Memorandum

Date JUN 22 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Humana's $21.7 Million Underpayment Claim for Beneficiaries Classified as Residing Outside the Plan's Service Area (A-06-99-00060)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

Attached are two copies of our final report entitled, "Review of Humana's $21.7 Million Underpayment Claim for Beneficiaries Classified as Residing Outside the Plan's Service Area."

The basis of the claim from Humana, Inc. (Humana), a national managed care organization chain with several risk contracts with the Centers for Medicare and Medicaid Services (CMS) was the assertion that CMS based its payments for enrolled Medicare beneficiaries on incorrect State and county codes resulting in a net underpayment to Humana. The CMS requested that the Office of Inspector General, Office of Audit Services verify Humana's claim.

We estimated that Humana's underpayment claim of about $21.7 million should be reduced by at least $12.2 million as follows:

- Based on our verification of the claim data submitted by Humana and the results of our analysis of supporting data on random items selected from the claim, we estimated a $11.5 million reduction for:
  - about $1.3 million in duplicate items in the claim and for beneficiaries not enrolled in a Humana plan, and
  - an estimated $10.2 million that was not supported by Humana's records.
- An additional reduction of $691,579 should be made for items that were not included in Humana's claim, but should have been considered in its underpayment assertion. Humana did not include: (1) a population of 702 beneficiaries identified by CMS' Group Health Plan (GHP) system as out of area and (2) an overpayment identified by Humana for incorrect

payments for beneficiaries classified by both Humana and CMS as residing in area, but in different counties. The specific additional reductions are as follows:

- < $117,695 was based on the results of our review of 30 random items selected from 702 beneficiaries identified by CMS' GHP system as out of area but not included in Humana's claim, and

- < $573,884 that Humana identified and removed from its original claim for beneficiaries classified by Humana and CMS as residing in area.

We recommended that CMS:

- < reduce the claim by at least $11.5 million for unsupported or invalid items in the claim;

- < make an additional reduction to the claim of $117,695 for beneficiaries identified by CMS as out of area but were not included in the claim;

- < make a further reduction to the claim to account for the overpayment of $573,884 that Humana identified and removed from its original claim; and

- < conduct additional audit work for the 702 beneficiaries identified on CMS' GHP system as out of area, but were not included in Humana's claim.

These reductions result in a net underpayment to Humana of about $9.5 million, not the $21.7 million originally claimed. We recommended that CMS not settle for this amount until further evaluation of the 702 beneficiaries is completed. We believe that the effect of this evaluation will further reduce Humana's claim. We submitted to CMS, under separate cover, a list of the beneficiaries with all identifying information.

We also recommended that CMS establish stringent guidelines for accepting additional documentation from Humana for claims that should be fully developed and supportable before submission to CMS. As part of our audit work, we required Humana to provide us with all of the supporting documentation for our sampled items from their claims within a reasonable time period, which Humana agreed to. We expected all of the supporting documentation to be ready for our on-site review at Humana's offices. Humana officials assured us on more than one occasion that they had ample time to gather the information and that all of the documentation was provided to us for our sample items at the time of our on-site review. However, subsequent to our work at Humana's offices, Humana provided us with additional supporting documentation 5 months after our on-site visit for sample items which we initially determined to be unsupported.

Although we felt this was unreasonable on Humana's part, per CMS' request, we reviewed the additional documentation and made the necessary changes to our draft report increasing the net underpayment to Humana from $5.5 million to $9.5 million. However, any subsequent documentation that Humana provides, that they believe is relevant, will need to be reviewed/adjudicated by CMS.

The CMS agreed with our evaluation of the claim and recommendations. Based on our report, Humana's claim of $21.7 million was reduced by $12.2 million. The CMS paid an interim amount of $5.5 million to Humana. The CMS will continue its review of Humana's documentation to determine the final payment amount and avoid any overpayment to Humana. The CMS' adjudication of the claim could result in an additional reduction of $4 million. The complete text of CMS' response is presented as APPENDIX E to this report.

Please note that the attached report was fully processed before the name change was made from the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). Thus, references are made to HCFA.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-06-99-00060 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HUMANA'S $21.7 MILLION UNDERPAYMENT CLAIM FOR BENEFICIARIES CLASSIFIED AS RESIDING OUTSIDE THE PLAN'S SERVICE AREA

JUNE 2001
A-06-99-00060

Memorandum

Date JUN 22 2001

From Michael Mangano

Michael F. Mangano
Acting Inspector General

Subject Review of Humana's $21.7 Million Underpayment Claim for Beneficiaries Classified as Residing Outside the Plan's Service Area (A-06-99-00060)

To

Thomas Scully
Administrator
Health Care Financing Administration

This final report presents the results of our audit of the underpayment claim of about $21.7 million for the 75-month period ending December 31, 1997 made by Humana, Inc. (Humana), a national managed care organization (MCO) chain under risk contracts with the Health Care Financing Administration (HCFA). The basis of the claim was Humana's assertion that HCFA based its payments for enrolled Medicare beneficiaries on incorrect State and county codes (SCC) resulting in a net underpayment to Humana. The HCFA requested that the Office of Inspector General (OIG), Office of Audit Services (OAS) verify Humana's claim.

We estimated that Humana's underpayment claim of about $21.7 million should be reduced by at least $12.2 million considering the additional documentation provided by Humana. The specific reductions are as follows:

- Based on our verification of the claim data submitted by Humana and the results of our analysis of supporting data on random items selected from the claim, we estimated a $11.5 million reduction for:
  - about $1.3 million in duplicate items in the claim and for beneficiaries not enrolled in a Humana plan, and
  - an estimated $10.2 million that was not supported by Humana's records.
- An additional reduction of $691,579 should be made for items that were not included in Humana's claim, but should have been considered in its underpayment assertion. Humana did not include: (1) a population of 702 beneficiaries identified by HCFA's Group Health Plan (GHP) system as out of area and (2) an overpayment identified by Humana for incorrect payments for beneficiaries classified by both Humana and HCFA as residing in area, but in different counties. The specific additional reductions are as follows:

- < $117,695 based on the results of our review of 30 random items selected from 702 beneficiaries identified by HCFA's GHP system as out of area but not included in Humana's claim, and

- < $573,884 that Humana identified and removed from its original claim for beneficiaries classified by Humana and HCFA as residing in area.

We recommended that HCFA:

- < reduce the claim by at least $11.5 million for unsupported or invalid items in the claim;

- < make an additional reduction to the claim of $117,695 for beneficiaries identified by HCFA as out of area but were not included in the claim;

- < make a further reduction to the claim to account for the overpayment of $573,884 that Humana identified and removed from its original claim; and

- < conduct additional audit work for the 702 beneficiaries identified on HCFA's GHP system as out of area, but were not included in Humana's claim.

