Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE CENTERS FOR MEDICARE & MEDICAID SERVICES PAID MEDICARE ADVANTAGE ORGANIZATIONS FOR SERVICES PROVIDED TO BENEFICIARIES CONFINED IN MENTAL HEALTH FACILITIES FOR COURT-ORDERED PURPOSES

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Deputy Inspector General

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Office of Inspector General

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EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services made payments to Medicare Advantage organizations totaling over $1 million on behalf of beneficiaries who were confined in mental health facilities by court order under a penal code during 2011 and 2012.

WHY WE DID THIS REVIEW

While performing a separate review of Medicare Part D prescription drug payments made on behalf of beneficiaries incarcerated in correctional facilities (incarcerated beneficiaries), we observed that although Part C (i.e., Medicare Advantage (MA)) and Part D requirements generally prohibit benefits paid on behalf of incarcerated beneficiaries, the requirements allow benefits paid on behalf of beneficiaries confined in mental health facilities (State hospitals, Institutions for Mental Diseases, psychiatric hospitals, or hospital psychiatric units) by court order under a penal code. (We refer to these individuals as "confined beneficiaries.") In contrast, Medicare's traditional fee-for-service (FFS) program (Part A and Part B) generally does not pay benefits on behalf of incarcerated or confined beneficiaries. Because of this inconsistent policy, we evaluated the impact on MA of paying for services provided to confined beneficiaries.

The objective of this review was to evaluate the impact of the payments that the Centers for Medicare & Medicaid Services (CMS) made to MA organizations on behalf of confined beneficiaries during calendar years (CYs) 2011 and 2012.

BACKGROUND

CMS's MA program offers beneficiaries managed care options by allowing them to enroll in private health plans rather than having their care covered through Medicare Parts A and B. CMS, which administers Medicare, contracts with MA organizations to provide health care services to beneficiaries enrolled in MA. MA organizations cover all medically necessary services, other than hospice care, that are allowable in Parts A and B. CMS makes monthly payments to MA organizations for enrolled beneficiaries.

Federal regulations state that an individual is eligible to enroll in an MA plan if he or she is entitled to Medicare under Part A and enrolled in Part B. However, under current policy for the administration of MA, CMS does not consider confined beneficiaries to be incarcerated for the purpose of MA eligibility, regardless of the reason for their confinement (*Medicare Managed Care Manual* (the Manual), chapter 2, § 10).

For Medicare Parts A and B, beneficiaries in custody of penal authorities include confined beneficiaries. Medicare generally does not pay Part A and Part B benefits to incarcerated beneficiaries, but those beneficiaries retain their entitlement to Part A and can retain their enrollment in Part B with the payment of premiums. Accordingly, these individuals would be eligible for payments under MA.

WHAT WE FOUND

CMS made 1,018 payments, totaling $1,012,907, to MA organizations on behalf of 207 confined beneficiaries during CYs 2011 and 2012. Had those same persons been enrolled in Medicare Parts A or B, payment would generally not have been made. This occurred because CMS policy permits Medicare payments to be made on behalf of confined beneficiaries enrolled in MA but not on behalf of those enrolled in Part A or Part B. Although the Social Security Act prohibits payment by Medicare Parts A and B when a confined beneficiary has no legal obligation to pay for the services or the services are paid for by a governmental entity, the MA program pays benefits on behalf of confined beneficiaries.

WHAT WE RECOMMEND

We recommend that, to be consistent with the relevant provisions of Medicare Part A and Part B, CMS revise the Manual to prohibit MA payments made on behalf of beneficiaries who have been confined in mental health facilities by court order under a penal code, which could have resulted in cost savings totaling $1,012,907 for the 2-year period we reviewed.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS did not concur with our recommendation. CMS stated that "not all individuals confined in [mental health facilities] are placed there due to violations of the jurisdiction's penal code." CMS also said that it agrees that "in cases where the information indicates an individual is incarcerated due to penal code violations, that individual is determined to no longer reside in the plan's service area and should be disenrolled…." Moreover, CMS said that it has recently proposed regulatory changes that will prohibit new or continued enrollment of incarcerated individuals. Finally, CMS said that "[i]f the proposed regulations clarifying the relevant policy are finalized, CMS will update the Manual to … clarify when confinement in [a mental health facility] is permitted for MA enrollment."

