

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS  
FOR BENEFICIARIES WITH  
INSTITUTIONAL STATUS**

**KANSAS CITY MARKET-HUMANA  
HEALTH PLAN  
KANSAS CITY, MISSOURI**



JANET REHNQUIST  
INSPECTOR GENERAL

DECEMBER 200 1  
A-05-01-00071



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

December 6, 2001

Common Identification Number: A-05-01-00071

Debra Smith, President  
Kansas City Market-Humana Health Plan  
10450 Holmes Street  
Kansas City, MO 64 13 1

Dear Ms. Smith:

This final 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 Health Plan (Contract H2649) were appropriate for beneficiaries reported as institutionalized.

We determined that Humana received Medicare overpayments totaling \$84,808 for 27 beneficiaries incorrectly classified as institutionalized during the period January 1, 1998 through December 31, 2000. Most of these beneficiaries were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. Humana should not have received payment at the enhanced institutional rate.

## **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 was 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 be 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 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 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. For example, during 2000, MCOs in the Kansas City area received a monthly advance payment of \$537 for each 77 years old non-Medicaid beneficiary, residing in a non-institutional setting. If the beneficiary was reported to CMS as institutionalized, the advance payment would have been adjusted to \$1,011.

## **SCOPE OF AUDIT**

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Humana Health Plan (Contract H2649) were appropriate for beneficiaries reported as institutionalized during the period January 1, 1998 through December 31, 2000. This review was performed as survey work prior to 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 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.

Our field work was performed during January 2001 at Humana's offices in Kansas City, Missouri and through April in our field office in Columbus, Ohio.

## **RESULTS OF AUDIT**

Humana received Medicare overpayments totaling \$84,808 for 27 beneficiaries incorrectly classified as institutionalized. Twenty-three of these beneficiaries were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. Humana should not have received payment at the enhanced institutional rate. The overpayments occurred because Humana staff did not adequately verify whether institutional facilities were certified for Medicare or Medicaid during 1998-1999. Humana officials were unable to provide residency information for the remaining four beneficiaries.

Humana's current internal control procedures for verifying the institutional residency of the Medicare beneficiaries enrolled in the MCO are adequate. Staff at Humana contacts the institutional facilities monthly to verify each beneficiary's residency and conduct periodic reviews to verify that facilities are certified for either Medicare or Medicaid. Humana did not report any beneficiaries residing in non-qualifying domiciliary facilities as institutionalized in the year 2000.

## RECOMMENDATIONS

We recommend that Humana refund the identified overpayments totaling \$84,808 by submitting adjustments to CMS for the related beneficiaries. We are making no recommendations related to internal controls because Humana has corrected the internal control weakness that caused beneficiaries to be incorrectly reported to CMS as institutionalized.

## AUDITEE COMMENTS AND OIG RESPONSE

In their October 12, 2001 response to our draft report, Humana officials provided additional information about the institutional residency of selected beneficiaries for which institutional payments were previously questioned. After verifying the additional information we removed any amounts related to these beneficiaries from our findings. Humana officials do not dispute the remaining questioned amounts contained in our final report. Humana's complete response is included with this report as Appendix A.

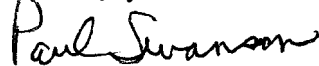
-----

Final determinations as to the actions taken on all matters reported will be made by the U.S. Department of Health and Human Services action official named below. We request that you respond to the 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 104-23 1, Office of the Inspector General, Office of Audit Services reports are made available to the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at <http://www.hhs.gov/proorg/oig>.

To facilitate identification, please refer to Common Identification Number A-05-01-00071 in all correspondence relating to this report.