These reductions result in a net underpayment to Humana of about $9.5 million, not the $21.7 million originally claimed. We recommended that HCFA not settle for this amount until further evaluation of the 702 beneficiaries is completed. We believe that the effect of this evaluation will further reduce Humana's claim. We submitted to HCFA, under separate cover, a list of the beneficiaries with all identifying information.

We also recommended that HCFA establish stringent guidelines for accepting additional documentation from Humana for claims that should be fully developed and supportable before submission to HCFA. As part of our audit work, we required Humana to provide us with all of the supporting documentation for our sampled items from their claims within a reasonable time period, which Humana agreed to. We expected all of the supporting documentation to be ready for our on-site review at Humana's offices. Humana officials assured us on more than one occasion that they had ample time to gather the information and that all of the documentation was provided to us for our sample items at the time of our on-site review. However, subsequent to our work at Humana's offices, Humana provided us with additional supporting documentation 5 months after our on-site visit for sample items which we initially determined to be unsupported.

Although we felt this was unreasonable on Humana's part, per HCFA's request, we reviewed the additional documentation and made the necessary changes to our final report increasing the net underpayment to Humana from $5.5 million to $9.5 million. However,

any subsequent documentation that Humana provides, that they believe is relevant, will need to be reviewed/adjudicated by HCFA.

The HCFA agreed with our evaluation of the claim and recommendations. Based on our report, Humana's claim of $21.7 million was reduced by $12.2 million. The HCFA paid an interim amount of $5.5 million to Humana. The HCFA will continue its review of Humana's documentation to determine the final payment amount and avoid any overpayment to Humana. The HCFA's adjudication could result in an additional claim reduction of $4 million. The complete text of HCFA's response is presented as APPENDIX E to this report.

INTRODUCTION

BACKGROUND

Managed care plans provide comprehensive health services on a prepayment basis to enrolled individuals. Medicare beneficiaries have the option to enroll in MCOs which contract with HCFA to furnish all medically necessary services covered under the Medicare program. Legislation allowed the Medicare program to contract with MCOs since 1972.

The major Medicare managed care program, the Medicare risk contract program, dates back to 1982 when the Congress enacted the Tax Equity and Fiscal Responsibility Act. This legislation was implemented in 1985 and gave Medicare enrollees the option to enroll in risk-based MCOs. Under the Medicare risk-based program, MCOs assumed responsibility for providing all Medicare-covered services in return for a predetermined capitated payment. The capitated payment varied according to the State and county in which the beneficiary resided. The monthly capitated payment was set at 95 percent of the estimated average cost to Medicare in the fee-for-service sector in a given county.

Prior to the Balanced Budget Act (BBA) of 1997, MCOs were required to disenroll a beneficiary who moved permanently out of its service area. An uninterrupted absence of more than 90 days was deemed to be a permanent move. However, MCOs could have elected to retain a beneficiary who is absent from its service area for more than 90 days but less than a year. The BBA of 1997 relaxed the requirement for residing in the plan's geographic area. Beneficiaries who moved out of a plan's service area may have been allowed to remain enrolled in the plan, provided the plan granted reasonable access to the full range of covered services as part of the basic benefit package.

Humana, a national chain MCO, provided Medicare health care services under risk contracts with HCFA. During the period covered under this review, Humana entered into risk-based contracts in the following areas: Arizona, the District of Columbia, Florida, Illinois, Kentucky, Missouri, Nevada, Ohio, and Texas.

The HCFA paid plans under risk contracts based on the beneficiary's county of record in its GHP system. The source data for the beneficiary's county is the SCC recorded by the Social Security Administration (SSA) in the Master Beneficiary Record (MBR) used in the SSA benefit payment systems. The SSA's MBR updates HCFA's Enrollment Data Base (EDB) system on a daily basis. The EDB provides data to HCFA's GHP system.

Each month HCFA provided risk-based plans with a listing of beneficiaries with addresses outside the plan's service area on a status report. For our audit period, Medicare's regulations and Humana's policies and procedures required MCOs to disenroll beneficiaries who were out of area more than 90 days.

OBJECTIVE AND SCOPE

Objective

The objective of this review was to verify the underpayment claim totaling about $21.7 million made by Humana. The basis of the claim was Humana's assertion that HCFA made payments for Medicare beneficiaries with incorrect SCCs resulting in a net underpayment to the plan. The HCFA requested that the OIG/OAS verify Humana's claim.

Scope

Our audit was performed in accordance with generally accepted government auditing standards. We limited consideration of the internal control structure to those controls concerning the claim. The internal control review was limited to obtaining an understanding of Humana's and HCFA's enrollment, disenrollment, and address validation processes. Our site work was conducted at Humana's centralized enrollment office in Louisville, Kentucky during October 1999, November 1999, February 2000, and March 2000. We also conducted audit work at the OIG/OAS headquarters in Baltimore, Maryland and the field office in Austin, Texas during the period April 2000 through October 2000.

Humana claimed a net underpayment of about $21.7 million for the period October 1, 1991 through December 31, 1997. Humana originally calculated a net underpayment of about $24.2 million and then reduced it by payment adjustments totaling about $2.5 million which were made by HCFA for SCC retroactive corrections. Member months with a retroactive adjustment were not removed from our sample populations because Humana could not identify the lump sum retroactive adjustment to individual member months. Retroactive adjustments in our sample were treated as non-errors.

Based on our validation testing of the detailed data submitted by Humana to support its claim, we revised Humana's claim from about $24.2 million to about $22.8 million because the claim submitted contained errors which are explained in APPENDICES A and A-1. For the purposes of our review, the revised data totaling about $22.8 million was separated into

two populations: underpayments (where Humana claimed additional Medicare funds) and overpayments (where Humana claimed it was overpaid Medicare funds). The underpayment population totaled about $27.9 million and the overpayment population totaled about $5 million. We also identified a third population totaling about $2.6 million for 213 beneficiaries that HCFA's system showed as out of area for more than 12 consecutive months that Humana did not include in its claim.

Using statistical sampling, we randomly selected 148 and 115 member months from the underpayment and overpayment populations, respectively, and extrapolated the test results using a variables appraisal sampling program. Each member month was considered a claim made by Humana. For the third population, we selected a probe sample of 30 beneficiaries, but did not extrapolate the test results because our sample methodology did not meet our extrapolation criteria. We did not select any additional samples from the third population due to time constraints. The HCFA agreed with our sampling plans which are described in APPENDICES B-2 and B-3. See APPENDIX A for a complete description of our methodology used in reviewing selected items.

Formal notification of the findings will be delivered to the contractor by HCFA. Therefore, we did not obtain written comments from Humana. However, we did brief Humana on our audit findings.

FINDINGS AND RECOMMENDATIONS

We estimated that Humana's underpayment claim of about $21.7 million should be reduced by at least $12.2 million to a value of $9.5 million after considering the additional documentation provided by Humana. However, if HCFA deems the additional documentation unacceptable, this amount would be adjusted accordingly. See APPENDIX C for a summary of the OIG recommended claim amount.

