DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

OCT 07 2005

Report Number: A-07-05-01013

Mr. Stephen D. Lynch, President
Health Net of California, Inc.
21281 Burbank Blvd.
Building B
Woodland Hills, California 91367

Dear Mr. Lynch:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicare Payments for Beneficiaries with Institutionalized Status at Health Net of California." A copy of this report will be forwarded to the HHS action official noted on the next page for his review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters in the report. We request that you respond to the HHS action official within 30 days. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-07-05-01013 in all correspondence.

Sincerely,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Officials:

Mr. Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services
75 Hawthorne Street, 4th Floor
San Francisco, CA 94105-3903

Ms. Cynthia Moreno
Acting Director, Medicare Plan Accountability Group
C4-21-14
7500 Security Boulevard
Baltimore, MD 21244-1850

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONALIZED STATUS AT HEALTH NET OF CALIFORNIA

Daniel R. Levinson
Inspector General

OCTOBER 2005
A-07-05-01013

Office of Inspector General

http://oig.hhs.gov

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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. Authorized officials of the awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) makes capitation payments at the beginning of each month to managed care organizations (MCO) for each enrolled Medicare beneficiary. The payment is generally higher for institutionalized beneficiaries. MCOs receive the enhanced rate for enrollees who are residents of Medicare- or Medicaid-certified institutions. Each month, MCOs are required to submit to CMS a list of enrollees meeting the institutionalized status requirements.

For the period July 2002 through December 2004, Health Net of California (Health Net) received payment at an enhanced rate for 1,546 beneficiaries it reported as institutionalized for at least 1 month.

OBJECTIVE

Our objective was to determine if Health Net reported beneficiaries as institutionalized for enhanced Medicare reimbursement pursuant to Federal laws and regulations.

SUMMARY OF FINDINGS

Health Net incorrectly reported 82 beneficiaries as institutionalized for enhanced Medicare reimbursement. As a result, Health Net received Medicare overpayments of $293,885. The errors occurred because Health Net did not have adequate internal controls to ensure that it correctly classified beneficiaries as institutionalized.

RECOMMENDATIONS

We recommend that Health Net:

- refund $293,885 to the Federal Government and

- ensure that its controls are adequate to correctly classify beneficiaries as institutionalized pursuant to Federal laws and regulations.

HEALTH NET'S COMMENTS

Health Net concurred with our findings and recommendations. The full text of Health Net's comments is included as an appendix.

INTRODUCTION

BACKGROUND

Medicare Managed Care

The Balanced Budget Act of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare+Choice (M+C) Program. Its primary goal was to provide a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans, or managed care organizations (MCO), have a network of providers under contract to deliver a health benefit package, which the Centers for Medicare & Medicaid Services (CMS) approves. Types of MCOs include health maintenance organizations, provider sponsored organizations, and preferred provider organizations.

CMS makes capitation payments at the beginning of each month to MCOs for each enrolled Medicare beneficiary. The payments are generally higher for institutionalized beneficiaries. MCOs receive the enhanced rate for enrollees who are residents of Medicare- or Medicaid-certified institutions (or the distinct part of an institution), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care, and swing-bed hospitals. Institutionalized status requirements contained in CMS's Medicare Managed Care Manual specify that the beneficiary (1) must be a resident of a qualifying facility for at least 30 consecutive days immediately prior to the month for which an institutionalized payment is being made and (2) must not be absent from the institution for more than 14 days due to hospitalization or therapeutic leave.

To receive enhanced payments for institutionalized beneficiaries, MCOs are required to submit to CMS a list of enrollees who meet institutionalized status requirements each month. The advanced payments paid to MCOs each month are adjusted by CMS to reflect the enhanced reimbursement for institutionalized status. For example, during 2004, the monthly advance payment for a 92-year-old woman residing in a non-institutional setting (with no other special status indicator) in California was $652. If the MCO had reported the beneficiary as institutionalized, CMS would have adjusted the payment to $1,004[1].

Health Net of California

Health Net of California (Health Net) began operations as a Medicare MCO (contract number H0562) in October 1992. For the period July 2002 through December 2004, Health Net received payment at an enhanced rate for 1,546 beneficiaries it reported as institutionalized for at least 1 month.

[1]This calculation does not take into account the risk adjustment method implemented January 1, 2000. This method adjusts the reimbursement according to health status and demographic factors. The inclusion of risk adjustment would not have a material impact on the overpayments.

OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

Our objective was to determine if Health Net reported beneficiaries as institutionalized for enhanced Medicare reimbursement pursuant to Federal laws and regulations.

SCOPE

We reviewed the 1,546 beneficiaries that Health Net reported as institutionalized and CMS paid at an enhanced rate for at least 1 month between July 2002 and December 2004.

We limited our review of internal controls to those controls necessary to meet the objective.

We performed our fieldwork at Health Net in Woodlands Hills, CA, during February 2005.

METHODOLOGY

To meet our objective, we reviewed applicable Federal criteria and the policies and procedures Health Net used to identify institutionalized beneficiaries.

To determine if payments had been made at an enhanced rate, we accessed CMS's Group Health Plan database and identified 1,268 beneficiaries classified as institutionalized during our audit period. Based on data from Health Net's system and retroactive adjustment letters Health Net submitted to CMS, we added 278 beneficiaries who Health Net retroactively reported as institutionalized. For the 1,546 individuals, we then used the beneficiary history information from CMS's Managed Care Option Information System, as of February 2005, to identify the months in which Health Net reported them as institutionalized to CMS during the audit period.

