Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS

# AETNA U.S. HEALTHCARE KING OF PRUSSIA, PENNSYLVANIA


**JANET REHNQUIST**
Inspector General

**JULY 2002**
**A-05-01-00090**

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

REGION V
OFFICE OF
INSPECTOR GENERAL

July 23, 2002

Common Identification Number: A-05-01-00090

Felicia Norwood, Regional Manager
Mid Atlantic Region
Aetna U.S. Healthcare
2201 Renaissance Boulevard
P.O. Box 61516
King of Prussia, Pennsylvania 19406

Dear Ms. Norwood:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicare Payments for Beneficiaries with Institutional Status." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contactors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-01-00090 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**
Director of Health Plan Benefits Group
C4-23-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Dear Ms. Norwood:

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 Aetna (Contract H3951) were appropriate for beneficiaries reported as institutionalized.

We determined that Aetna received Medicare overpayments totaling $87,516 for 90 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. Institutional status requirements specify that a beneficiary must be a resident of a qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month. The 90 beneficiaries included 48 that had admittance or discharge dates during the 30-day residency period and 42 beneficiaries residing in facilities not certified for Medicare or Medicaid.

## INTRODUCTION

### BACKGROUND

The Balanced Budget Act of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare + Choice (M+C) Program. Its primary goal is to provide a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans have a network of providers under contract to deliver a health benefit package that has been approved by the Centers for Medicare and Medicaid Services (CMS). Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. Beneficiaries eligible to enroll in the new M+C Plans must be entitled to Part A and enrolled in Part B.

The CMS makes monthly advance payments to managed care organizations (MCOs) at the per capita rate set for each enrolled beneficiary. Medicare pays a higher monthly rate to MCOs for beneficiaries who are institutionalized. The MCOs receive the enhanced institutional rate for enrollees who are residents of Medicare or Medicaid certified institutions such as: skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally

retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care hospitals, and swing-bed hospitals. Institutional status requirements, outlined in CMS's Operational Policy Letter #54 (OPL #54), specify that a beneficiary must be a resident of a qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The CMS requires MCOs to submit a monthly list of enrollees meeting institutional status requirements. The advance payments received by MCOs each month are subsequently adjusted by CMS to reflect the enhanced reimbursement for institutional status. During 2000, MCOs in the Pittsburgh, Pennsylvania area received a monthly advance payment of $548 for each 75 years old female beneficiary, residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to $1,123.

**SCOPE OF AUDIT**

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Aetna (Contract H3951) were appropriate for beneficiaries reported as institutionalized during the period January 1, 1998 through December 31, 2000. This review was performed as part of our National review of institutional status issues.

In 1998, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. Our audit verified that Aetna was complying with CMS's current definition of an institutional facility. We reviewed the Plan's records documenting where 611 beneficiaries with institutional status resided to determine if beneficiaries were in qualifying Medicare or Medicaid certified facilities. The Medicare overpayment for each incorrectly reported beneficiary was calculated by subtracting the non-institutional payment that Aetna should have received from the institutional payment actually received. We reviewed the institutional residency documentation for all beneficiaries reported as institutionalized during our audit period, placing no reliance on the Plan's internal controls. Our limited review of internal controls focused on procedures for verifying institutional residency.

Our field work was performed during July and November 2001, and April 2002, at Aetna's offices in King of Prussia, Pennsylvania and in our field office in Columbus, Ohio.

## RESULTS OF AUDIT

We determined that Aetna received Medicare overpayments totaling $87,516 for 90 beneficiaries incorrectly reported as institutionalized. Institutional status requirements in OPL #54 specify that a beneficiary must be a resident of a qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month. The 90 beneficiaries included 48 that had admittance or discharge dates during the required 30-day residency period. These beneficiaries were incorrectly reported as institutionalized because of inaccurate residency data provided by the nursing facilities and clerical errors by Aetna staff.

Aetna also incorrectly reported 42 beneficiaries as institutionalized while they were residents of non-certified facilities. In 1998, CMS changed the definition of an institutional facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities that provide no medical care. During the early part of our audit period, Aetna staff did not always verify that institutional facilities were certified for Medicare or Medicaid before reporting the beneficiaries as institutionalized.

Aetna's current internal control procedures for verifying the institutional residency of Medicare beneficiaries enrolled in the Plan are adequate. Aetna staff members contact the institutional facilities monthly to verify each beneficiary's residency. The current procedures were implemented in August 2000, and we identified only one beneficiary incorrectly reported as institutionalized after the new verification process began. The difficulties identified during our review have been corrected.

**RECOMMENDATIONS**

We recommend that Aetna refund the identified overpayments totaling $87,516. We are making no recommendations related to internal controls because Aetna's current procedures are adequate.