Humana's claim contained errors because it did not apply proper edit checks to its claim data and Humana did not provide the supporting documentation required to substantiate its full claim. Also, Humana did not include in its claim a population of beneficiaries that should have been included. Humana did not consistently follow its procedures for sending beneficiaries notification that their address on record was outside the service area, and for disenrolling beneficiaries who were out of area for more than 90 consecutive days. These Humana procedures were designed to implement Medicare's regulations and the health maintenance organization (HMO) manual instructions.

Discussion of Humana's Claim Methodology and Supporting Documentation

Humana's Claim Preparation Methodology

Humana developed its claim by using a computer match which compared HCFA's SCC to Humana's SCC for each member month. If the SCCs were different, then Humana calculated an overpayment or underpayment. In our opinion, Humana's computer match methodology applied the assumption that HCFA's SCC of record was inaccurate and Humana's SCC was correct for payment purposes without consideration of the required supporting documentation to substantiate its claim.

Based on our review, we found Humana did not verify the accuracy of its SCC of record before making its claim to HCFA. Humana's claim was established by using a computer match and then working backwards into what information it could provide for items sampled for the audit. Humana did not gather the supporting documentation for its claim until we selected sample items for review. Humana's claim submitted to HCFA only included listings of what Humana's records showed as the correct county. Humana did not submit to HCFA any enrollment applications, correspondence with the member or his/her family or power of attorney, out-of-area letters sent to the members, or any other address verification documents to substantiate its claim. If Humana had based its claim on this type of evidence, rather than a computer match, then it would not have included members who were residing out of area based on member contacts recorded on Humana's system. Humana also would not have included members whose residency was not verified. In other words, Humana made no attempt to validate the accuracy of its computer match with supporting documentation.

Supporting Documentation Not Provided on a Timely Basis

The following events show that Humana did not provide all of the supporting documentation for our review on a timely basis.

During our meeting with HCFA and Humana in July 1999, we discussed the documentation criteria and the use of sampling to audit the claim. Humana's Chief Operating Officer stated that they were ready for our audit and assured us on several occasions that Humana had all of the supporting documentation ready for our review. Humana officials estimated that it would take about 65 hours to retrieve the information from their files for 100 claims. However, it became apparent that Humana would need additional time to provide the required documentation for our review of our probe sample.

During our on-site visit in October 1999 for the probe sample review, Humana could not provide supporting documentation for most of the sample items because Humana's computer had been damaged by lightning and data had been purged from their system prior to 1993.

We left the audit site until Humana could locate the information. We returned 2 weeks later when a Humana official stated that they had all of the information except what was purged prior to 1993. We used the results of the probe review to determine the sample sizes for our regular sample selections. Because of the problems we experienced during our probe review, we established cut-off dates for providing supporting documentation for our regular samples. These dates were agreed with by Humana officials. During our on-site visits in February and March 2000, we were assured by a Humana official that they had ample time to gather the supporting documentation, and that all of the records were provided to us and were ready for our review. However, during our meetings with Humana in August and September 2000, Humana provided us with additional supporting documentation for sample items that we initially determined to be unsupported.

Disenrollment Criteria

For our audit period, Humana was required to disenroll a beneficiary who moved permanently out of its service area. Under 42 CFR 417.460 and section 2004.3 of the Medicare HMO Manual, an uninterrupted absence of more than 90 days is considered to be a permanent move. In accordance with these Medicare requirements, Humana's policies and procedures during our audit period prescribed an involuntary disenrollment for beneficiaries who moved permanently out of area for more than 90 days. According to Humana's procedures, the following sources of information are valid grounds for involuntary disenrollment:

- conversation with beneficiary,
- medical claims not being paid for routine care provided out of the service area, indicating an absence of more than 90 days, and
- return of certified letters sent to the beneficiary.

Humana's policies and procedures required that certified letters be sent to the beneficiary to confirm residency and to provide notification that his/her new address on record was outside the service area. The language in the certified letter Humana used stated that, "If you have been outside of our service area for more than 90 days, HCFA requires that you disenroll from the plan." For beneficiaries with a SCC change identified by HCFA, Humana's procedures required that a disenrollment be processed at the end of 90 days unless the beneficiary responded as not being out of area.

Of the 148 sample items reviewed from the *underpayment* population, 39 items had a SCC change after enrollment in the plan to an out-of-area status. For 21 of these 39 items, Humana did not provide evidence of action taken to resolve the out-of-area status that was reported by HCFA monthly. Humana did not provide documentation to show that out-of-area letters were sent or members were contacted to verify the correct address. In addition,

Humana did not show that an address verification was conducted upon enrollment for 36 of the items reviewed.

Of the 115 sample items reviewed from the *overpayment* population, 30 items had a SCC change after enrollment in the plan to an out-of-area status. For 20 of these 30 items, Humana did not provide evidence of action taken to resolve the out-of-area status that was reported by HCFA monthly. Humana did not provide documentation to show that out-of-area letters were sent or members were contacted to verify the correct address. In addition, Humana did not show that an address verification was conducted upon enrollment for 23 of the items reviewed.

OIG's Calculation of Adjustment to the Humana Claim

RESULTS OF OIG'S REVIEW OF CLAIM AS SUBMITTED

Based on our verification of the claim data submitted by Humana and the results of our analysis of supporting data on random items selected from the claim, we estimated a $11.5 million reduction to Humana's claim as follows:

- Issue 1: About $1.3 million reduction for duplicate items in the claim and for beneficiaries not enrolled in a Humana plan, and

- Issue 2: An estimated $10.2 million reduction because the claims were not supported by Humana's records.

Issue 1: Errors in the Claim Submission

Our analysis of the file provided by Humana officials identified a number of errors resulting in a reduction in the claim amount of about $1.3 million due to duplicate claims and beneficiaries who were not enrolled in Humana. The type of errors in the file were:

- 431 claims totaling $27,468 that involved duplicate entries for the same beneficiary (based on the health insurance claim number) and the same month.

- 2,630 claims totaling $158,644 that involved beneficiaries with no enrollment history with Humana during the claim period.

- 15,186 claims totaling $1,146,438 that involved beneficiaries who did have an enrollment history with Humana during the claim period, but not for the particular month claimed.

Issue 2: Sample Review Results

Based on our test of random items selected from the *underpayment* and *overpayment* populations used by Humana, we estimated a reduction to Humana's claim of about $10.2 million.

