Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

UNITEDHEALTHCARE OF FLORIDA SUNRISE, FLORIDA

JANET REHNQUIST
Inspector General

SEPTEMBER 2002
A-05-01-00091

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

REGION V
OFFICE OF
INSPECTOR GENERAL

September 5, 2002

Common Identification Number: A-05-01-00091

Michael Muchnicki, CEO
UnitedHealthcare of Florida
13621 NW 12th Street
Sunrise, Florida 33323

Dear Mr. Muchnicki:

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 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-05-01-00091 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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Michael Muchnicki, CEO
UnitedHealthcare of Florida
13621 NW 12th Street
Sunrise, Florida 33323

Dear Mr. Muchnicki:

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 UnitedHealthcare (United) under Contract H9011 were appropriate for beneficiaries reported as institutionalized.

We determined that United received Medicare overpayments totaling $121,023 for 127 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. Reasons for questioning the institutional status of the beneficiaries included: no documentation of institutional residency, admit or discharge dates during the required 30 day residency period, and issues related to hospital stays.

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 hospitals, and swing-bed hospitals. Institutional status requirements 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 calendar year 2000, MCOs in the Sunrise, Florida area received a monthly advance payment of $558 for each 70 years old male beneficiary, residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to $1,251.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to United 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 United was complying with CMS's current definition of an institutional facility. We reviewed the plan's records documenting where 1,172 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 United 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 2001 at United's offices in Sunrise, Florida and through January 2002 at our field office in Columbus, Ohio.

RESULTS OF AUDIT

We determined that United received Medicare overpayments totaling $121,023 for 127 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. Reasons for questioning the institutional status of the beneficiaries include: no documentation of institutional residency, admit or discharge dates during the required 30 day residency period, and issues related to hospital stays. United received unallowable institutional payments for more than one reason for 4 of the 127 beneficiaries, bringing our total number of questioned events to 131.

United erroneously reported 69 beneficiaries as institutionalized during the period from June 1998 through May 1999. During this period, United was implementing a new tracking system for beneficiaries and United staff made errors by filing enhanced rate claims for beneficiaries that were not institutionalized.

Institutional status requirements 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. We identified 33 beneficiaries who were admitted or discharged during the required 30-day residency period, and one beneficiary who was residing in a facility that was not certified for Medicare or Medicaid.

We also questioned institutional payments for 28 beneficiaries for reasons related to hospital stays. Medicare continues to pay the institutional rate while an enrolled member is temporarily absent from the institutional facility for hospital stays of less than 15 days. We identified 17 beneficiaries with hospital visits exceeding 15 days, and 11 beneficiaries who did not return to the institutional facility following a hospital stay.

Current internal control procedures, implemented in January 2000, for verifying the institutional residency of Medicare beneficiaries enrolled in the Plan are adequate. United staff members contact the institutional facilities monthly to verify each beneficiary's residency. United has received only two Medicare overpayments resulting from an incorrect residency verification since the current procedures were implemented.

In December 1998, United submitted adjustments to CMS reversing the institutional overpayments for 52 of the beneficiaries identified in our review. The adjustments have not been processed.

RECOMMENDATIONS

We recommend that United Healthcare refund the identified overpayments totaling $121,023. We are making no recommendations related to internal controls because United's current procedures for verifying institutional residency are adequate.

AUDITEE COMMENTS AND OIG RESPONSE

In their July 10, 2002 response to our draft report, United officials provided the following comments:

- United has submitted adjustments to CMS reversing the institutional payments for all 69 beneficiaries for which there was no evidence of institutional residency.

- United staff conducted an internal reconciliation of selected beneficiaries questioned in the draft report and contended that 33 of the institutional payments were allowable.

Additional comments by United officials have been omitted because they concern issues no longer included in our report.

We reviewed the additional documentation for the 33 payments, that United believed were allowable, and concluded that eight of the 33 payments were appropriate. We changed our determinations for those eight. The documentation provided for the remaining 28 payments did not alter our findings.

In addition, United officials requested that our audit report and their response be considered proprietary and, therefore, not subject to disclosure under the Freedom of Information Act. We do not believe the information contained in the report qualifies for exemption under the Act and cannot agree to this request. United's complete response is included with this report as Appendix A.

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Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

APPENDIX

OVATIONS
A UnitedHealth Group Company

Kenneth Nunez, Director, Medicare Operational Compliance
8095 NW 12th Street 2nd Floor, Miami, FL 33126
Tel: 305-639-2012 Fax: 305-639-1735
Email: kenneth_r_nunez@uhc.com

July 10, 2002

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

Re: Review of Medicare Payments for Beneficiaries with Institutional Status
UnitedHealthcare of Florida- H9011
Common Identification Number: A-05-01-00091

Dear Mr. Shaner:

This is in response to the draft report received on June 11, 2002. Our review of the findings are addressed as follows:

- The 69 beneficiaries that had no evidence of institutional residency have been submitted to CMS for adjustment through regional office letters. The majority of these letters were sent in a December 1998 ROL and additional ROLs were submitted in December 2001 and January 2002, which captures all 69 beneficiaries.

- The 66 beneficiaries that were identified as inappropriately reported as institutionalized for several reasons (i.e. did not return from the hospital, domicilary care, over 15 day hospital stay and admit or discharge in first or last 30 days) have gone through an internal reconciliation process. We were able to identify several beneficiaries that were appropriately reported, thus we were entitled to the enhanced payment. Out of the total 80 overpayment months identified by the OIG, we were able to capture 33 months that we were entitled to the enhanced payments. These 33 months result in $13,756.77 of entitled payments. Regional Office Letters will be generated for the remainder 47 overpayment months within the next two weeks. Attached to our response are the corresponding spreadsheets that detail our reconciliation process. We respectfully request that your final report reflect our findings.

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- The 143 beneficiaries that incurred a temporary absence during the first 30 days of residency are valid based on section 170.2 of Chapter 7 of CMS' Medicare Managed Care Manual. Our interpretation of this section of the Manual has been confirmed by Anne Hornsby, Division of Program Policy, Center for Beneficiary Choices at CMS. She confirmed that there is no "initial qualifying period" in which a temporary absence is not allowed. Please see attached email from Ms. Hornsby. Therefore, we believe that these 143 beneficiaries did meet the definition of institutional and the plan was entitled to the $90,761.21 in enhanced payments. We are hoping that you will contact CMS directly to resolve any differences in interpretation of this issue related to temporary absences.

In conclusion, with consideration of the above reconciliation, we respectfully request that the final audit report reflect total overpayments of $108,776.25.

Under the Freedom of Information Act, we request that all materials concerning the Review of Medicare Payments for Beneficiaries with Institutional Status be considered proprietary and not subject to disclosure, including your report/findings, and the Plan's responses.

We thank you for the opportunity to address these findings and for your consideration of our response. Should you have any questions or concerns please feel free to contact me at 305-639-2012.

Sincerely,

Debbie Fishamber on behalf of Kenneth Nunez

Kenneth Nunez

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