After reviewing CMS's comments, we sharpened our definition of "confined beneficiaries" and revised our recommendation in this final report. We did so to clarify that throughout the report we are referring only to beneficiaries who are confined in mental health facilities by court order under a penal code. Our review identified confined beneficiaries according to CMS's Prison Reply Data file. It is with respect to those beneficiaries (i.e., beneficiaries who are reported as incarcerated on the Prison Reply Data file for violating the penal code) that we are recommending that CMS prohibit MA payments. We note, however, that CMS's proposed change to the definition of "service area" will exclude mental health facilities from facilities in which individuals are incarcerated. This will not serve to exclude from MA coverage individuals held in the custody of penal authorities in mental health facilities. CMS could implement our recommendation by taking two steps, the first of which would involve not adopting the proposed change to the definition of "service area." The second step would be to define individuals who are in custody of penal authorities for purposes of MA in the same manner that it defines those individuals for Medicare Parts A and B in Federal regulations and the *Medicare Benefit Policy Manual*. These measures would have the effect of implementing our recommendation by differentiating between individuals confined to mental health facilities under a penal statute (who

would not be covered) and individuals confined to mental health facilities under a civil statute (who would be covered).

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INTRODUCTION

WHY WE DID THIS REVIEW

While performing a separate review of Medicare Part D prescription drug payments made on behalf of beneficiaries incarcerated in correctional facilities (incarcerated beneficiaries),[1] we observed that although Part C (i.e., Medicare Advantage (MA)) [2] and Part D requirements generally prohibit benefits paid on behalf of incarcerated beneficiaries, the requirements allow benefits paid on behalf of beneficiaries confined in mental health facilities (State hospitals, Institutions for Mental Diseases, psychiatric hospitals, or hospital psychiatric units) by court order under a penal code. (We refer to these individuals as "confined beneficiaries.") In contrast, Medicare's traditional fee-for-service (FFS) program (Part A and Part B) generally does not pay benefits on behalf of incarcerated or confined beneficiaries. Because of this inconsistent policy, we evaluated the impact on MA of paying for services provided to confined beneficiaries.[3]

OBJECTIVE

Our objective was to evaluate the impact of the payments that the Centers for Medicare & Medicaid Services (CMS) made to MA organizations on behalf of confined beneficiaries during calendar years (CYs) 2011 and 2012.

BACKGROUND

Medicare Advantage Program

CMS's MA program offers beneficiaries managed care options by allowing them to enroll in private health plans rather than having their care covered through Medicare Parts A and B. Participating MA organizations include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private FFS plans. CMS, which administers Medicare, contracts with MA organizations to provide health care services to beneficiaries enrolled in MA. MA organizations cover all medically necessary services, other than hospice care, that are allowable in Parts A and B.

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[1] *Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Incarcerated Beneficiaries During 2006 Through 2010* (A-07-12-06035), January 27, 2014.

[2] The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, revised Medicare Part C and renamed the program the MA program.

[3] A separate audit, *Medicare Part D Paid Sponsors for Prescription Drugs Provided to Beneficiaries Confined in Mental Health Facilities for Court-Ordered Purposes* (A-07-13-06041), will report on the impact on the Part D program.

CMS makes monthly payments to MA organizations for enrolled beneficiaries.[4] CMS makes these payments at the beginning of the month on the basis of the most current information available.[5]

Medicare Payments on Behalf of Confined Beneficiaries

An individual is eligible to enroll in an MA plan if he or she is entitled to Medicare under Part A and enrolled in Part B (42 CFR § 422.50(a)(1)). In addition, an individual must also meet residency requirements of the MA plan (42 CFR § 422.50(a)(3)).

Chapter 2 of CMS's *Medicare Managed Care Manual* (the Manual), uses the term "incarceration" to refer to the status of an individual who has been placed in a correctional facility, such as a jail or a prison. According to the Manual, an individual who is incarcerated is considered to be residing outside of any MA plan's service area for the purposes of eligibility, even if the correctional facility is located within a plan's service area. Federal regulations similarly state that facilities in which individuals are incarcerated are not regarded as being within MA plan service areas (42 CFR § 422.2).

The Manual, chapter 2, provides guidance to MA organizations as to MA beneficiary enrollment and disenrollment. Under CMS policy, confined beneficiaries[6] are not considered to be incarcerated for the purpose of MA eligibility and are not excluded from the service area of an MA plan (the Manual, chapter 2, § 10).

