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

REGION V
OFFICE OF
INSPECTOR GENERAL

April 11, 2002

Common Identification Number: A-05-01 -00078

Jeffery D. Fox
Vice President of Medicare Programs
Health Net of Arizona, Inc.
2800 North 44th Street, Suite 900
Phoenix, Arizona 85008

Dear Mr. Fox:

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 104-23 1), OIG, OAS 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://oig.hhs.gov/.

To facilitate identification, please refer to Common Identification Number A-05-0 l-00078 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, Health Plans Benefit Group
C4-23-07
7500 Security Boulevard
Baltimore, Maryland 2 1244- 1850

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

# HEALTH NET OF ARIZONA, INC. PHOENIX, ARIZONA


**JANET REHNQUIST**
**Inspector General**

**APRIL2002**
**A-05-01-00078**

# *Notices*

## THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

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Jeffery D. Fox
Vice President of Medicare Programs
Health Net of Arizona, Inc.
2800 North 44th Street, Suite 900
Phoenix, Arizona 85008

Dear Mr. Fox:

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 Health Net (Contract HO35 1) were appropriate for beneficiaries reported as institutionalized.

We determined that Health Net received Medicare overpayments totaling $2 1,233 for 53 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 3 1, 2000. The majority of the beneficiaries were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. Health Net 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 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 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

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 1999, MCOs in the Tucson, Arizona area received a monthly advance payment of $431 for each 72 years old male, residing in a non-institutional setting. If the beneficiary was reported to CMS as institutionalized, the advance payment would have been adjusted to $994.

**SCOPE OF AUDIT**

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Health Net (Contract H0351) 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 Health Net was complying with CMS's current definition of an institutional facility. We reviewed the plan's records documenting where 772 beneficiaries with institutional status resided to determine if the 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 Health Net 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 May 2001 at Health Net's offices in Tucson, Arizona and through August in our field office in Columbus, Ohio.

## RESULTS OF AUDIT

Health Net received Medicare overpayments totaling $21,233 for 53 beneficiaries incorrectly reported as institutionalized. Most of the beneficiaries were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. Health Net should not have received payments at the enhanced institutional rate.

Health Net incorrectly reported 47 beneficiaries as institutionalized while they were residents of domiciliary care facilities. Many of these beneficiaries were incorrectly reported because Health Net staff did not fully implement CMS's guidance concerning domiciliary facilities until February 1998. The overpayments that Health Net received for 39 of the 47 beneficiaries were applicable to January 1998. For another six beneficiaries, the overpayments occurred from

applicable to January 1998. For another six beneficiaries, the overpayments occurred from January 1998 through December 1999. Health Net received overpayments for the remaining two beneficiaries during calendar year 2000.

In addition, we identified Medicare overpayments, unrelated to domiciliary care, for six beneficiaries. Four of the six beneficiaries did not meet the 30-day residency requirement in a qualifying institutional facility. Health Net officials could not document an institutional residence for the other two beneficiaries.

Health Net's current internal control procedures for verifying the institutional residency of the Medicare beneficiaries enrolled in the MCO are adequate. Health Net staff contacts the institutional facilities monthly to verify each beneficiary's residency. The number of beneficiaries incorrectly reported as institutionalized in the year 2000 was not significant, supporting the effectiveness of the MCO's current verification procedures.

**RECOMMENDATIONS**

We recommend that Health Net refund the identified overpayments totaling $21,233 by submitting adjustments to CMS for the related beneficiaries. We are making no recommendations related to internal controls because Health Net's current procedures are adequate.

## AUDITEE COMMENTS AND OIG RESONSE

In their December 11, 200 1 response to our draft report, Health Net 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. Health Net officials do not dispute the remaining questioned amounts contained in our final report. Health Net's complete response is included with this report as Appendix A.

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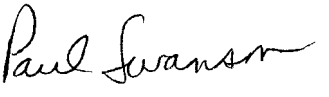
Sincerely yours,



Paul Swanson
Regional Inspector General
for Audit Services

# APPENDIX

APPENDIX A

Health Net of Arizona, Inc.
930 N. Finance Center Dr.
Tucson, AZ 857 10-1362
520.258.5777 Fax
520.721.1122

2800 N. 44th St, Suite 900
Phoenix, AZ 85008-1553
602470.7878 Fax
602224.5528

800.289.2818
www.health.net



Health Net

December 11, 2001

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

Re: Common Identification Number A-05-01-00078

Dear Mr. Shaner:

Review of the draft report entitled "Review of Medicare Payments for Beneficiaries with institutional Status" has been completed.

On the attached spreadsheet you will find Medicare Facility numbers for eight beneficiaries' institutional stays. Should you require any additional documentation from these facilities, please let me know and the information will be requested and supplied to you for further review.

In addition, Health Net, AZ is in agreement on the remaining findings. Per our previous telephone discussion, Health Net misinterpreted the implementation date of Operational Policy Letter #54. This misinterpretation led to the reporting of beneficiaries residing in facilities that no longer met criteria as a Qualified Institutional Facility.

Since you indicated in your draft letter that Health Net's current procedures for verifying institutional residency are adequate, no corrective action document is included. Health Net will continue to verify institutional residence as per our current process.

Your assistance and understanding during our review process has been greatly appreciated. Should you have questions relating to any information provided, please call Beth Pennell, Medicare Compliance Analyst at (520) 258-4229, or Jane Scott, Director of Medicare Compliance and Operations at (520) 258-4717.

Sincerely,

Jeffery D. Fox
Vice President, Medicare Programs

enclosure