalized population (i.e., it took the OIG approximately seven months to complete its audit of only 100 of Medica's 1,942 institutionalized members), we request that HCFA work with Medica to project an overpayment amount that all parties feel accurately reflects overpayments.

We hope the above information is helpful and evidences the complexity of institutionalized reporting. Medica recognizes the need to assure accurate reporting and has taken steps to implement new policies and procedures to achieve this goal. We are happy to work with HCFA to identify any other necessary modification and to determine a final overpayment calculation.

March 10, 1995
Page 6

APPENDIX B
Page 6 of 17

If you need any additional information or have questions regarding the above, please contact Olivia Mastry, Director, Center for Healthy Aging at (612)992-3424.

Sincerely,

A handwritten signature in black ink, appearing to read "David R. Strand". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David R. Strand
President

DRS:pao

Attachments

PROPRIETARY

United HealthCare Corporation

Section: Medicare
Subject: Institutionalized Reporting, SeniorCare Product
Effective Date: 04/08/92
Revision Date:

Policy & Procedure

Document Number: 7.82
Page 1 of 2

Approved By: _____

I. SCOPE

The procedure below defines the methods used to submit institutionalized membership information to the Health Care Financing Administration (HCFA), and applies to all Coordinators responsible for Medicare RISK product enrollment.

II. POLICY

It is the policy of United HealthCare to maintain proper registration of all special status members with the Health Care Financing Administration (HCFA).

III. PROCEDURE

Overview:

The Health Plan is responsible for notifying UHC Enrollment whenever a SeniorCare member qualifies as institutionalized status per HCFA guidelines, and when the member no longer qualifies for this special status.

Processes:

1. Notification is received by Enrollment to change a member's status to INSTITUTIONALIZED.
2. The member record is retrieved on the EP220 screen of the COSMOS membership system, and the following changes are made:

End Current Timeline:

- a. Enter "C" in the action field
- b. End date entered = day prior to the status change date
- c. Reason code = 318 (Rollover)
- d. Sight verify for accuracy; transmit.

Establish New Timeline:

PROPRIETARY

United HealthCare Corporation

Policy & Procedure

Section: Medicare

Document Number: 7.82

Subject: Institutionalized Reporting, SeniorCare Product

Page 2 of 2

Effective Date: 04/08/92

Revision Date:

Approved By: _____

-
- a. Enter "A" in the action field
 - b. Effective date = effective date of status change
 - c. "Clear out" end date field (keep blank)
 - d. Reason code = 318 (Rollover)
 - e. Status code = "I"
 - f. Sight verify for accuracy; transmit
3. A message is entered on the EP329 (MEMBER NOTES) screen, indicating the institution name and address.
 4. When the Institutionalized status is no longer valid, enrollment receives notification to update the member record. The same procedures are used, except that the status code for the latest timeline is "X".

Policy/Procedure Title: Special Member Status Notification, Procedures for Medicare Risk Program

Originated by: Pat Bibbey

Effective Date: 5/1/92

Replaces former Policy/Procedure titled and dated: _____

Policy/Procedure Applies to:

Departments: Medical Services/Billing and Enrollment

Products: Senior Care

Policy reviewed and determined to be current (date and signature): DLS 2/93

PRODUCT	PRIMARY	PRIMARY INDIVIDUAL	SENIOR CARE	SHARE SENIOR MATE	CHOICE CLASSIC	CHOICE SELECT
ELIGIBILITY			X			

PRODUCT	CHOICE PREMIER	CHOICE INDIVIDUAL	CHOICE CARE	CHOICE SELF-INSURED	PHP + MEDICARE
ELIGIBILITY					

OBJECTIVE: To identify the steps in the Primary Care Clinic's process of notifying the Health Plan of special memb status for the Medicare Risk Program (Senior Care).

APPLICATION: The Health Plan receives adjusted funds from HCFA for members reported in the following categorie Institutionalized, Chronic Renal Disease (ESRD) and Medicare Hospice Program. Funds from HCFA are decreased f members participating with the Medicare Hospice Program. Funds are increased for members in the other tv categories. With the gatekeeper model, the Primary Care physician is usually the first provider to become aware any member status change.

I. Institutionalized Status

A. A member is regarded as institutionalized if he/she is a Medicare beneficiary who has been a reside for 30 days or longer in a:

1. Nursing Home (includes non-covered skilled care)
2. Sanitarium
3. Rest Home
4. Convalescent home
5. Long-term care hospital, including free
6. Standing psychiatric hospital (as long as the member is not receiving active treatment)
7. Domiciliary home

5. If the member elects their hospice benefit during an inpatient hospital stay, the Primary Care Management Coordinator will forward both forms to the Senior Case Management Associate at 7828 to log in to the PAC F07 screen. The Senior CMA will submit both forms to the Supervisor of Medicare Billing and Enrollment at route #7533.

III. End Stage Renal Disease (ESRD)

- A. HCFA will pay a higher reimbursement for members on dialysis with a diagnosis of ESRD.
- B. Notification Steps
 1. The Primary Care Clinic should complete the attached form for reporting ESRD members who have started dialysis (see attachment D).
 2. The Primary Care Clinic should report those members who have stopped dialysis on the Cessation of Dialysis Form (see attachment E).
 3. Members on HCPP and cost programs also need to be reported as there is a year end settlement for these members.
 4. Medica must also send a copy of the HCFA 2728 (see attachment F) which can be obtained from the dialysis units. Billing and Enrollment must have both reports before they are able to process eligibility with HCFA.
 5. All forms should be mailed to the supervisor of Medicare Billing and Enrollment Department Route #7533 by the 25th of the month.