Sincerely yours,



Paul Swanson  
Regional Inspector General  
for Audit Services

### Direct Reply to HHS Action Official:

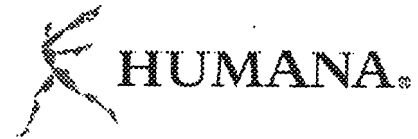
Director, Office of Managed Care  
33-02-01  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

## APPENDIX A

**Humana Health Care Plans**  
Administrative Offices  
10450 Holmes  
Kansas City, MO 64131-3471  
816 941 8900 Tel

October 12, 2001

Mr. David Shaner  
Senior Auditor  
HHS/OIG Office of Audit Services  
Two Nationwide Plaza  
280 North High Street, Room 710  
Columbus, OH 43215



Re: Common Identification # A-05-01 -0007 1

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." Following Humana's receipt of the draft report, Laura Kelley, Regulatory Compliance Director for Humana, contacted you to obtain additional information related to the 59 members believed to have been inaccurately reported as institutional during the review period. Based on the information provided and in agreement with your office, we are providing additional information related to the draft report findings.

The draft report indicates that Humana received Medicare overpayments totaling \$164,324 for 59 beneficiaries incorrectly classified as institutionalized during the period January 1, 1998 through December 31, 2000. According to your report, the majority of these members were believed to be residents of domiciliary type facilities that were not Medicare or Medicaid certified as required. Our review of these 59 members revealed the following:

- We were able to verify/confirm that 32 of the 59 members did reside in a Medicare and/or Medicaid certified facility during the time period reported. The certification information is contained within the *New Life Styles Pamphlet* that is provided to Medicare beneficiaries in the area and includes both Medicare and Medicaid certification information.
- 19 of the 59 members could not be verified as having resided in a certified facility during the period reported.
- For 5 of the 59 members, we were unable to locate the Humana institutional file.
- For 3 of the 59 members, we were unable to verify the facility through the existing CMS records.

We have attached a copy of the Winter/Spring 1999 *New Life Styles Pamphlet* for your review of the certification information. We have included this pamphlet because the CMS website listing Medicare/Medicaid certification information does not provide historical information. In addition,

we have 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 facilities where we were able to verify Medicare and/or Medicaid certification.

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 be 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 that you would like us to follow.

If you would like to discuss the information provided, please feel free to contact Laura Kelley at (770) 350-2163.

Sincerely,

Debra Smith  
President, Kansas City Market

cc: Laura Kelley, Humana  
Sharon Ware, Humana

## APPENDIX A

Humana Health Care Plans  
Administrative Offices  
10450 Holmes  
Kansas City, MO 64131-3471  
816 941 8900 Tel

October 12, 2001

Mr. David Shaner  
Senior Auditor  
HHS/OIG Office of Audit Services  
Two Nationwide Plaza  
280 North High Street, Room 710  
Columbus, OH 43215



Re: Common Identification # A-05-01-00071

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." Following Humana's receipt of the draft report, Laura Kelley, Regulatory Compliance Director for Humana, contacted you to obtain additional information related to the 59 members believed to have been inaccurately reported as institutional during the review period. Based on the information provided and in agreement with your office, we are providing additional information related to the draft report findings.

The draft report indicates that Humana received Medicare overpayments totaling \$164,324 for 59 beneficiaries incorrectly classified as institutionalized during the period January 1, 1998 through December 31, 2000. According to your report, the majority of these members were believed to be residents of domiciliary type facilities that were not Medicare or Medicaid certified as required. Our review of these 59 members revealed the following:

- We were able to verify/confirm that 32 of the 59 members did reside in a Medicare and/or Medicaid certified facility during the time period reported. The certification information is contained within the *New Life Styles Pamphlet* that is provided to Medicare beneficiaries in the area and includes both Medicare and Medicaid certification information.
- 19 of the 59 members could not be verified as having resided in a certified facility during the period reported.
- For 5 of the 59 members, we were unable to locate the Humana institutional file.
- For 3 of the 59 members, we were unable to verify the facility through the existing CMS records.

We have attached a copy of the Winter/Spring 1999 *New Life Styles Pamphlet* for your review of the certification information. We have included this pamphlet because the CMS website listing Medicare/Medicaid certification information does not provide historical information. In addition, we have 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 facilities where we were able to verify Medicare and/or Medicaid certification.

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 be 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 that you would like us to follow.

If you would like to discuss the information provided, please feel free to contact Laura Kelley at (770) 350-2163.

Sincerely,

Debra Smith  
President, Kansas City Market

cc: Laura Kelley, Humana  
Sharon Ware, Humana