Section 1862 of the Act provides that no payment will be made under Medicare Parts A or B for services for which a beneficiary has no legal obligation to pay or which are paid for by a governmental entity. Accordingly, Federal regulations (42 CFR § 411.4(b)) generally prohibit Parts A and B payments for services rendered to beneficiaries in custody of penal authorities. Federal regulations provide that, for Parts A and B, beneficiaries in custody of penal authorities include confined beneficiaries. Medicare generally does not pay Part A and Part B benefits to incarcerated beneficiaries, but those beneficiaries retain their entitlement to Part A and can retain their enrollment in Part B with the payment of premiums. Accordingly, these individuals would be eligible for payments under MA.

Obtaining Information for Confined Beneficiaries

The Social Security Administration (SSA) is CMS's primary source of information about incarcerated beneficiaries. Generally, SSA collects information, such as the names of Medicare beneficiaries and the dates on which beneficiaries begin periods of incarceration, directly from

[4] The Social Security Act (the Act), § 1853(a)(1)(A), 42 U.S.C. § 1395w-23(a)(1)(A).

[5] The monthly payments are based on each beneficiary's demographic and health status information.

[6] The classification "confined beneficiaries" includes beneficiaries who are confined in mental health facilities by court order under a penal code, including those beneficiaries determined to be incompetent to stand trial, adjudged not guilty by reason of insanity, or awaiting a determination of competence to stand trial.

penal authorities. SSA also collects incarceration end dates from beneficiaries' requests for reinstatement of Social Security benefits.

CMS's Enrollment Database (EDB) interfaces with SSA's systems to identify incarcerated beneficiaries.[7] Each month, CMS receives a file, known as the Prison Reply Data file, from SSA. This file includes information about each incarcerated beneficiary, the incarceration start date and end date (if applicable), and facility information (such as the name and type of facility) that we used to determine whether the facility was a mental health facility.

HOW WE CONDUCTED THIS REVIEW

We identified confined beneficiaries according to CMS's Prison Reply Data file as of November 27, 2012, and used the EDB (as of February 23, 2013) to identify confined beneficiaries (as listed in the Prison Reply Data file) who were confined in mental health facilities at some point during CYs 2011 and 2012.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDING

CMS made 1,018 payments, totaling $1,012,907, to MA organizations on behalf of 207 confined beneficiaries during CYs 2011 and 2012. Had those same persons been enrolled in Medicare Parts A or B, payment would generally not have been made. This occurred because CMS policy permits Medicare payments to be made on behalf of confined beneficiaries enrolled in MA but not on behalf of those enrolled in Part A or Part B. Although the Act prohibits payment by Medicare Parts A and B when a confined beneficiary has no legal obligation to pay for the services or the services are paid for by a governmental entity, the MA program pays benefits on behalf of confined beneficiaries.

FEDERAL REQUIREMENTS

Section 1862 of the Act and Federal regulations generally prohibit payment for Medicare Part A and Part B services rendered to beneficiaries in custody of penal authorities. Federal regulations, however, allow payment if the State or local law requires these beneficiaries to repay the cost of medical services and if the State or local government entity enforces the requirement to pay (42 CFR § 411.4(b)).

[7] The EDB uses information from SSA to identify incarcerated individuals. These data are ultimately provided to MA organizations to verify a beneficiary's eligibility for MA.

Federal regulations governing Medicare Parts A and B define individuals who are in custody of penal authorities as "… individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, *required to reside in mental health facilities*, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule" (42 CFR § 411.4(b); emphasis added).

Federal regulations state that an individual is eligible to enroll in an MA plan if he or she is (1) entitled to Medicare benefits under Part A and enrolled in Part B and (2) resides in the service area of the MA plan (42 CFR § 422.50(a)(1), (3)(i)).[8] Facilities in which individuals are incarcerated are not included in the service area of an MA plan (42 CFR § 422.2). A beneficiary who is incarcerated "is considered to be residing outside the plan's service area, even if the correctional facility is located within the plan's service area" (the Manual, chapter 2, § 50.2).

The Manual, chapter 2, provides guidance to MA organizations as to MA beneficiary enrollment and disenrollment. Individuals who fall within the classification of confined beneficiaries[6] are not considered to be incarcerated for the purpose of MA eligibility and are not excluded from the service area of an MA plan on that basis (the Manual, chapter 2, § 10).