## AUDITEE COMMENTS AND OIG RESPONSE

In their May 16, 2002 response to our draft report, Aetna officials stated that they did not agree with the amounts questioned and provided additional documentation, not available during our field work.

After reviewing the additional documentation, we concluded that 305 of the 459 member/months questioned in the draft report were allowable, but that 23 other member/months should be added to the questioned payments. The Aetna officials agreed with this conclusion and asked that we adjust questioned costs in the final report to reflect the revised calculation of unallowable member/months. We have made the necessary adjustments in this final report.

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Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

# APPENDIX

2001 Renaissance Boulevard F244
P.O. Box 61516
King of Prussia, PA 19406-0916
Tel: 484-322-5187 Fax: 484-322-2100
E-Mail: sedlakmm@aetna.com

May 16,2002

Mr. David Shaner
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
277 West Nationwide Boulevard, Suite 225
Columbus OH 43215

*Via fax and overnight mail*

**Re: Common Identification Number: A-05-01-00090; Contract H3951**

Dear Mr. Shaner:

This is in response to the draft report dated February 25, 2002 issued by the Office of Inspector General for the Department of Health and Human Services (the "OIG"), relating to the OIG's review of Medicare payments for beneficiaries reported as institutionalized to the Centers for Medicare and Medicaid Services ("CMS") by Aetna U.S. Healthcare, Inc. (H3951) ("Aetna") between January 1, 1998 through December 31, 2000 (hereinafter referenced as the "Draft Report").

Per our letter of May 8, 2002 the OIG granted Aetna an extension to respond to the Draft Report until May 16, 2002. We thank you for this extension and we offer the following comments in response to the OIG's review and resulting recommendations outlined in the Draft Report.

I. RESULTS OF AUDIT & RECOMMENDATIONS

On page 2 of the Draft Report, the OIG states the following:

> *We determined that Aetna received Medicare overpayments, totaling $220,188, for 199 beneficiaries incorrectly reported as institutionalized. Aetna staff could not provide institutional residence information for 188 beneficiaries included in our review. Adequate controls were not in place to ensure that residency was verified during the audit period. During 1998, Aetna incorrectly reported 11 additional beneficiaries as institutionalized, while they were residents of non-qualifying domiciliary facilities. Aetna did not report any residents of non-certified facilities as institutionalized in the years 1999 and 2000.*

Based on our review, we believe that the 199 beneficiaries identified by the OIG above represent 459 member/months. The OIG recommends in the Draft Report that Aetna refund a total of $220,188 in overpayments associated with these 459 member/months.

Following the issuance of the Draft Report, the OIG conducted a document review at Aetna's offices during the week of April 22, 2002 in connection with this audit. We understand that during this on-site review, the OIG identified an additional 23 member/months that it asserts Aetna incorrectly reported for institutional payment. The OIG has not yet estimated the amount of any overpayments made to

Aetna for these 23 member/months. Therefore, to summarize the results of the OIG's review, we understand that the OIG has identified 482 total member/months that the OIG believes Aetna incorrectly reported for institutional payment during the audit period of January 1, 1998 through December 31, 2000.

Aetna has reviewed these 482 member/months and we do not concur with the OIG's determination regarding the number of member/months incorrectly reported for institutional payment. More specifically, of the 482 member/months identified by the OIG, Aetna located institutional residence information confirming that 305member/months were, in fact, correctly reported by Aetna to CMS for institutional payment. During the OIG on-site review at Aetna last month, we supplied David Shaner, a Senior Auditor with the OIG's Office of Audit Services, with this additional institutional residence information. On April 26, 2002, the Senior Auditor provided Aetna with a written summary prepared by the OIG that reflects the OIG's review of this additional institutional residence information, and we believe that this written summary confirms our position that Aetna correctly reported 305of the 482 total member/months identified as errors by the OIG as part of this institutional audit.

Based on the above-referenced information, Aetna believes that the overpayment amount estimated by the OIG in the Draft Report is incorrect and should be decreased to reflect that 305 of the 482 total member/months identified by the OIG were correctly reported by Aetna for institutional payment. Please advise us when this adjustment is made to the overpayment amount and we further request that the final report reflect this revised determination.

II. INTERNAL CONTROLS

In the Draft Report, the OIG states that: "Since Aetna's current procedures are adequate, we are making no recommendation related to internal controls." Aetna concurs with the OIG's finding that Aetna's current verification procedures for institutional residency are adequate.

* * * *

If you have any further questions or concerns regarding the above, please do not hesitate to contact me at 301-636-1019.

Sincerely,

Martina M. Sedlak

Martina Sedlak
Regional Compliance Director