

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

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

**BLUECROSS OF NORTHEASTERN  
PENNSYLVANIA  
WILKES-BARRE, PENNSYLVANIA**



**JANET REHNQUIST**  
Inspector General

**MAY 2002**  
**A-05-01-00086**



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601  
May 22, 2002

REGION V  
OFFICE OF  
INSPECTOR GENERAL

Common Identification Number: A-05-01-00086

Denise Cesare  
President & CEO  
BlueCross of Northeastern Pennsylvania  
19 North Main Street  
Wilkes-Barre, Pennsylvania 18711

Dear Mrs. Cesare.

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 the 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 are made available to the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-01-00086 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "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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Denise Cesare  
President & CEO  
Bluecross of Northeastern Pennsylvania  
19 North Main Street  
Wilkes-Barre, Pennsylvania 18711

Dear Mrs. Cesare.

This final 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 Bluecross (Contract H3953) were appropriate for beneficiaries reported as institutionalized.

We determined that Bluecross received Medicare overpayments totaling \$62,432 for 99 beneficiaries incorrectly reported as institutionalized during the period January 1, 1998 through December 31, 2000. Forty-four of the beneficiaries did not meet the 30-day residency requirement for the month claimed in an institution. For 37 other beneficiaries, there was no evidence of institutional residency for the month(s) questioned. The remaining 18 beneficiaries were residents of domiciliary 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 specify that the beneficiary must be a resident of the qualifying facility for a minimum of 30 consecutive days immediately prior to the first day of the current reporting month.

The MCOs are required to submit to CMS 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 Wilkes-Barre, Pennsylvania area received a monthly advance payment of \$396 for each 69 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 \$79.1.

## **SCOPE OF AUDIT**

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if payments to Bluecross (Contract H3953) 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 Bluecross was complying with CMS's current definition of an institutional facility. We reviewed the Plan's records documenting where 1,115 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 Bluecross 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 June 2001 at the Bluecross offices in Wilkes-Barre, Pennsylvania and through September in our field office in Columbus, Ohio.

## **RESULTS OF AUDIT**

We determined that during our audit period, Bluecross received Medicare overpayments totaling \$62,432 for 99 beneficiaries incorrectly reported as institutionalized. 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. Of the 99 beneficiaries, 44 had admittance or discharge dates during the 30-day residency period for months that Bluecross received payment at the enhanced institutional rate. The institutional payments for 37 additional beneficiaries were questioned because Bluecross was unable to document any institutional residency for the reporting month under review.

In addition, Bluecross incorrectly reported 18 beneficiaries as institutionalized while they were residents of non-certified domiciliary 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.

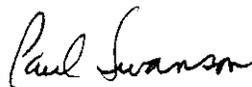
## **RECOMMENDATIONS**

We recommend that Bluecross refund the identified overpayments totaling \$62,432 to CMS. We are making no recommendations related to internal controls because Bluecross (Contract H3953) is no longer participating in the Medicare Program.

## **AUDITEE COMMENTS AND OIG RESPONSE**

In their February 4, 2002 response to our draft report, Bluecross officials provided additional information about the institutional residency of 148 beneficiaries for which institutional payments were previously questioned. After verifying the additional information, we removed the questioned amounts for 127 beneficiaries from our findings. The additional information provided for the remaining beneficiaries did not change our earlier determination, that the beneficiaries did not meet institutional status requirements. BlueCross's complete response is included with this report as Appendix A.

Sincerely yours,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson  
Regional Inspector General  
for Audit Services

# **APPENDIX**

19 North Main Street

Wilkes-Barre

Pennsylvania

18711



February 4, 2002

Mr. David Shaner, Senior Auditor  
HHS/OIG Office Of Audit Services  
277 West Nationwide Boulevard  
Suite 225  
Columbus, OH 43215

Re: Draft Report. Common Identification No. A-05-01-00086

Dear Mr. Shaner:

Enclosed are the results of our review of the exceptions noted in the draft Report dated December 19, 2001 covering your review of Medicare payments for beneficiaries with institutional status at Blue Cross of Northeastern Pennsylvania under the Medicare+Choice program during the period January 1, 1998 through December 31, 2000.

Enclosed you will find three spreadsheets. The first spreadsheet which you provided lists the exceptions noted in the draft Report. We have added two additional columns that indicate whether the Plan agrees or disagrees with the each specific exception and a brief explanation as to our conclusion. The second spreadsheet lists those exceptions where we disagree with your conclusion, and these exceptions are accompanied by supporting documentation to provide you with the detail for our analysis. We would ask that you review our detail and if you are in agreement, adjust the draft Report accordingly. The third spreadsheet lists the exceptions where we are in agreement with your analysis. We have provided some additional detail support for your information based on our review of these exceptions.

Should you have any questions, please contact me. Thank you

Sincerely,

Joseph F. Bardinelli  
General Auditor & Corporate Compliance Officer