Memorandum

Date APR 16 1997

From June Gibbs Brown
Inspector General

Subject Audit of Medicare Payments Made to Group Health Cooperative of Puget Sound on Behalf of Beneficiaries Classified As Having End Stage Renal Disease (A-10-96-00001)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on April 18, 1997, of our final report. A copy of the report is attached.

The objective of our audit was to determine the appropriateness of the Medicare payments to Group Health Cooperative of Puget Sound in Seattle, Washington (Group Health) for Medicare beneficiaries classified as having end stage renal disease (ESRD) status during the period March 1992 through April 1996.

We identified 40 beneficiaries enrolled with Group Health between March 1992 and April 1996 who were inappropriately classified as having ESRD status. As a result, Group Health received Medicare overpayments of $2,763,498 for that period.

In our audit, we determined that Group Health was providing timely notification to the Health Care Financing Administration (HCFA) when the ESRD status of beneficiaries changed. However, because of a HCFA computer system deficiency, the ESRD designation for beneficiaries was not changed and the enhanced payments continued. We have been advised by your staff that, in August 1996, HCFA began implementing system enhancements to address the problem of incorrect ESRD status.

We are recommending that Group Health refund the $2,763,498 in Medicare overpayments. We are also recommending that Group Health review the ESRD status of Medicare enrollees subsequent to the period covered by our audit, and refund overpayments received for beneficiaries inappropriately classified as having ESRD during this period.

In a written response to the draft report dated January 9, 1997, Group Health acknowledged that overpayments were received, but did not agree with the beginning date of March 1, 1992 for determining the amount that should be reimbursed to the Federal Government. Group Health stated that a beginning date of September 1, 1993 was appropriate based on instructions received from HCFA. By use of this beginning date, and including the period

subsequent to our audit period, Group Health determined that the amount to be repaid was $1,966,502. The response stated that reimbursement of the overpayment began on October 1, 1996.

We believe that the beginning date of March 1, 1992 for determining amounts to be reimbursed is appropriate in light of the circumstances involving the overpayments, and related policy decisions that are applied to fee-for-service Medicare providers.

For further information, please contact:

Lawrence Frelot
Regional Inspector General
for Audit Services, Region IX
(415) 437-8360

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

GROUP HEALTH COOPERATIVE OF PUGET SOUND SEATTLE, WASHINGTON

AUDIT OF MEDICARE PAYMENTS MADE ON BEHALF OF BENEFICIARIES WITH END STAGE RENAL DISEASE

FOR THE PERIOD MARCH 1992 THROUGH APRIL 1996

JUNE GIBBS BROWN
Inspector General

APRIL 1997
CIN: A-10-96-00001

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-10-96-00001

Phil Nudelman, PhD
President & Chief Executive Officer
Group Health Cooperative of Puget Sound
521 Wall Street
Seattle, WA 98121-1536

Dear Dr. Nudelman:

This report provides you with the results of our audit of enhanced Medicare payments made to Group Health Cooperative of Puget Sound (Group Health) for beneficiaries classified as having end stage renal disease (ESRD). Our audit included Medicare payments made during the period March 1992 through April 1996.

Group Health is a managed care organization and has been providing services to Medicare beneficiaries under contract with the Health Care Financing Administration (HCFA) since January 1, 1989. Group Health is paid a fixed monthly payment for each enrolled Medicare beneficiary. Enhanced payments are made on behalf of certain high-cost categories of beneficiaries, such as those having ESRD. However, when a beneficiary's ESRD status changes, such as after a 3-year time period following a successful transplant, the enhanced payments are to be discontinued.

SUMMARY OF FINDINGS

We identified 40 beneficiaries enrolled with Group Health between March 1992 and April 1996 who were inappropriately classified as having ESRD status. As a result, Group Health received Medicare overpayments of $2,763,498 for that period.

In our audit, we determined that Group Health was providing timely notification to HCFA when the ESRD status of beneficiaries changed. However, because of a HCFA computer system deficiency, the ESRD designation for beneficiaries was not changed and the enhanced payments continued. We have been advised by HCFA officials that, in August 1996, they began implementing system enhancements to address the problem of incorrect ESRD status.

We are recommending that Group Health refund the $2,763,498 in Medicare overpayments. We are also recommending that Group Health review the ESRD status of Medicare enrollees subsequent to the period covered by our audit, and refund overpayments received for beneficiaries inappropriately classified as having ESRD during this period.

In a written response to the draft report dated January 9, 1997, Group Health acknowledged that overpayments were received, but did not agree with the beginning date of March 1, 1992 for determining the amount that should be reimbursed to the Federal Government. Group Health stated that a beginning date of September 1, 1993 was appropriate based on instructions received from HCFA. By use of this beginning date, and including the period subsequent to our audit period, Group Health determined that the amount to be repaid was $1,966,502. The response stated that reimbursement of the overpayment was begun on October 1, 1996.