Neil Smith
Manager, Outpatient Medical Services

5/13/93
Date

ELECTION OF HOSPICE BENEFITS

NAME _____

MEDICA MEMBER # _____

HCFA # _____

MEDICARE CERTIFIED
HOSPICE FACILITY _____

ADMIT DATE _____

DATE INFO TAKEN _____

NAME OF MEDICAL
OFFICE _____

REPORTING CHRONIC RENAL DISEASE
BEGINNING DIALYSIS TREATMENT

TO: Medica Primary Billing and Enrollment
Route #7531

RE: NAME: _____

MEDICA PRIMARY ID #: _____

HCFA ID #: _____

BIRTH DATE: _____

The above patient was hospitalized for chronic renal failure on _____. The patient began acute dialysis on _____. Below is the schedule for this patients dialysis.

Where is the patient receiving dialysis?

Should you need further information with regard to the patient and his/her dialysis treatment, please do not hesitate to contact me.

(Authorizing Signature)

(Date)

**POLICY/PROCEDURE: SPECIAL MEMBER INSTITUTIONAL STATUS
NOTIFICATION FOR MEDICARE RISK PROGRAM**

Policy reviewed and determined to be current (date and initials): Feb. 1, 1995 KLA

Revised from 2/93

POLICY/PROCEDURE:

Applies to:

- Provider Services;
- Billing and Enrollment;
- Primary Care Clinics.

PRODUCTS:

Applies to:

- SeniorCare Risk Products.

SCOPE:

To identify, track and report to HCFA institutional subsequent status and status changes for Medicare risk program members (SeniorCare).

APPLICATION:

Medica receives adjusted funds from HCFA for members who are reported by their health plan under a special institutional status. Funds are increased for members who are reported as institutionalized under HCFA special status reporting. As a result, to ensure appropriate reimbursement levels from HCFA, it is crucial to accurately report initial institutionalization and subsequent changes in institutional status.

DEFINITIONS:

Institutionalized:

A member is regarded as institutionalized if s/he is a Medicare beneficiary who has been a resident for 30 days or longer in a:

1. nursing home (includes non-covered skilled care);
2. sanitarium;

3. rest home;
4. convalescent home;
5. long-term care hospital;
6. standing psychiatric hospital (as long as the member is not receiving active treatment); and
7. domiciliary home, including bed and board.

For disabled beneficiaries, an institution also includes a:

1. halfway home;
2. state school.

A member is no longer deemed institutionalized if:

1. the member is discharged from the institution to home for any period of time; or
2. the member is discharged from the institution to an acute hospital setting for greater than 15 days.

In either of the above events, the member must be institutionalized for another consecutive 30 days to requalify for institutionalized status.

PROCEDURE:

Overview

To receive an institutionalized payment rate for members who meet the above definition of institutionalized, HCFA requires special status reports from Medica. To be considered eligible for the institutionalized payment rate, a Medicare beneficiary must:

1. be enrolled in the health plan for the current month; and
2. have been a resident of a skilled nursing facility, swing bed facility, intermediate care facility, sanatorium, rest home, convalescent home, long-term care hospital, or a domiciliary home for a minimum of 30 consecutive days, including the last day before the first day of the month of reporting. It is not necessary that the individual be enrolled in Medica or any other health plan during the prior month.

Specific Procedures

1. Physicians Services will send a cumulative list of institutionalized members to each PCP no later than the 17th of each month.
2. PCPs' must review the cumulative listing of institutionalized members to ensure that all members still qualify for institutional status. Based on this listing, PCPs' must verify the ongoing institutional status of members previously reported as institutionalized.
3. After review of the cumulative institutionalized listing provided by Medica each month, each PCP must annotate the listing or develop a new listing to inform Medica of any status changes. No earlier than the 25th of each month, the PCP must provide Medica with a list that indicates the PCP has verified continued institutional status of currently reported members, identifies any transfer of facilities, or indicates a discharge or other change of status. Status should be identified as follows:
 - I = institutional status verified for most current month.
 - T = transferred to new facility or new clinic, but still eligible for institutional status (also list new facility name).
 - N = no longer institutionalized due to discharge to facility or residence that does not qualify as institution (include date of discharge), death, or other change in status.
4. When a Medica member is admitted to an institution, the primary care provider (PCP) should record the date of admission and should add all key information regarding the admission to the Institutionalized Verification Report (Exhibit A) that was received from Medica that month. This should include member name, member number, Medicare number (if possible), date of birth, date of admission and facility name. By at least the end of the month, the member will have been institutionalized for 30 consecutive days to qualify for institutionalized status. Status should be identified as follows:
 - A = admission of newly qualified institutionalized member.
5. If Medica receives institutional status information before the 25th of the month, it may contact the PCP to verify continued institutionalization or exclude the member from the institutional status listing.
6. Upon receipt of the Institutionalized Verification Report from the PCP by facsimile (612) 992-3270, Medica Physician Services shall review it for completeness, update its records to reflect the change in institutional status and facility of residence, and forward the log sheet by facsimile to the Billing and Enrollment Department, administered by United HealthCare.

7. If Medica Physician Services does not receive verifying information on each of the members listed as institutionalized by the 27th of the month, Medica will contact the PCP to inquire about the listings. If, however, no listing is received by the 27th (or the last business day prior to the 27th if the 27th falls on a weekend), Medica will remove each member's name, for whom it lacks verifying information, from the institutional listing in its next month's report to HCFA.
8. Upon receipt of annotated or new listings from PCPs, the Enrollment Department will determine proper status change or eligibility based on information provided on the listing.
9. Monthly reports (Exhibit A) are generated from the COSMOS system listing all members identified and reported to HCFA as institutionalized for the month.
10. A quarterly internal audit will be conducted by Medica to verify institutionalized member status. If there are indications that reporting is inaccurate, Medica may audit the entire membership.