Underpayment Sample Results

Based on our random sample of 148 claims, we estimated that Humana was underpaid about $21.1 million rather than the claimed amount of about $27.9 million for the underpayment population, resulting in a reduction of about $6.8 million to Humana's claim. Humana was originally paid about $91.8 million for the underpayment population, however, we estimated that the payment should have been about $112.9 million. Of the 148 sample claims we reviewed, 105 claims were valid for beneficiaries who resided inside the plan's service area, 24 were incorrect or unsupported, and the remaining 19 involved retroactive adjustments to an in-area status. Of the 24 claims:

- 9 were for beneficiaries who resided inside the plan's service area but Humana miscalculated the claim amount or used the wrong SCC,
- 5 were for beneficiaries who resided out of area and should have been disenrolled after 90 days, and
- 10 were not supported because Humana did not provide us sufficient documentation to determine the beneficiaries' place of residence for the sampled month.

Overpayment Sample Results

Based on our random sample of 115 claims, we estimated that Humana was overpaid $8.4 million rather than the claimed amount of about $5 million for the overpayment population, resulting in a reduction of about $3.4 million to Humana's claim. Humana was paid about $37.5 million for the overpayment population, however, we estimated that the payment should have been about $29.1 million. Of the 115 sample claims reviewed, 76 were valid for beneficiaries who resided inside the plan's service area, 30 were incorrect or unsupported, and the remaining 9 involved retroactive adjustments to an in-area status. Of the 30 claims:

- 5 were for beneficiaries who resided inside the plan's service area but Humana miscalculated the claim amount or used the wrong SCC,

- 8 were for beneficiaries who resided out of area and should have been disenrolled after 90 days, and

- 17 were unsupported because Humana did not provide sufficient documentation to determine the beneficiaries' place of residence for the sampled month.

ADDITIONAL ADJUSTMENT NEEDED BASED ON INFORMATION NOTED BY OIG BUT NOT INCLUDED IN HUMANA'S CLAIM AS SUBMITTED

The net underpayment claim submitted by Humana needs to be reduced by an additional $691,579 for items that were not included in Humana's claim, but should have been considered in Humana's underpayment assertion. Humana did not include: (1) a population of 702 beneficiaries identified by HCFA's GHP system as out of area, and (2) an overpayment identified by Humana for incorrect payments for beneficiaries classified by both Humana and HCFA as residing in area, but in different counties. The specific additional reductions were as follows:

- Issue 3: $117,695 based on the results of our review of random items selected from beneficiaries identified by HCFA's GHP system as out of area but not included in Humana's claim, and

- Issue 4: $573,884 which Humana identified and removed from its original claim for beneficiaries classified by Humana and HCFA as residing in area.

Issue 3: Beneficiaries Reported Out of Area by HCFA

The review of 30 beneficiaries who were identified on HCFA's GHP system as being out of area during the claim period but were not included in the claim showed a net overpayment of $117,695. According to Humana's methodology for constructing the original claim, it only included those beneficiaries where Humana's records and HCFA's records did not match. We constructed an out-of-area universe of beneficiaries for which Humana and HCFA had the same out-of-area SCC recorded, but Humana did not include these beneficiaries in its underpayment claim:

- 702 beneficiaries were identified as being out of area in Humana plans more than 3 consecutive months, and

- 213 of the 702 beneficiaries were identified as being out of area in Humana plans for more than 12 consecutive months.

Medicare payments for the 213 beneficiaries totaled about $2.6 million. The review of 30 beneficiaries randomly selected from this population showed a net overpayment to Humana of $117,695. Of the 30 beneficiaries reviewed, 14 resided in the service area, 6 resided outside the service area and should have been disenrolled. Three beneficiaries resided out of area but were enrolled in Humana's commercial plan immediately prior to their Medicare entitlement, therefore, we accepted HCFA's payment in accordance with 42 CFR 417.432. The out-of-area periods for the six out-of-area beneficiaries who should have been disenrolled after 90 days ranged from 13 to 41 months. For the remaining seven beneficiaries, a determination could not be made as to where the beneficiary resided based on the supporting documentation Humana provided. Due to time constraints, these results were not extrapolated as part of the OIG review, but we recommended that HCFA continue to review these 702 cases.

Issue 4: Overpayment Removed From Humana's Original Claim

The original underpayment claim Humana provided to HCFA totaled about $23.6 million. Humana developed its claim by using a computer match which compared the SCCs from HCFA's data to the SCCs from Humana's records for each member month. If discrepancies were noted between HCFA's data and Humana's records, then Humana calculated an overpayment or underpayment. This methodology captured SCC discrepancies for beneficiaries recorded as residing both within and outside Humana's approved service area.

Based on meetings we had with HCFA staff, the scope of the audit was limited to those SCC discrepancies outside of Humana's service area. The claim was modified to remove any SCC discrepancies within the Humana service area, that is, between counties already in Humana's service area. To omit in-area SCC discrepancies, Humana removed an overpayment of $573,884 identified in its original claim for the period of July 1, 1995 through December 31, 1997, and submitted a revised underpayment claim of about $24.2 million. We believe that the overpayment amount for in-area SCC discrepancies should be accounted for as a reduction to the claim amount.

The Effect of Additional Documentation Supplied by Humana

Based on the supporting documentation provided by Humana at the time of our on-site visits during February and March 2000, we determined that Humana's underpayment claim of about $21.7 million should have been reduced to about $5.5 million. (See APPENDIX D for the specific reductions.) For our on-site visit, we established a timeline for Humana to provide the required supporting documentation because of the problems we experienced in obtaining information for our initial probe testing. Humana was more than agreeable with the established timeline. During our on-site visits, we were assured by Humana that it had ample time to gather the supporting documentation, and that all of the required records were provided for the sample items selected from the claim. However, during our meetings with Humana in August and September 2000, Humana provided additional supporting

documentation for sample items that we initially determined to be unsupported, increasing the net underpayment to Humana to about $9.5 million. The additional documentation provided by Humana, which was not available at the time of our initial audit work, had a $4 million impact on the claim. The estimated $14.2 million (see APPENDIX D) reduction based on our review of random items selected from the claim will be adjusted to $10.2 million (see APPENDIX C) if the additional evidence offered by Humana is taken into consideration by HCFA.

CONCLUSION

Humana's underpayment claim to HCFA of about $21.7 million should be reduced by at least $12.2 million to a value of $9.5 million considering the additional documentation provided by Humana. However, if HCFA deems the additional documentation unacceptable, this amount would be adjusted accordingly.

The review of the claim data provided by Humana showed that Humana's estimate of the value of the underpayment (or amount due from Medicare) was overstated because of four issues. First, it was overstated by about $1.3 million because it contained duplicate claims and beneficiaries not enrolled in Humana. Second, extrapolating the results of a random sample of items selected from Humana's claim, we estimated an additional overstatement of $10.2 million. We attained our estimate using a variables appraisal sampling program and reporting the midpoint estimates and 95 percent confidence intervals (see APPENDIX B-1). Third, another overpayment value of $117,695 was associated with beneficiaries who were identified on HCFA's GHP as being out of area during the claim period, but were not included in Humana's claim. And fourth, an additional overpayment of $573,884, identified by Humana, was removed from the claim for beneficiaries classified by Humana and HCFA as residing within Humana's service area, but different counties. As a summary of these four issues, APPENDIX C details the reductions we recommended be made to Humana's claim amount.

