

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
FOR BENEFICIARIES WITH
INSTITUTIONAL STATUS**

MARICOPA COUNTY HEALTH PLAN



JUNE GIBBS BROWN
Inspector General

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A-05-97-00018

Office of Inspector General

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OFFICE OF
INSPECTOR GENERAL

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Gail Silverstein, Vice President
Maricopa County Health Plan
2516 East University Drive
Phoenix, Arizona 85034

Dear Ms. Silverstein:

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 Maricopa County Health Plan under Medicare risk contract H0350 were appropriate for beneficiaries reported as institutionalized.

We found that Medicare payments to Maricopa 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 Maricopa's procedures for verifying the institutional status of its beneficiaries.

INTRODUCTION

BACKGROUND

Maricopa County participates as a Medicare risk-based health maintenance organization (HMO) through contract H0350. An 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 1995 HMOs received a monthly advance payment of \$445 for each non-Medicaid female beneficiary, age 80 to 84, residing in a non-institutional setting in Maricopa County, Arizona. The Medicare payment to HMOs for a similar beneficiary living in an institutional setting was \$833. The monthly advance payment of \$445 would have been adjusted to \$833 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 Maricopa were appropriate for beneficiaries reported as institutionalized. We also conducted a review of Maricopa's internal controls, focusing on procedures for verifying the institutional status of Medicare beneficiaries.

A simple random sample of 100 was selected from a universe of 1,211 Medicare beneficiaries reported as institutionalized by Maricopa during the period October 1994 through September 1996. From Maricopa, 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 Maricopa 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 Maricopa should have received from the institutional payment actually received.

Our audit field work was performed February through September 1997 at Maricopa offices in Phoenix, Arizona; HCFA offices in San Francisco, California; and our field office in Columbus, Ohio.

RESULTS OF AUDIT

Medicare payments made to Maricopa for beneficiaries reported as institutionalized were generally correct. The dates of residency obtained from institutional facilities support Maricopa's claims of institutional status, except for minor errors. Medicare overpayments resulting from five beneficiaries incorrectly reported as institutionalized were immaterial.

The staff at Maricopa was generally able to accurately verify the institutional status of the Medicare beneficiaries enrolled in the HMO. Maricopa's procedures require that all institutional facilities be contacted by fax machine or telephone prior to submitting the monthly list of institutionalized members to HCFA. The facilities are provided the names of

beneficiaries previously identified as residents, and are asked to verify that the beneficiaries have not been discharged.

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-05-97-00018 in all correspondence relating to this report.

Sincerely yours,



Paul Swanson
Regional Inspector General
for Audit Services