Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

HUMANA HEALTH PLANS, INC. PHOENIX, ARIZONA

JANET REHNQUIST
Inspector General

JUNE 2002
A-05-01-00095

DEPARTMENTOF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

June 25, 2002

Common Identification Number: A-05-0 1-00095

William Howard, CEO
Humana Health Plans, Inc.
2710 East Camelback Road
Phoenix, Arizona 85016

Dear Mr. Howard:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicare Payments for Beneficiaries with Institutional Status." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contactors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-01-00095 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply *to* HHS Action Official:

Director of Health Plan Benefits Group
C4-23-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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William Howard, CEO
Humana Health Plans, Inc.
2710 East Camelback Road
Phoenix, Arizona 85016

Dear Mr. Howard:

This report provides the results of our audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status." Our objective was to determine if payments to Humana (Contract H0307) were appropriate for beneficiaries reported as institutionalized.

We determined that Humana received Medicare overpayments, totaling $18,645, for 37 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31,2000. The 37 beneficiaries include 23 that did not meet the 30-day residency requirement in an institutional facility, five beneficiaries for whom Humana staff could provide no institutional residency information and 9 beneficiaries residing in non-certified facilities.

INTRODUCTION

BACKGROUND

The Balanced Budget Act of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare + Choice (M+C) Program. Its primary goal is to provide a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans have a network of providers under contract to deliver a health benefit package that has been approved by the Centers for Medicare and Medicaid Services (CMS). Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. Beneficiaries eligible to enroll in the new M+C Plans must he entitled to Part A and enrolled in Part B.

The CMS makes monthly advance payments to managed care organizations (MCOs) at the per capita rate set for each enrolled beneficiary. Medicare pays a higher monthly rate to MCOs for beneficiaries who are institutionalized. The MCOs receive the enhanced institutional rate for enrollees who are residents of Medicare or Medicaid certified institutions; such as: skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care hospitals, and swing-bed hospitals. Institutional status requirements outlined in CMS's

Operational Policy Letter #54 (OPL #54), specify that a beneficiary must be a resident of a qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The MCOs are required to submit to CMS, a monthly list of enrollees meeting institutional status requirements. The advance payments received by MCOs each month are subsequently adjusted by CMS to reflect the enhanced reimbursement for institutional status. During 2000, MCOs in the Phoenix, Arizona area received a monthly advance payment of $459 for each 78 years old female beneficiary, residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to $937.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Humana (Contract H0307) were appropriate for beneficiaries reported as institutionalized during the period January 1, 1998 through December 31, 2000. This review was performed as part of our National review of institutional status issues.

In 1998, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. Our audit verified that Humana was complying with CMS's current definition of an institutional facility. We reviewed the Plan's records documenting where 386 beneficiaries with institutional status resided to determine if beneficiaries were in qualifying Medicare or Medicaid certified facilities. The Medicare overpayment for each incorrectly reported beneficiary was calculated by subtracting the non-institutional payment that Humana should have received from the institutional payment actually received. We reviewed the institutional residency documentation for all beneficiaries reported as institutionalized during our audit period, placing no reliance on the Plan's internal controls. Our limited review of internal controls focused on procedures for verifying institutional residency.

Our field work was performed during July and August 2001 at Humana's offices in Phoenix, Arizona and through November in our field office in Columbus, Ohio.

RESULTS OF AUDIT

We determined that Humana received Medicare overpayments totaling $18,645 for 37 beneficiaries incorrectly reported as institutionalized. Institutional status requirements in OPL #54 specify that the beneficiary must be a resident of the qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The 37 beneficiaries included 23 that had admittance or discharge dates during the initial 30-day residency period and 5 that were questioned because Humana was unable to document any institutional residency for the reporting month under review. In addition, Humana incorrectly reported 9 beneficiaries as institutionalized, while they were residents of non-certified facilities.

In 1998, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. The 9 beneficiaries were incorrectly reported during 1998 and 1999. Humana did not report any residents of non-certified facilities as institutionalized in the year 2000.

INTERNAL CONTROLS

Humana staff contacts nursing facilities, towards the end of each month, to verify the institutional residency of beneficiaries enrolled in the Plan. Beneficiaries identified as residents of qualifying facilities, will be reported to CMS as institutionalized at the beginning of the coming month. In the year 2000, Humana incorrectly reported as institutionalized 10 beneficiaries who were discharged from an institutional facility during the required 30-day residency period that includes the last day of the month. Most of the discharges took place, late in the month, after Humana staff had already verified that the beneficiaries were still residents of the institutions.