Humana's claim contained errors because Humana did not apply proper edit checks to its claim data and did not ensure that it provided the supporting documentation required to substantiate its claim. In addition, Humana did not consistently follow its procedures for sending beneficiaries notification that their address on record was outside the service area, and for disenrolling beneficiaries who were out of area for more than 90 consecutive days. These Humana procedures were designed to implement Medicare's regulations and the HMO Manual instructions.

RECOMMENDATIONS

We recommended that HCFA:

- reduce the Humana underpayment claim by at least $11.5 million for unsupported or invalid items in the claim;

- make an additional reduction to the claim of $117,695 for beneficiaries identified by HCFA as out of area but were not included in the claim;

- make a further reduction to the claim to account for the overpayment of $573,884 which Humana identified and removed from its original claim; and

- conduct additional audit work for the 702 beneficiaries identified on HCFA's GHP system as out of area, but were not included in Humana's claim.

The reductions in the first three bullets above result in a net underpayment to Humana of about $9.5 million (the original claim of $21.7 million less about $12.2 noted above). We recommended that HCFA not settle for this amount until further evaluation of the 702 beneficiaries is completed. We believe that the effect of this evaluation will further reduce Humana's claim.

We also recommended that HCFA establish stringent guidelines for accepting additional documentation from Humana for claims that should be fully developed and supportable before submission to HCFA. As part of our audit, we required Humana to provide us with all of the supporting documentation for our sample items from their claims within a reasonable time period, which Humana agreed with. We expected all of the supporting documentation to be ready for our on-site review at Humana's offices. Humana officials assured us on more than one occasion that they had ample time to gather the information, and that all of the documentation was provided to us for our sample items at the time of our on-site review. However, subsequent to our work at Humana's offices, Humana provided us with additional supporting documentation 5 months after our on-site visit for sample items which we initially determined to be unsupported.

Although we felt this was unreasonable on Humana's part, per HCFA's request, we reviewed the additional documentation and made the necessary changes to our final report increasing the net underpayment to Humana from $5.5 million to $9.5 million. However, any subsequent documentation that Humana provides that they believe is relevant will need to be reviewed/adjudicated by HCFA.

HCFA'S COMMENTS

The HCFA agreed with our evaluation of the claim and recommendations. Based on our report, HCFA paid Humana an interim payment adjustment of $5.5 million. The HCFA will continue its review of Humana's documentation to determine the final payment amount and avoid any overpayment to Humana. In response to our recommendations, HCFA will: (1) pay the proper amount by requiring supporting documentation for each entry in the claim; (2) process data for the additional beneficiaries that were not included in Humana's claim, but which the OIG identified as additional cases; and (3) research the matter to determine how to resolve the issue. See APPENDIX E for the complete text of HCFA's comments.

OIG'S RESPONSE

Based on HCFA's positive response to our work, Humana's claim was reduced by $12.2 million subject to further evaluation. The HCFA's adjudication of the claim could result in an additional reduction of $4 million. We appreciated the opportunity to assist HCFA in reviewing Humana's claim. We look forward to working with HCFA in the future to resolve managed care issues.

METHODOLOGY

Humana's claim of $21,719,199 represented 400,514 member months from October 1, 1991 to December 31, 1997. Humana submitted its claim based on a calculated underpayment or overpayment per member month. Humana divided the claim population into the following two groups: (1) October 1, 1991 through June 30, 1995 and (2) July 1, 1995 through December 31, 1997.

Humana calculated a net underpayment of $24,181,729 and then reduced it by adjustments totaling $2,462,530 for SCC retroactive corrections. Member months with a retroactive adjustment were not removed from our sample populations because Humana could not identify the lump sum retroactive adjustment to individual member months. Retroactive adjustments in our sample were treated as non-errors.

Based on our validation testing of the detailed data submitted by Humana to support its claim, we revised Humana's claim (without the retroactive adjustments removed) from $24,181,729 with 400,514 member months to $22,840,573 with 378,284 member months. We made this revision to remove:

- $27,468 for 431 duplicate claims;
- $158,644 for 2,630 member months involving beneficiaries with no enrollment history with Humana;
- $1,146,438 for 15,186 member months with enrollment history with Humana, but not for the particular month claimed;
- 3,591 claims with a zero claimed amount; and
- $8,606 for 392 beneficiaries enrolled in Humana's Ohio and DC plans. We did not test claims under these two plans because the Ohio plan was not in existence until late 1997 and the DC plan is now out of existence.

For the purposes of our review, the revised data submitted by Humana totaling $22,840,573 was separated into two populations: underpayments (where Humana claimed additional Medicare funds) and overpayments (where Humana claimed it was overpaid Medicare funds). The underpayment population totaled $27,863,089 and the overpayment population totaled $5,022,516. We also identified a third population totaling about $2.6 million for 213 beneficiaries that HCFA's system showed as out of area for more than 12 consecutive months, which Humana did not include in its claim.

METHODOLOGY

Using statistical sampling, we randomly selected 148 and 115 member months from the underpayment and overpayment populations, respectively, and extrapolated the test results using a variables appraisal sampling program. For the third population, we selected a probe sample of 30 beneficiaries, but did not extrapolate the test results because our sample methodology did not meet our extrapolation criteria. We did not select any additional samples from the third population due to time constraints.

For each sampled item, we reviewed the supporting documentation provided by Humana to determine if Medicare payments made for the beneficiary included in the claim were correct, based on the beneficiary's actual place of residence. We requested the following supporting documentation as the basis to substantiate the beneficiary's address:

- enrollment application address verification, applicable to our sample period, as evidenced by either Humana's: (1) transaction report showing the verification control number listed on the application, (2) enrollment telephone verification script, or (3) inquiry control system-purged calls report;
- address verification letter completed by the beneficiary;
- Humana's electronic billings from the beneficiary's physician;
- hard copy of physician's billing;
- Humana's enrollment change or disenrollment form; or
- miscellaneous correspondence documented on inquiry control system-purged calls report.

We could not rely on the enrollment application alone for SCC changes that occurred more than 6 months after enrollment and before the sampled period. For beneficiaries flagged by HCFA as out of area upon enrollment, we accepted the enrollment application verification, alone, for proof of residency. We did not accept as evidence the listing of beneficiaries' addresses or the physician encounter data which were created in-house by Humana.