We believe that the beginning date of March 1, 1992 for determining amounts to be reimbursed is appropriate in light of the circumstances involving the overpayments, and related policy decisions that are applied to fee-for-service Medicare providers. In a separate report, we are recommending to HCFA that it recover all overpayments that have occurred since at least 1992 that resulted from the computer system deficiency.

We have summarized Group Health's comments and the Office of Inspector General (OIG) response to those comments beginning after the Recommendations section of the report. The complete text of Group Health's comments is included as an Appendix to this report.

BACKGROUND

A person is classified as having ESRD when that person is medically determined to have a kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. Federal regulations prohibit Medicare beneficiaries who are being treated for ESRD from enrolling in managed care organizations. However, beneficiaries who develop ESRD after enrollment may remain enrolled.

Group Health, a managed care organization, is paid a fixed monthly payment on a prepaid basis to provide or arrange for health care services for enrolled Medicare beneficiaries. The Tax Equity and Fiscal Responsibility Act of 1982 provides that the fixed monthly payments to managed care organizations for Medicare beneficiaries be adjusted by a set of risk factors, such as age, gender, and Medicare entitlement status. During 1995, Group Health's rate for regular Medicare beneficiaries averaged approximately $276 per month. However, for ESRD beneficiaries, Group Health's enhanced rate was approximately $3,200 per month.

The HCFA payment process includes the following:

- To receive payment for a Medicare beneficiary, a managed care organization must notify HCFA that the individual has enrolled in the organization.

- The HCFA places the individual into a managed care payment data base.

- This payment data base classifies beneficiaries by status (e.g., ESRD, institutionalized, regular.)

- The status classification sets the automatic monthly rate for the beneficiary which is paid by HCFA to the managed care organization.

- Monthly, HCFA provides managed care organizations with Medicare enrollees Special Status Beneficiary Reports which identify those beneficiaries for whom the organizations receive more than the regular payment.

- The HCFA requires managed care organizations with enrolled beneficiaries to monitor monthly status reports and inform HCFA of any change in status, which will result in a change in the payment rate.

If a beneficiary receives a successful kidney transplant or dialysis is no longer needed, the enhanced payments must be discontinued. According to Federal regulations at 42 CFR 406.13(f), ESRD Medicare entitlement ends with:

- the end of the 36th month after the month in which the individual has received a kidney transplant, unless the individual receives another kidney transplant or begins a regular course of dialysis during that period; or

- the end of the 12th month after the month in which a course of dialysis ends, unless the individual receives a kidney transplant during that period or begins another regular course of dialysis.

SCOPE

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 to Group Health for Medicare beneficiaries classified as having ESRD status during the period March 1992 through April 1996.

The beginning date of our audit period was based on information obtained at the start of our audit regarding a 3-year time limitation for retroactive adjustments to Medicare payments. On February 15, 1995, HCFA notified Medicare managed care organizations of a computer system problem involving payments in behalf of beneficiaries classified as having ESRD. Based on the date of notification, we established a beginning date for our audit period of March 1, 1992. However, after the completion of field work, we obtained information indicating that the HCFA 3-year time limitation was not applicable to managed care organizations. The ending date of the audit period was April 30, 1996, based on the most current information available at the time of our field work.

From HCFA records, we identified 49 beneficiaries[1] enrolled at Group Health who did not appear to be properly classified as having ESRD based on information in the records indicating a prior transplant or discontinuation of dialysis. The information indicated that a transplant had taken place more than 36 months previously, or that the last dialysis had been provided more than 12 months previously.

We reviewed Group Health records for the 49 beneficiaries to verify their ESRD status during the audit period and determine if overpayments were made. For the beneficiaries for whom Group Health's records indicated were undergoing a course of dialysis, we verified this information to records maintained by the Northwest Renal Network, a nonprofit organization in Seattle which tracks the status of individuals with ESRD. In determining overpayments, we calculated the difference between (1) the enhanced ESRD amount paid to Group Health by Medicare, and (2) the amount Medicare should have paid Group Health as determined from HCFA's Group Health Plan Maintenance System Rate Tables for 1992 through 1996.

We determined that to achieve the objective of the audit, a review of the internal controls at Group Health was not necessary. To plan the audit and determine the nature, timing and extent of tests to be performed, we relied on HCFA records which indicated that inappropriate payments had been made.

Our field work was performed from December 1995 to August 1996, and included on-site work at the offices of Group Health and the Northwest Renal Network in Seattle, Washington.