DIFFERING POLICY ALLOWS CMS TO PROVIDE MEDICARE ADVANTAGE COVERAGE TO CONFINED INDIVIDUALS

CMS made payments to MA organizations on behalf of confined beneficiaries because CMS policy is different for MA than it is for Parts A and B. This policy difference allows confined beneficiaries to receive MA benefits even though Federal requirements prohibit coverage under Parts A and B (the Act, § 1862; 42 CFR § 411.4(b)). Although the original Medicare Parts A and B legislation worked to generally prohibit payments for confined individuals, CMS permits MA payments on behalf of confined beneficiaries even though confined beneficiaries have no legal obligation to pay for services or the services are paid for by a governmental entity.

Because of the foregoing policy differences, CMS made 1,018 payments totaling $1,012,907 to MA organizations on behalf of 207 confined beneficiaries during CYs 2011 and 2012. The absence of a consistent payment policy across the various Medicare programs works to prevent those programs from achieving the uniformity they need to be administered efficiently.

RECOMMENDATION

We recommend that, to be consistent with the relevant provisions of Medicare Part A and Part B, CMS revise the Manual to prohibit MA payments made on behalf of beneficiaries who have been confined in mental health facilities by court order under a penal code, which could have resulted in cost savings totaling $1,012,907 for the 2-year period we reviewed.

[8] There is a limited exception for beneficiaries residing outside the service area who are enrolled in a health plan offered by the MA organization during the month immediately preceding the month in which they are entitled to both Medicare Part A and Part B (42 CFR § 422.50(a)(3)(ii)).

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not concur with our recommendation. CMS stated that "not all individuals confined in [mental health facilities] are placed there due to violations of the jurisdiction's penal code." CMS also said that it agrees that "in cases where the information indicates an individual is incarcerated due to penal code violations, that individual is determined to no longer reside in the plan's service area and should be disenrolled…." Moreover, CMS said that it has recently proposed regulatory changes that will prohibit new or continued enrollment of incarcerated individuals.[9] Finally, CMS said that "[i]f the proposed regulations clarifying the relevant policy are finalized, CMS will update the Manual to … clarify when confinement in [a mental health facility] is permitted for MA enrollment."

CMS's comments are included in their entirety as Appendix B.

After reviewing CMS's comments, we sharpened our definition of "confined beneficiaries" and revised our recommendation in this final report. We did so to clarify that throughout the report we are referring only to beneficiaries who are confined in mental health facilities by court order under a penal code. As indicated in "How We Conducted This Review" and Appendix A, our review identified confined beneficiaries according to CMS's Prison Reply Data file. It is with respect to those beneficiaries (i.e., beneficiaries who are reported as incarcerated on the Prison Reply Data file for violating the penal code) that we are recommending that CMS prohibit MA payments. We note, however, that CMS's proposed change to the definition of "service area" will exclude mental health facilities from facilities in which individuals are incarcerated.[10] This will not serve to exclude from MA coverage individuals held in the custody of penal authorities in mental health facilities. CMS could implement our recommendation by taking two steps, the first of which would involve not adopting the proposed change to the definition of "service area." The second step would be to define individuals who are in custody of penal authorities for purposes of MA in the same manner that it defines those individuals for Medicare Parts A and B in 42 CFR 411.4(b) and the *Medicare Benefit Policy Manual*, chapter 16, section 50.3.3(2). These measures would have the effect of implementing our recommendation by differentiating between individuals confined to mental health facilities under a penal statute (who would not be covered) and individuals confined to mental health facilities under a civil statute (who would be covered).

[9] 79 Fed. Reg. 1917 (Jan. 10, 2014).

[10] 79 Fed. Reg. at 2051.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $1,012,907 that CMS paid to MA organizations on behalf of 207 confined beneficiaries during CYs 2011 and 2012. We did not review CMS's overall internal control structure because our objective did not require us to do so. We reviewed only the internal controls directly related to our objective.

We did not verify the confinement status or dates of confinement of the beneficiaries whom we identified as confined.