METHODOLOGY

We verified that the beneficiary's correct address was within Humana's service area and calculated the correct payment using: (1) HCFA's annual Adjusted Average Per Capita Cost rate book for Calendar Years 1991 through 1997; (2) listings of the approved SCCs for each of Humana's plans obtained from HCFA's Plan Information Control System; and (3) beneficiary information such as special status and date of birth obtained from HCFA's GHP system. When calculating the correct payment, we did not apply special status factors for the period October 1, 1991 through June 30, 1995 to be consistent with Humana's methodology used in computing its claim.

For beneficiaries in our samples who were residing outside Humana's service area, we accepted the HCFA payment as correct for the first 90 days of the out-of-area period. However, if our sample period was not within this 90-day period, then the correct payment was zero. We applied this same methodology to claims for which Humana did not provide us sufficient documentation to support where the beneficiary resided during the sample period. Humana was expected to provide sufficient documentation to support its claim.

APPENDIX A-1

RECONCILIATION OF CLAIM AMOUNT TO NET CLAIM AUDITED

Reconciliation

Claim Amount Before Adjustments	$24,181,729
Retroactive SCC Adjustments Made by HCFA	($ 2,462,530)
Net Amount Claimed by Humana	$21,719,199
Retroactive SCC Adjustments Not Removed from Claim Audited	2,462,530
Total Errors in Claim	($ 1,332,550)
Net Claim Audited	**$22,849,179**

Populations of Net Claim Audited

Underpayment Population	$27,863,089
Overpayment Population	$ 5,022,516
Net Population Audited	$22,840,573
Amount Not Audited	$ 8,606[1]
Net Claim Audited	**$22,849,179**

[1] The difference between the sample population amount and claim amount after adjustments for the errors in the claim was due to our excluding from our sample the claim amounts for the Ohio plan and the DC plan. We did not test claims under these two plans because the Ohio plan was not in existence until late 1997 and the DC plan was out of existence. Both plans combined represented an immaterial group in relation to the total amount of beneficiaries in the claim. We accepted the amount Humana claimed for these two plans and did not reduce the claim amount.

APPENDIX B-1

REVIEW OF HUMANA'S UNDERPAYMENT CLAIM

STATISTICAL SAMPLE INFORMATION FOR THE *UNDERPAYMENT* POPULATION

Population	Sample	Nonzero Differences	Total of Differences Values	Total of Adjusted Values
291,947 claims	148 claims	140 claims	-$11,698	$57,272
$91,843,222	$45,574			

PROJECTION OF SAMPLE RESULTS
95 Percent Confidence Interval

Point Estimate:	$112,975,243
Lower Limit:	$105,431,639
Upper Limit:	$120,518,848

STATISTICAL SAMPLE INFORMATION FOR THE *OVERPAYMENT* POPULATION

Population	Sample	Nonzero Differences	Total of Differences Values	Total of Adjusted Values
86,337 claims	115 Claims	100 claims	$8,161	$38,747
$37,544,913	$46,908			

PROJECTION OF SAMPLE RESULTS
95 Percent Confidence Interval

Point Estimate:	$29,089,691
Lower Limit:	$26,454,363
Upper Limit:	$31,725,018

SAMPLE PLAN FOR THE UNDERPAYMENT AND OVERPAYMENT POPULATIONS

Review Objective	The objective was to verify the Medicare underpayment claim made by Humana totaling about $22 million.
Population	The population was the Medicare member months that were included in Humana's underpayment claim. The claim is the net effect of underpayments and overpayments for Medicare members who were classified by HCFA as residing outside the plan's geographic service area. We derived two populations: one for the underpayments and one for the overpayments.
Sampling Frame	The sampling frame was the computer disk provided by Humana to support its claim. We tested the validity of the sampling frame.
Sample Unit	The sample unit was a Medicare member month defined as a beneficiary classified by HCFA as residing outside the plan's geographic service area for a particular month and year.
Sample Design	A single stage random sample was used.
Sample Size	A sample of 148 member months was selected from the underpayment population and a sample of 115 was selected from the overpayment population.
Method of Selecting Sample Items	Random numbers were generated and matched to the sequential numbers in the universe.
Estimation Methodology	Using the Department of Health and Human Services' Variables Appraisal Program, we made two projections of the amounts HCFA should have paid Humana: one for the underpayments and one for the overpayments.
How Results Will Be Reported	The results were reported at the midpoint estimates and the 95 percent confidence intervals.

APPENDIX B-3

PROBE SAMPLE PLAN FOR POPULATION EXCLUDED FROM THE CLAIM

Review Objective	The objective was to verify Medicare payments for beneficiaries with out-of-area SCCs that were enrolled in Humana, but were not included in its underpayment claim of about $22 million.
Population	The population was the Medicare beneficiaries enrolled in Humana with out-of-area SCCs reported by HCFA for more than 12 consecutive months, and who were not included in Humana's underpayment claim.
Sampling Frame	A computer file that compared Health Insurance Claim Numbers (HICN) on the computer disk provided by Humana to support its claim, and the HICNs of out-of-area beneficiaries identified by HCFA's GHP system.
Sample Unit	The sample unit was a Medicare beneficiary classified by HCFA as residing outside the plan's geographic service area.
Sample Design	A single stage random sample was used.
Sample Size	A probe sample of 30 beneficiaries was selected.
Method of Selecting Sample Items	Random numbers were generated and matched to the sequential numbers in the universe.
Estimation Methodology	Using the Department of Health and Human Services' Variables Appraisal Program, we calculated the mean and standard deviation of the sample.
How Results Will Be Reported	These results were used to determine the sample size for the population. Due to time constraints, we did not conduct further testing on the population and only reported on the specific items reviewed. We did not extrapolate our findings for this sample.

APPENDIX C

RECOMMENDED CLAIM AMOUNT

Claim Amount Before Adjustments	$24,181,729	
Retroactive SCC Adjustments Made by HCFA	($ 2,462,530)	
Net Amount Claimed by Humana		**$21,719,199**

Adjustments Made to the Claim

Issue 1: Errors in the Claim	($ 1,332,550)	
Issue 2: Reduction to the Claim	($10,163,774)	
Issue 3: Out-of-Area Beneficiaries Not Included in the Claim	($ 117,695)	
Issue 4: Overpayment for Special Status Beneficiaries	($ 573,884)	
Total Adjustments		**($12,187,903)**

Recommended Claim Amount[1] **$ 9,531,296**

[1] See APPENDIX C-1 for further detail regarding the summary of reductions made to Humana's underpayment claim.