RESULTS OF AUDIT

We reviewed the Group Health records for the 49 enrolled Medicare beneficiaries who, according to HCFA records, did not appear to be properly classified and determined that 40 were inappropriately classified as having ESRD. Thirty-nine of the beneficiaries received successful kidney transplants and were no longer receiving dialysis more than 3 years after their transplant date. For the other person, a period of 12 consecutive months transpired since the last course of dialysis ended. For the 40 beneficiaries, Group Health received overpayments of $2,763,498[2] between March 1, 1992 and April 30, 1996.

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[1]On a monthly basis, Group Health's enrolled Medicare ESRD population ranged from 152 to 180 beneficiaries, based on data from calendar years 1994 and 1995.

[2]During 1993, Group Health had another contract with HCFA, known as a health care prepayment plan (HCPP) agreement, to cover some of its ESRD beneficiaries. This agreement allowed Group Health to provide Part B Medicare services to some of its ESRD beneficiaries and receive payment on a reasonable cost basis. Of the total overpayment, $227,114 was paid under the HCPP contract.

The remaining nine beneficiaries were appropriately classified because they had resumed a course of dialysis treatment or terminated enrollment in Group Health prior to the end of the Medicare entitlement period.

In our review, we determined that Group Health was appropriately notifying HCFA when the ESRD status of beneficiaries changed. However, because of a HCFA computer system deficiency, the ESRD designation for beneficiaries was not changed and the enhanced payments continued.

In February 1996, the Office of Inspector General issued a report titled, "Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries," report number A-04-94-01090. The report recommended that HCFA make procedural and systems changes to prevent further erroneous classifications of ESRD status and overpayments due to such misclassifications. The HCFA officials concurred with the recommendation, and advised us that the necessary computer modifications had been completed in August 1996.

The overpayments of $2,763,498 made to Group Health that were identified in our audit should be refunded to the Federal Government. In addition, since the conditions that caused the overpayments continued to exist after our audit period, Group Health should review the ESRD status of Medicare enrollees subsequent to the audit period, determine the amount of overpayments received for beneficiaries inappropriately classified, and refund the overpayments to the Federal Government.

Recommendations

We recommend that Group Health:

1. Refund the $2,763,498 in Medicare overpayments identified in our audit.

2. Review the ESRD status of Medicare enrollees subsequent to the period covered by our audit, and refund overpayments received for beneficiaries inappropriately classified as having ESRD during this period.

Group Health Response

We submitted a draft report on the results of this audit to Group Health on August 20, 1996, and Group Health provided a written response in a letter dated January 9, 1997. The response acknowledged the need to reimburse the Federal Government for the overpayments received, but disagreed with the period of time for which reimbursement was due. Group Health performed its own analysis of the overpayments using a starting date of September 1, 1993, rather than March 1, 1992 as included in this audit report. The analysis extended

through October 31, 1996, and resulted in a determination that a reimbursement of $1,966,502 was due.

Group Health stated that the beginning date of September 1, 1993 was appropriate based on instructions received from HCFA. The instructions were provided in a memorandum dated August 8, 1996 that was sent to all managed care organizations providing services under contracts with HCFA. The written response to our draft report requested that the HCFA guidelines be applied to Group Health as they are applied to all risk based health maintenance organizations and competitive medical plans in the United States.

Group Health stated it has already made payment arrangements with HCFA and began reimbursement of the overpayment on October 1, 1996. Group Health provided HCFA a letter in December 1996 with numerous detailed schedules supporting its computations.

OIG Comments

We consider March 1, 1992 to be the appropriate beginning date for determining the amount of overpayments that should be reimbursed to the Federal Government, rather than September 1, 1993 as used by Group Health. In a separate audit involving systems and overpayment issues at HCFA, the OIG Office of Audit Services is recommending that HCFA recover all overpayments that have occurred at least since 1992 that resulted from the computer system deficiency. The following are the primary reasons for making this recommendation:

- Our review of statutory, regulatory, and Medicare manual requirements disclosed no provisions that specify any time limits for recovery of overpayments from managed care organizations. Per 42 CFR 417.598 and section 5005 of the HMO Manual, HCFA is authorized to conduct enrollment reconciliations, as necessary, to ensure that payments do not exceed or fall short of the appropriate per capita rate of payment, but these sections do not address time frames for the reconciliations.

- Although there are no provisions that specify time limits for managed care organizations, HCFA has specified time limits for fee-for-service providers, i.e., up to 3 years. For managed care organizations, it is logical to collect overpayments at least on the same basis as overpayments are collected from providers in the Medicare fee-for-service program. Since HCFA advised managed care organizations in February 1995 that overpayments were made for ESRD beneficiaries due to the computer system problem, this served as due notice and it is reasonable that recoveries be made retroactively at least 3 years from that date.