We conducted this audit from November 2011 through August 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of CMS's internal controls related to incarcerated beneficiaries and policies for eligibility for confined beneficiaries;
- held discussions with SSA officials to gain an understanding of SSA's systems and processes for obtaining data on incarcerated individuals;
- obtained CMS's Prison Reply Data file (received monthly from SSA) to identify (as of November 27, 2012) confined beneficiaries;
- used the EDB (as of February 23, 2013) to identify confined beneficiaries (from CMS's Prison Reply Data file) who were confined in mental health facilities at some point during CYs 2011 and 2012;
- obtained payment information for these confined beneficiaries from the Medicare Advantage and Prescription Drug system for CYs 2011 and 2012;
- identified 1,018 payments totaling $1,012,907 that CMS made to MA organizations for confined beneficiaries; and
- discussed the results of our review and provided detailed information to CMS officials on March 12, 2013.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR - 2 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "The Centers for Medicare & Medicaid Services Paid Medicare Advantage Organizations for Services Provided to Beneficiaries Confined in Mental Health Facilities for Court-Ordered Purposes" (A-07-13-06043)

Thank you for the opportunity to review and comment on this OIG draft report aimed at determining the extent to which the Centers for Medicare & Medicaid Services (CMS) paid Medicare Advantage Organizations (MAOs) for individuals confined in mental health facilities by court order. Individuals may enroll in MAOs if they meet the eligibility requirements, which include residing within the plan's service area. Consistent with this policy, and as outlined in the definition of "service area" in 42 CFR 422.2, an individual who is incarcerated does not reside in a plan service area; service is provided by the penal facility in which the individual is confined. However, not all individuals confined in Institutions for Mental Disease (IMDs) are placed there due to violations of the jurisdiction's penal code. A number of individuals are confined by other types of court orders for which there is not another appropriate payer for services. Thus, the current Medicare Managed Care Manual outlines the availability for individuals confined to IMDs to reside within the MAO's service area.

The status of incarceration comes from data provided by the Social Security Administration (SSA) based on information from penal facilities. That information is used to apply payment rules for fee-for-service. To help align the Fee-for-Service program with the Medicare Advantage (MA) program, CMS recently proposed regulation changes which prohibit new or continued enrollment of incarcerated individuals (79 FR 1917). As part of this proposed regulation, incarcerated individuals will lose enrollment eligibility for MA based on the data provided to CMS by SSA. In such cases, CMS proposed that individuals will be involuntarily disenrolled from their MAO.

Although CMS does not support the report's recommendation to modify the Medicare Managed Care Manual to prohibit MA payments made on behalf of confined beneficiaries, we strive to ensure payments are not made for individuals not eligible for MAO enrollment. Accordingly, we agree that in cases where the information indicates an individual is incarcerated due to penal

code violations, that individual is determined to no longer reside in the plan's service area and should be disenrolled, following regulatory requirements.

The CMS is taking steps to clarify the policies and ensure that the enrollment policies are in accordance with the information we receive from the correctional facilities and SSA.

Below is the CMS response to the OIG recommendation in the draft report.

OIG Recommendation

The OIG recommends CMS revise the Manual to prohibit MA payments made on behalf of confined beneficiaries, which could have resulted in cost savings totaling $1,012,907 for the two year period reviewed.

CMS Response

The CMS non-concurs with this recommendation because the Medicare Managed Care Manual is related to enrollment guidance, and this guidance outlines a process for disenrolling incarcerated individuals resulting in the cessation of MA payments. As MA capitated payment is based on whole months of enrollment, CMS is not able to establish partial payments based on an exact incarceration date. However, CMS has recently proposed regulation changes which prohibit new or continued enrollment of incarcerated individuals (79 FR 1917). As part of this proposed regulation, CMS proposed to share incarceration data with MAOs so that eligibility for enrollment can be determined appropriately and disenrollments can occur based on the data regarding the incarceration provided by SSA. CMS believes that if the proposed regulation is finalized, it would serve to meet OIG's goal of limiting MAO capitation payments for known incarcerated individuals.

The CMS continues to believe that it is appropriate for beneficiaries confined to IMDs, not based on criminal offenses, to be included within the MAO's service area, as there are individuals who are confined by court order to an IMD for which no penal codes were violated. Thus, some enrollments of individuals residing in IMDs are appropriate and these individuals will remain able to enroll and obtain services through the MAO. If the proposed regulations clarifying the relevant policy are finalized, CMS will update the Manual to include the policy and clarify when confinement in an IMD is permitted for MA enrollment.

Thank you again for the opportunity to review and comment on this report. We appreciate the time and effort that went into developing it, and look forward to continuing to work with the OIG on this issue.