Humana should establish procedures to identify beneficiaries incorrectly reported as institutionalized because of discharges occurring in the period between the Plan's monthly verification of institutional residency and the end of the month. This could be accomplished by reconciling the list of beneficiaries reported as institutionalized at the beginning of each month, with the institutional residency information gathered at the end of the same month. The discharges previously missed, will appear in the residency data provided by the nursing facilities in the subsequent month. If incorrectly reported beneficiaries are identified, adjustments reversing the institutional payments should be sent to CMS.

RECOMMENDATIONS

We recommend that Humana:

1. refund the identified overpayments totaling $18,645.

2. establish reconciliation procedures that identify beneficiaries incorrectly reported as institutionalized, because of discharges occurring in the period between the Plan's monthly verification of institutional residency and the end of the month.

AUDITEE COMMENTS AND OIG RESPONSE

In their March 13, 2002 response to our draft report, Humana officials provided additional information about the institutional residency of I5 beneficiaries for which institutional payments were previously questioned. Humana officials also stated that they have changed the Plan's verification process and now verify institutional residency after the first of the month. Finally, Humana officials ask how the overpayments identified in our review should be returned.

After verifying the additional residency information provided by Humana, we removed all of the questioned payments for 9 beneficiaries and part of the questioned payments for one beneficiary. Humana provided documentation that staff at the Plan had submitted adjustments to CMS reversing the unallowable institutional payments for the five additional beneficiaries mentioned in their comments. These adjustments have not been processed by CMS so we continue to question the institutional payments.

We believe the procedural change made by Humana will make the Plan's reporting of institutionalized beneficiaries more accurate. Humana officials should work with the provided HHS Action Official in determining how to return the identified overpayments. Humana's complete response is included with this report as Appendix A.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

APPENDIX

2710 East Camelback Road
Phoenix, AZ 85016
602 381 6300 Tel
602 381 4381 Fax

March 13,2002

HUMANA

Mr. David Shaner
Senior Auditor
HHS/OIG Office of Audit Services
277 West Nationwide Boulevard, Suite 225
Columbus, Ohio 43215

RE: Common Identification Number: A-05-01-00095

Dear Mr. Shaner:

This is in response to the Office of Inspector General (OIG) draft audit report entitled "Review of Medicare Payments for Beneficiaries with Institutional Status," mailed to William Howard on February 11,2002. Based on the information provided in this report and our research, we are providing additional information related to the draft report findings.

The draft report indicates that Humana received Medicare overpayments totaling $32,015 for 46 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. According to your report, there were 27 members that had admittance or discharge dates during the 30-day residency period; seven members that Humana was could not document my institutional residency for the reporting month under review; and 12 members were believed to be residents of non-certified facilities. Our review of these 46 members revealed the following:

- We were able to verify/confirm that five of the 27 members did meet the 30-day residency period. Two of the members were nor discharged during the 30-day residency period, these members were admitted to the hospital for a period of time less than 15 days, and subsequently returned to the skilled nursing facility (SNF). In addition, three of the members changed SNFs, the members were discharged from one certified SNF and admitted to another certified SNF. In order to ensure a more accurate reporting process, in early 2001, Humana changed its verification process and now verifies residency after the first of the month.
- We were able to find information on two of the seven members lacking supporting documentation. One person listed on the spreadsheet was not a Humana member for the month indicated on the draft report. As per our records, this person was not listed on the Plan Payment Report for the month indicated. We have enclosed the supporting documentation for the other member, illustrating adherence to the

institutional verification process. We were unable to locate additional supporting documentation for the remaining **six** members.

- We **were** able to verify/confirm that three of the 12 members believed to be residents of non-certified facilities were actually in a Medicare certified facility during the time period reported. These members resided in Central Arizona Center – Skilled Nursing Facility, Medicare #03-5226. One of the twelve members was on hospice during the reporting period. While this member was incorrectly reported **as** institutional, no institutional payment adjustment is necessary because the plan was reimbursed at the hospice rate.

We attached a copy of your spreadsheet listing of members believed to **have** been incorrectly reported. The last column includes information based on our review. The red highlighted comments include addirional information supporting the beneficiaries' institutional status.

After you have had **an** opportunity to review the additional information we *are* providing, please provide us with direction on the process you would **like us** to use to return any overpayment amounts. Generally, should an overpayment bc identified during the **normal** course of reporting institutional members. Humana submits an overpayment report to the CMS Regional Office for correction. It is our understanding that this process allows For retro-corrections of **up** to ***36*** months. Please let us know if this is the process **you** would like us to follow.

If you would like to discuss the information provided, please feel free to contact me at (602) 381-4337.

Sincerely,

Tammi Goldberg

Tammi Goldberg
Director of Compliance

Enclosures

cc: Bill Howard, CEO, Phoenix Marker
Laura Kelley, Humana
Sharon Ware, Humana