Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

HUMANA HEALTH PLAN

JUNE GIBBS BROWN
Inspector General

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION V
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OFFICE OF
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Barry Averill, Vice President
Humana Health Plan
30 South Wacker Drive
Chicago, Illinois 60606

Dear Mr. Averill:

This report provides the results of our audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status." Our objective was to determine if capitation payments to Humana Health Plan (H1406) were appropriate for beneficiaries reported as institutionalized.

We found that Medicare payments to Humana for beneficiaries reported as institutionalized were generally correct. Our results are based on a statistical sample of 100 Medicare beneficiaries reported as institutionalized during the period October 1, 1994 through September 30, 1996. We determined the beneficiaries in our sample were correctly reported as institutionalized, with the exception of minor errors. The positive results are attributed to Humana's procedures for verifying the institutional status of its beneficiaries.

INTRODUCTION

BACKGROUND

A health maintenance organization (HMO) is a legal entity that provides or arranges for basic health services for its enrolled members. An HMO can contract with the Health Care Financing Administration (HCFA) to provide medical services to Medicare beneficiaries. Medicare beneficiaries enrolled in HMOs receive all services covered by Parts A and B of the program.

Under risk-based contracts, HCFA makes monthly advance payments to HMOs at the per capita rate set for each enrolled beneficiary. The rates are set at 95 percent of the expected fee-for-service costs that would have been incurred by Medicare had beneficiaries not enrolled in HMOs.

A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. Requirements for institutional status are met if a Medicare beneficiary has been a resident of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital or domiciliary home for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month. Risk contract HMOs are required to submit to HCFA each month a list of enrollees meeting the institutional status requirements. The advance payments

received by HMOs each month are subsequently adjusted to reflect the enhanced reimbursement for institutional status. For example, during 1996 HMOs received a monthly advance payment of $443 for each non-Medicaid female beneficiary, age 80 to 84, residing in a non-institutional setting in Du Page County, Illinois. The Medicare payment to HMOs for a similar beneficiary living in an institutional setting was $834. The monthly advance payment of $443 would have been adjusted to $834 after the beneficiary was reported to HCFA as having institutional status.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. The objective was to determine if capitation payments to Humana were appropriate for beneficiaries reported as institutionalized.

A simple random sample of 100 was selected from a universe of 635 Medicare beneficiaries reported as institutionalized by Humana during the period October 1994 through September 1996. From Humana, we obtained the names and addresses of the institutions in which the beneficiaries in the sample resided. Confirmation letters were sent to institutional facilities to verify that the sample beneficiaries were institutionalized for the periods Humana reported to HCFA. Based on responses received from institutional facilities, we identified Medicare beneficiaries who were incorrectly reported as having institutional status. For each incorrectly reported beneficiary, we calculated the Medicare overpayment by subtracting the non-institutional payment that Humana should have received from the institutional payment actually received. We also conducted a review of Humana's internal controls focusing on procedures for verifying the institutional status of Medicare beneficiaries.

Our audit field work was performed from January through August 1997 at Humana and HCFA offices in Chicago, Illinois, and our field office in Columbus, Ohio.

RESULTS OF AUDIT

Medicare payments made to Humana for beneficiaries reported as institutionalized were generally correct. The dates of residency obtained from institutional facilities support Humana's claims of institutional status, except for minor errors. Medicare overpayments resulting from six beneficiaries incorrectly reported as institutionalized were immaterial. Humana records show that clerical errors and incorrect dates of residency provided by institutional facilities caused the minor incidents of incorrect reporting of institutional status found in our sample.

The staff at Humana was generally able to accurately verify the institutional status of the Medicare beneficiaries enrolled in the HMO. Humana's procedures require that all institutional facilities be contacted by telephone prior to submitting the monthly list of institutionalized members to HCFA. The facilities are asked to confirm that Medicare beneficiaries were present for the 30 days prior to first day of the current month.

RECOMMENDATIONS

Because of the positive results of our review, no recommendations are necessary.

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Any questions or comments on any aspect of the report are welcome. Please address them to Frank Polasek at (312) 353-7896. To facilitate identification, please refer to Common Identification Number A-05-97-00009 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services