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Claim Amount Before Adjustments				$24,181,729
Retroactive SCC Adjustments Made by HCFA (see Note 1)				($ 2,462,530)
Net Amount Claimed by Humana				$21,719,199
ADJUSTMENTS				
ISSUE 1:				
Errors in Claim:				
Duplicate Claims	($ 27,468)			
Beneficiaries Not Enrolled in Humana	($ 158,644)			
Beneficiaries Not Enrolled in Month Claimed	($1,146,438)			
Total Errors in Claim (see Note 2)			($1,332,550)	
ISSUE 2:				
Results of Samples Selected From the Claim:				
Underpayment Claimed	($27,863,089)			
LESS: Audit Finding - Humana Underpaid	($21,132,021)			
Adjustment to Claim (see Note 3)		($6,731,068)		
Overpayment Claimed	$ 5,022,516			
LESS: Audit Finding - Humana Overpaid	$ 8,455,222			
Adjustment to Claim (see Note 4)		($ 3,432,706)		
Net Reduction to Claim			($10,163,774)	
				($11,496,324)
ISSUE 3:				
Results of Samples Not Included in the Claim:				
Total Amount HCFA Should Have Paid for Selected Samples	$ 275,859			
LESS: Total Amount HCFA Paid	$ 393,554			
Net Overpayment (see Note 5)			($ 117,695)	
ISSUE 4:				
Other Adjustment:				
Original Claim Amount Submitted by Humana	$23,607,845			
LESS: Revised Claim Amt Submitted by Humana	$24,181,729			
Humana's Adjustment from Original Claim (see Note 6)			($ 573,884)	($ 691,579)
Total Adjustments				($12,187,903)
Recommended Claim Amount				$ 9,531,296

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Note 1

Humana claimed a net underpayment of about $21.7 million for the period October 1, 1991 through December 31, 1997. Humana had calculated a net underpayment of about $24.2 million and then reduced it by payment adjustments totaling about $2.5 million which were made by HCFA for SCC retroactive corrections. Member months with a retroactive adjustment were not removed from our sample populations because Humana could not identify the lump sum retroactive adjustment to individual member months.

Note 2

Humana inappropriately included $1,332,550 in its claim for duplicate claims and beneficiaries who were not enrolled in a Humana plan. Specifically, the claim contained:

< $27,468 for 431 duplicate claims;

< $158,644 for 2,630 claims involving beneficiaries with no enrollment history with Humana; and

< $1,146,438 for 15,186 claims involving beneficiaries who do have an enrollment history with Humana, but not for the particular month claimed.

Note 3

Based on our random sample of 148 claims from the underpayment population, we estimated that Humana was underpaid $21,132,021 rather than $27,863,089 claimed by Humana. Humana was paid $91,843,222 for the underpayment population, however, we estimated that the payment should have been $112,975,243.

Sample Results:

< 105 claims were valid for beneficiaries who resided in the service area;
< 24 claims were incorrect or unsupported (9 in area, 5 out of area, and 10 with insufficient documentation); and
< 19 claims involved retroactive adjustments and were treated as valid claims.

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Note 4

Based on our random sample of 115 claims from the overpayment population, we estimated that Humana was overpaid $8,455,222 rather than the $5,022,516 claimed by Humana. Humana was paid $37,544,913 for the overpayment population, however, we estimated that the payment should have been $29,089,691.

Sample Results:

- < 76 claims were valid for beneficiaries who resided in the service area;
- < 30 claims were incorrect or unsupported (5 in area, 8 out of area, and 17 with insufficient documentation); and
- < 9 claims involved retroactive adjustments and were treated as valid claims.

Note 5

We believe that the population of beneficiaries who were identified on HCFA's GHP system as out of area, but excluded from Humana's claim should be further evaluated and properly considered in settling the claim. According to Humana's methodology for constructing the original claim, it only included those beneficiaries where Humana's records and HCFA's records did not match. We constructed an out-of-area universe of claims not included in Humana's claim:

- < 702 beneficiaries identified as being out of area in Humana plans more than 3 consecutive months and

- < 213 beneficiaries were identified as being out of area in Humana plans for more than 12 consecutive months.

Medicare payments for the 213 beneficiaries totaled about $2.6 million. Our review of 30 beneficiaries randomly selected from this population, disclosed a net overpayment to Humana of $117,695. Of the 30 beneficiaries reviewed, 14 resided in the service area, 6 resided outside the service area and should have been disenrolled, and 3 resided out of area but were enrolled in Humana's commercial plan immediately prior to their Medicare entitlement so we accepted HCFA's payment. For the remaining seven beneficiaries, we could not determine where the beneficiary resided based on the supporting documentation provided by Humana.

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Note 6

The original underpayment claim Humana provided to HCFA totaled $23,607,845. Humana developed its claim by using a computer match which compared HCFA's SCC to Humana's SCC for each member month. If they were different, then Humana calculated an overpayment or underpayment. This methodology captured SCC differences for beneficiaries recorded as residing in area by both HCFA and Humana. Specifically, for the period between July 1, 1995 and December 31, 1997, Humana included in its claim a net overpayment of $573,884 for beneficiaries who were classified by both HCFA and Humana as residing inside the service area. To omit in-area SCC differences, Humana removed the overpayment of $573,884 from its original claim, and submitted a revised underpayment claim of $24,181,729. Humana identified this overpayment for these beneficiaries which occurred because the State and county code reported by HCFA was different than the one Humana had on file. We believe that the overpayment amount for in-area SCC differences should be accounted for as a reduction to the claim amount.

APPENDIX D

RECOMMENDED CLAIM AMOUNT BEFORE CONSIDERING ADDITIONAL DOCUMENTATION

Claim Amount Before Adjustments	$24,181,729	
Retroactive SCC Adjustments Made by HCFA	($ 2,462,530)	
Net Amount Claimed by Humana		**$21,719,199**

Adjustments Made to the Claim

Issue 1: Errors in the Claim	($ 1,332,550)	
Issue 2: Reduction to the Claim	($14,145,946)	
Issue 3: Out-of-Area Beneficiaries Not Included in the Claim	($ 117,695)	
Issue 4: Overpayment for Special Status Beneficiaries	($ 573,884)	
Total Adjustments		**($16,170,075)**

Recommended Claim Amount Before Considering Additional Documentation[1]	**$ 5,549,124**

[1] See APPENDIX D-1 for further detail regarding the summary of reductions made to Humana's underpayment claim.