Health Net provided the names and addresses of the institutions in which the 1,546 beneficiaries resided. We contacted 59 institutions to verify the institutionalized status of 535 beneficiaries for the months that Health Net received the enhanced rate. We selected 28 institutions that had at least 10 beneficiaries. We also selected 27 institutions because Health Net could not initially provide documentation demonstrating which beneficiaries resided at the institutions and for how long. In addition, we selected four institutions that were not certified, had lost certification, or had a distinct part of its institution that was not certified.

We reviewed hospital admission and discharge dates obtained from Health Net and from the institutions to determine if any of the beneficiaries were absent for more than the 14-day limit as specified in CMS's Medicare Managed Care Manual.

We then calculated overpayments for each incorrectly reported beneficiary, without regard to risk adjustment factors (described in footnote 1), by subtracting the non-institutionalized payment that Health Net should have received from the institutionalized payment actually received.

Some of the overpayments occurred for periods outside the 3-year limit in which CMS can make a retroactive payment adjustment (positive or negative). According to the Medicare Managed Care Manual, CMS can retroactively adjust payments for up to 3 years from the date it receives data indicating a change is needed to a Medicare enrollee's record. The overpayments that we identified for periods beyond the 3-year limit were for retroactive payment adjustment requests that CMS received from Health Net during 2003-2004.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Health Net incorrectly reported 82 beneficiaries as institutionalized for enhanced Medicare reimbursement. As a result, Health Net received Medicare overpayments of $293,885. The errors occurred because Health Net did not have adequate internal controls to ensure that it correctly classified beneficiaries as institutionalized.

INSTITUTIONALIZED STATUS REQUIREMENTS

CMS's Medicare Managed Care Manual, chapter 7, states that MCOs can classify beneficiaries as institutionalized if the beneficiaries:

- resided in a Medicare- or Medicaid-certified institution, or distinct part of the institution, for at least 30 consecutive days immediately prior to the month for which an institutionalized payment is made; and

- were not absent from the institution for more than 14 days due to hospitalization.

BENEFICIARIES INCORRECTLY CLASSIFIED AS INSTITUTIONALIZED

Health Net incorrectly classified 82 beneficiaries as institutionalized:

- 81 of whom did not reside in a Medicare- or Medicaid-certified institution, or distinct part of the institution, for at least 30 consecutive days immediately prior to the month for which an institutionalized payment was made; and

- 1 who was absent from the institution for more than 14 days due to hospitalization.

The errors occurred because Health Net did not have adequate internal controls to ensure that it correctly classified beneficiaries as institutionalized. Specifically, Health Net's policies and procedures for non-certified beds did not comply with Federal laws and regulations. The policies and procedures stated that beneficiaries residing in a non-certified portion of an institution should be classified as institutionalized. In addition, Health Net did not always detect when beneficiaries were discharged from institutions or when institutions lost certification.

As a result, Health Net received $293,855 that did not qualify for the Medicare enhanced rate.

RECOMMENDATIONS

We recommend that Health Net:

- refund $293,885 to the Federal Government and
- ensure that its controls are adequate to correctly classify beneficiaries as institutionalized pursuant to Federal laws and regulations.

HEALTH NET'S COMMENTS

Health Net concurred with our findings and recommendations. Specifically, Health Net stated that it would:

- submit retroactive adjustments to correctly classify the 82 beneficiaries' institutionalized status,
- reeducate its providers about their reporting responsibilities,
- retrain its staff how to classify beneficiaries as institutionalized, and
- revise its policies and procedures that address the identification of institutionalized beneficiaries.

Health Net's comments are included as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We commend Health Net for its efforts to address the findings and recommendations.

APPENDIX

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August 26, 2005

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Patrick Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Offices of Audit Services – Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Dear Mr. Cogley:

This letter is Health Net of California's response to your letter dated August 3, 2005, that included the draft report entitled "Review of Medicare Payments for Beneficiaries with Institutionalized Status at Health Net of California."

OIG Comments

Health Net incorrectly classified 82 beneficiaries as institutionalized:

- 81 of whom did not reside in a Medicare- or Medicaid-certified institution, or distinct part of the institution, for at least 30 consecutive days immediately prior to the month for which an institutionalized payment was made; and
- 1 who was absent from the institution for more than 14 days due to hospitalization.

HNCA Comments

- Concur – All 81 have been corrected and submitted for retroactive adjustment.
- Concur – Health Net of California has corrected this record and is preparing a retroactive adjustment for submission.

OIG Recommendations

We recommend that Health Net:

- refund $293,885 to the Federal Government and
- ensure that its controls are adequate to correctly classify beneficiaries as institutionalized pursuant to Federal laws and regulations.

HNCA Response

Health Net of California has taken these steps to address the OIG recommendations:

- Concur – 81 records have been corrected and submitted for retroactive adjustment.
- One final record has been corrected and is being submitted as a retroactive adjustment.
- Health Net of California is preparing a provider communication for distribution on August 30, 2005. This communication will reeducate providers on the CMS definition of Institutionalized Members. This also reminds the providers of their reporting responsibilities.
- The Staff responsible for auditing and processing the monthly institutional status of members has also been retrained on the correct procedure and CMS definition of institutional status.
- Health Net of California revised its Policy and Procedures (P&P) and Step-by-Step processes addressing how to identify members that qualify as institutionalized.

If you have any questions about this response, please do not hesitate to contact me at (818) 676-7942 or by e-mail at jeanette.haber@healthnet.com.

Sincerely,

Jeanette Haber

Jeanette Haber
Manager, Compliance & Reporting
Health Net, Inc.