- Managed care organizations, including Group Health, were advised each month through the monthly special status report of each beneficiary for whom they were receiving the enhanced ESRD payment. We noted in our review that Group Health provided notification to HCFA when the ESRD status of beneficiaries changed. However, because of a HCFA computer system deficiency, the ESRD designation for beneficiaries was not changed and the enhanced payments continued. Overpayments for some of the misclassified beneficiaries continued for years, with Group Health receiving money each month which it knew it was not due.

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We request that you respond within 30 days from the date of this letter to the HHS official named below, presenting any comments or additional information that you believe may have a bearing on the final determination. Final determinations as to actions taken on all matters reported will be made by the HHS action official named below.

Deputy Regional Administrator
Health Care Financing Administration
Division of Medicare
2201 Sixth Avenue, Mailstop: RX-43
Seattle, Washington 98121

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To facilitate identification, please refer to the common identification number (CIN) A-10-96-00001 in all correspondence relating to this report.

Sincerely,

for Lawrence Frelot
Regional Inspector General
for Audit Services

Attachment

APPENDIX

Group Health Cooperative
of Puget Sound

Medicare Administration
1730 Minor Ave N
PO Box 34750
Seattle, Washington 98124-1750

January 9, 1997

Lawrence Frelot
Regional Inspector General for Audit Services
c/o Barry Diamond Johnson
Department of Health and Human Services
Office of Inspector General (OIG)
Fax No: (206) 615-2258

Re: Group Health Cooperative of Puget Sound (H5050)
Audit of Medicare payments made on behalf of beneficiaries with End Stage Renal Disease for the period of March, 1992 through April, 1996

Dear Mr. Frelot:

On December 23, 1996 Group Health Cooperative (GHC) provided you with a copy of a letter sent to Yolanda Robinson, Office of Managed Care at the Health Care Financing Administration (HCFA). That letter reported the detailed results of the Group Health Cooperative of Puget Sound End Stage Renal Disease audit conducted by the HCFA and GHC.

Your office had previously completed an ESRD audit of GHC enrollees dated August 20, 1996.

GHC would like to respond to the OIG recommendation taking into consideration the most recent HCFA ESRD audit.

In your report you made two specific recommendations. Those recommendations were:

1. Refund the $2,763,498.00 in Medicare overpayments identified in our (OIG) audit.

2. Review the ESRD status of Medicare enrollees before and after the period covered by our audit and refund overpayments received for beneficiaries inappropriately classified as having ESRD during these periods. The retroactive review should include payments made since January 1, 1989. *See Office of Audit Services Note below.*

Attached please find a copy of a memo issued to all Medicare Risk Based Health Maintenance Organizations and Competitive Medical Plans regarding End Stage Renal Disease processing and payment information issued by Bruce Merlin Fried, Director of the Department of Health and Human Services at the Health Care Financing Administration, Office of Managed Care.

Office of Audit Services Note. The recommendation was revised subsequent to the issuance of the draft report.

The memo outlines the parameters for the End Stage Renal Disease processing and payment audit conducted by HCFA. In compliance with that memo, Group Health has done a complete and thorough review of HCFA records and Group Health records related to GHC enrollees for the time period specified in Director Fried's memo.

Using the parameters outlined by HCFA, GHC has concluded that we owe HCFA $1,966,502. GHC has met all of the requirements specified by HCFA related to the End Stage Renal Disease audit.

Recommendation 2 suggests that GHC review the ESRD status of Medicare enrollees before and after the period covered by the OIG audit and refund overpayments received for beneficiaries inappropriately classified as having ESRD during this period, and that retroactive review should include payments made since January 1, 1989. *See Office of Audit Services Note on page 1 of 2 of the Appendix.*

In accordance with the HCFA memo of August 8, 1996, the time periods for the ESRD audit are very different from those indicated in the OIG audit. We are, therefore, requesting that the HCFA guidelines be applied to GHC as they apply to all risk based health maintenance organizations and competitive medical plans in the United States.

GHC believes that we owe HCFA a total of $1,966,502. Payment arrangements have been made with HCFA, and GHC began reimbursement of the overpayment on October 1, 1996.

We would like to thank and to acknowledge the HCFA Region X OIG staff for the spirit of cooperation and concern that they demonstrated in their audit.

If you have questions or concerns, may I ask you to contact me directly at (206) 287-2510.

Sincerely,

Kathie Harris
Assistant Administrator, Government Programs,
Medicare Administration and Security Care
Group Health Cooperative of Puget Sound

cc: Yolanda Robinson, Office of Managed Care, Health Care Financing Administration
Ed Madden, Health Care Financing Administration, Region X

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