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM BEFORE CONSIDERING ADDITIONAL DOCUMENTATION

				$24,181,729
Retroactive SCC Adjustments Made by HCFA (see Note 1)				($ 2,462,530)
Net Amount Claimed by Humana				$21,719,199
ADJUSTMENTS				
ISSUE 1:				
Errors in Claim:				
Duplicate Claims	($ 27,468)			
Beneficiaries Not Enrolled in Humana	($ 158,644)			
Beneficiaries Not Enrolled in Month Claimed	($1,146,438)			
Total Errors in Claim (see Note 2)			($1,332,550)	
ISSUE 2:				
Results of Samples Selected From the Claim:				
Underpayment Claimed	($27,863,089)			
LESS: Audit Finding - Humana Underpaid	($17,579,875)			
Adjustment to Claim (see Note 3)		($10,283,214)		
Overpayment Claimed	$ 5,022,516			
LESS: Audit Finding - Humana Overpaid	$ 8,885,248			
Adjustment to Claim (see Note 4)		($ 3,862,732)		
Net Reduction to Claim			($14,145,946)	
				($15,478,496)
ISSUE 3:				
Results of Samples Not Included in the Claim:				
Total Amount HCFA Should Have Paid for Selected Samples	$ 275,859			
LESS: Total Amount HCFA Paid	$ 393,554			
Net Overpayment (see Note 5)			($ 117,695)	
ISSUE 4:				
Other Adjustment:				
Original Claim Amount Submitted by Humana	$23,607,845			
LESS: Revised Claim Amt Submitted by Humana	$24,181,729			
Humana's Adjustment from Original Claim (see Note 6)			($ 573,884)	
				($ 691,579)
Total Adjustments				($16,170,075)
Recommended Claim Amount				$ 5,549,124

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Note 1

Humana claimed a net underpayment of about $21.7 million for the period October 1, 1991 through December 31, 1997. Humana had calculated a net underpayment of about $24.2 million and then reduced it by payment adjustments totaling about $2.5 million which were made by HCFA for SCC retroactive corrections. Member months with a retroactive adjustment were not removed from our sample populations because Humana could not identify the lump sum retroactive adjustment to individual member months.

Note 2

Humana inappropriately included $1,332,550 in its claim for duplicate claims and beneficiaries who were not enrolled in a Humana plan. Specifically, the claim contained:

< $27,468 for 431 duplicate claims;

< $158,644 for 2,630 claims involving beneficiaries with no enrollment history with Humana; and

< $1,146,438 for 15,186 claims involving beneficiaries who do have an enrollment history with Humana, but not for the particular month claimed.

Note 3

Based on our random sample of 148 claims from the underpayment population, we estimated that Humana was underpaid $17,579,875 rather than $27,863,089 claimed by Humana. Humana was paid $91,843,222 for the underpayment population, however, we estimated that the payment should have been $109,423,097.

Sample Results:

< 101 claims were valid for beneficiaries who resided in the service area;
< 28 claims were incorrect or unsupported (9 in area, 5 out of area, and 14 with insufficient documentation); and
< 19 claims involved retroactive adjustments and were treated as valid claims.

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Note 4

Based on our random sample of 115 claims from the overpayment population, we estimated that Humana was overpaid $8,885,248 rather than the $5,022,516 claimed by Humana. Humana was paid $37,544,913 for the overpayment population, however, we estimated that the payment should have been $28,659,665.

Sample Results:

- < 75 claims were valid for beneficiaries who resided in the service area;
- < 31 claims were incorrect or unsupported (5 in area, 8 out of area, and 18 with insufficient documentation); and
- < 9 claims involved retroactive adjustments and were treated as valid claims.

Note 5

We believe that the population of beneficiaries who were identified on HCFA's GHP system as out of area, but excluded from Humana's claim, should be further evaluated and properly considered in settling the claim. According to Humana's methodology for constructing the original claim, it only included those beneficiaries where Humana's records and HCFA's records did not match. We constructed an out-of-area universe of claims not included in Humana's claim:

- < 702 beneficiaries identified as being out of area in Humana plans more than 3 consecutive months and

- < 213 beneficiaries were identified as being out of area in Humana plans for more than 12 consecutive months.

Medicare payments for the 213 beneficiaries totaled about $2.6 million. Our review of 30 beneficiaries randomly selected from this population, disclosed a net overpayment to Humana of $117,695. Of the 30 beneficiaries reviewed, 14 resided in the service area, 6 resided outside the service area and should have been disenrolled, and 3 resided out of area but were enrolled in Humana's commercial plan immediately prior to their Medicare entitlement so we accepted HCFA's payment. For the remaining seven beneficiaries, we could not determine where the beneficiary resided based on the supporting documentation provided by Humana.

SUMMARY OF REDUCTIONS MADE TO THE UNDERPAYMENT CLAIM

Note 6

The original underpayment claim Humana provided to HCFA totaled $23,607,845. Humana developed its claim by using a computer match which compared HCFA's SCC to Humana's SCC for each member month. If they were different, then Humana calculated an overpayment or underpayment. This methodology captured SCC differences for beneficiaries recorded as residing in area by both HCFA and Humana. Specifically, for the period between July 1, 1995 and December 31, 1997, Humana included in its claim a net overpayment of $573,884 for beneficiaries who were classified by both HCFA and Humana as residing inside the service area. To omit in-area SCC differences, Humana removed the overpayment of $573,884 from its original claim, and submitted a revised underpayment claim of $24,181,729. Humana identified this overpayment for these beneficiaries which occurred because the State and county code reported by HCFA was different than the one Humana had on file. We believe that the overpayment amount for in-area SCC differences should be accounted for as a reduction to the claim amount.

DEPARTMENT OF HEALTH & HUMAN SERVICE

Health Care Financing Administration
Center for Health Plans and Providers
7500 Security Boulevard, C4-23-07
Baltimore, MD 21244

DATE: MAY 11 2001

FROM: Gary Bailey
Acting Director
Medicare Managed Care Group

SUBJECT: Comments on the Office of the Inspector General (OIG) Draft Report of the Review of Humana's $21.7 Million Underpayment Claim for Beneficiaries Classified as Residing Outside the Plan's Service Area (A-06-99-00060)

TO: Michael Mangano
Acting Inspector General

Thank you for the opportunity to comment on the OIG draft report on Humana's underpayment claim for $21.7 million, for the period 1991 through 1997, for beneficiaries residing outside the plan's service area. We have the following comments:

First, HCFA would like to take this opportunity to thank you for your support in reviewing Humana's claim. The basis of the review was to determine if Humana's documentation would support its claim. Your efforts identified additional cases that should have been included in Humana's claim, but were not and determined that documentation submitted by Humana was deficient in several areas.

Your draft report estimates that HCFA may owe Humana $9.5 million. HCFA has paid Humana an interim payment adjustment in the amount of $5.5 million, based on the OIG audit, since HCFA believes that Humana has documentation to support at least the $5.5 million. The payment was included in Humana's February 1, 2001 regular monthly payment. HCFA will continue its review of Humana's documentation to determine the final payment amount. In limiting the payment to $5.5 million, HCFA is working to resolve the issue but avoiding an overpayment to Humana, as the impact of the additional cases is unknown. HCFA is requiring that Humana provide documentation to support the $5.5 million payment.

Regarding your specific recommendations in order:

1. HCFA will pay the proper amount for this claim by requiring supporting documentation for each entry in the claim;

2. HCFA will process data for the additional beneficiaries that were not included in Humana's claim, but which you identified as additional cases;

3. HCFA will research this matter to determine how to resolve this issue; and

4. As stated above, HCFA will process data for the additional beneficiaries that were not included in Humana's claim.

Any questions on this matter may be directed to Yolanda Robinson at (410) 786-7627. Thank you.